Governmental Public Health's Capacity for Community Collaboration in Oregon

by

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Abstract

Persistent health inequities and changes to the healthcare delivery system ushered in by the Affordable Care Act led to calls for a complementary transformation of the public health system that emphasizes cross-sector collaboration and community engagement. Governmental public health transformation in many states has centered the adoption of a national Foundational Public Health Services (FPHS) framework, which describes a minimum package of public health programs and workforce capabilities that should be present in every community. The Oregon legislature codified the foundational public health services in state law in 2015 as a process of "Public Health Modernization" and dedicated funding to the state Oregon Health Authority Public Health Division (OHA-PHD) and Local Public Health Authorities (LPHAs) for implementation. The OHA-PHD further operationalized the FPHS framework in a "Public Health Modernization Manual" that describes the roles of state and local government in fulfilling each program and workforce capability of the FPHS framework. More recently, Public Health Modernization funding was allocated to community-based organizations (CBOs), recognizing the essential role of culturally-specific outreach and education in connecting historically-marginalized communities with vaccines and wraparound supports during the COVID-19 pandemic response. However, Public Health Modernization has historically been an endeavor of governmental public health, so the inclusion of CBOs as funded partners requires careful consideration of how public health departments can effectively collaborate with community.

This study used focus groups and key informant interviews with OHA-PHD, LPHA, and CBO staff to characterize the extent to which partners are collaborating on Public Health Modernization implementation. Focus group and key informant interview data collection and analysis were guided by the Framework for Aligning Sectors, which specifies shared purpose,

governance, data and measurement, and financing as core components of effective cross-sector collaboration. Shared communications was also explored as a fifth core component of effective collaboration based on the study literature review. The study also used a modified Delphi survey to explore the distinct but complementary roles of each partner in advancing the equity workforce capability of the FPHS framework.

Study results inform how governmental public health can improve collaboration with CBOs for transformation efforts. Focus groups and key informant interviews suggest several changes to the Public Health Modernization shared purpose statement, governance structure, funding approach, accountability metrics framework, and investments in communications to better align governmental public health and community partners and center equity. Delphi survey results suggest modifications to existing state and local roles described in Oregon's Public Health Modernization Manual and the addition of new, complementary roles for CBOs to advance the equity workforce capability. Study results also confirm the use of the Framework for Aligning Sectors as relevant to the study of collaboration between governmental public health and CBOs for systems change initiatives and suggest potential refinements to the FAS, including the addition of the shared communications core component. Furthermore, the study confirms hypotheses from institutional theory and social movement theory, including the potential for "path-breaking" behavior that deviates from institutional norms and structures when system disruptions occur that change the balance of power. Lastly, the study describes how policymakers can support the equitable implementation of FPHS by ensuring that a focus on population-level health improvement does not come at the cost of decreasing health inequities.

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List of Abbreviations

CBO	Community-based organization
CCO	Coordinated Care Organization
CLHO	Conference of Local Health Officials
COC	Communities of Color
DASH	Data Across Sectors for Health
EPHS	Essential Public Health Services
FAS	Framework for Aligning Sectors
FPHS	Foundational Public Health Services
HECR	Health equity and cultural responsiveness
LPHA	Local Public Health Authority
OHA-PHD	Oregon Health Authority Public Health Division
OPP	Other priority populations
PHAB	Public Health Advisory Board

Chapter 1. Introduction and Problem Statement

The Social Determinants of Health

In the United States, public health interventions and high-quality clinical care have significantly improved the health of the general population, including a 10-year increase in life expectancy at birth since the 1950s.[1] These improvements, however, have not equally benefitted all groups within the population. For example, racial and ethnic inequities persist across many health outcomes and factors that increase the risk for developing disease, including life expectancy, infant mortality, and exposure to environmental pollutants.[1] In addition, life expectancy between people with the highest and lowest incomes has been found to differ by as much as 20 years in neighborhoods just a few miles apart, strongly suggesting the influence of social and structural drivers of health in creating inequities.[1]

Health inequality refers to differences in the health of individuals and groups, as in rank, amount, or quality.[2] In contrast, health inequity contextualizes those inequalities as stemming from unjust policies, practices or institutions and are therefore avoidable and unnecessary.[2] Health inequities are health differences that are "socially produced, systematic in their distribution across the population, and unfair," which implies not an objective description of health status but rather an appeal to ethical norms and values.[2] Taken together, health equity is "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[3,4]

Advancing health equity requires not only equitable access to healthcare but also efforts outside of the healthcare system to address broader social well-being. The social determinants of health (SDH) are the non-medical factors that influence health outcomes, including educational attainment, employment, access to transportation, food security, housing stability, and social

cohesion.[4] Broadly, the social determinants of health are the social, political and economic conditions in which people are born, live, work, play and socialize, and are shaped by distributive public policies that allocate financial, human and physical resources.[5]

The structural determinants of health inequities include the socioeconomic and political context determined by forms of governance, macroeconomic policies, social policies, public policies, and culture/societal values. These structures influence an individual's socioeconomic position based on characteristics such as gender, race/ethnicity, education, occupation, and income, which results in differing material circumstances, behaviors, and biologic and psychosocial factors.[6] Structural interventions attempt to change the social, physical, economic, or political environments and target factors such as economic instability, limited educational and employment opportunity, societal racism, systemic discrimination, and lack of resources.[7] Structural inequities also reflect an imbalance in power that consistently benefits some over others. Power is described in brief by Martin Luther King Jr. as "the ability to achieve a purpose" and is considered by some health equity scholars as the most fundamental determinant of health inequity.[8] Given structural inequities are highly aligned with discriminatory policy legacies (e.g., redlining, racial bias in criminal legal system),[9] dismantling policy-based structural inequity will require a more democratic approach to health improvement that prioritizes community power-building to engage in decision-making.[10]

Although many studies suggest that the SDH account for between 30-55% of health outcomes,[4] social and structural factors rarely appear to be the target of interventions aimed at reducing inequity. Rather, interventions are more frequently aimed at the accessibility of health care (e.g., increasing access to healthcare insurance) and at behavioral "intermediary" determinants that target only one determinant and without relation to other intermediary factors

or to the deeper structural factors.[1,4] This focus is reinforced by the biomedical understanding of health and technocratic approaches to developing population health interventions that often ignore a community's socioecological context as a point of intervention in favor of factors that can be more easily researched, measured, and reported. Givens et al. describe how the influence of topics such as gerrymandering and the #MeToo movement on population health do not fall neatly within logic models for public health research or community health indicators, and encourage an expansion of current conceptual frameworks, research inquiry, and metrics to support the movement toward health equity.[8] The intermediary determinants of health include material circumstances (e.g., housing quality), psychosocial circumstances (e.g., social support), behavioral (e.g., nutrition, tobacco), and biological or genetic factors.[4] The current US National Prevention Strategy, developed in 2011, reflects this focus on behavioral intermediary determinants; while one of four strategic directions is eliminating health disparities, all nine of the underlying policy priorities focus on intermediary determinants, including tobacco-free living, prevention of substance use disorders and excessive alcohol use, healthy eating, active living, and mental and emotional well-being.[11] While public health interventions across the continuum of care are warranted, overlooking broader structural factors in population health allow inequities to persist.

The focus on intermediary determinants is often justified as a health equity approach because these determinants are distributed disproportionately in communities who experience marginalization and thus are disproportionately impacted by associated poor health outcomes.[4] While some intermediary determinants' connection to health outcomes is clearer – such as smoking rates – focusing on such measures without a broader strategy to address the SDH is problematic in that the means can easily become the end, subsequently obscuring the ultimate

outcomes that population health improvement seeks.[2] Benach et al. note the limitations of approaches that do not account for existing inequalities; public policies targeting behavioral determinants and implemented universally will have differential effects on the population with individuals experiencing systematic advantage likely to benefit to a greater extent than groups who experience systematic disadvantage (or oppression).[12] The result is a widening of disparities, and the persistence of inequities. Indeed, policies associated with positive trends in health determinants (e.g., decline in smoking) have also been associated with persistent socioeconomic disparities in the distribution of these determinants (marked socioeconomic differences in smoking rates).[4] Without understanding the social-structural conditions that expose people to individually-based determinants, interventions will fail to decrease inequities because they target behaviors resistant to change for reasons not acknowledged by the policy approach and do not build community power to dismantle policy-based structural inequities.[13]

Public Health System Transformation

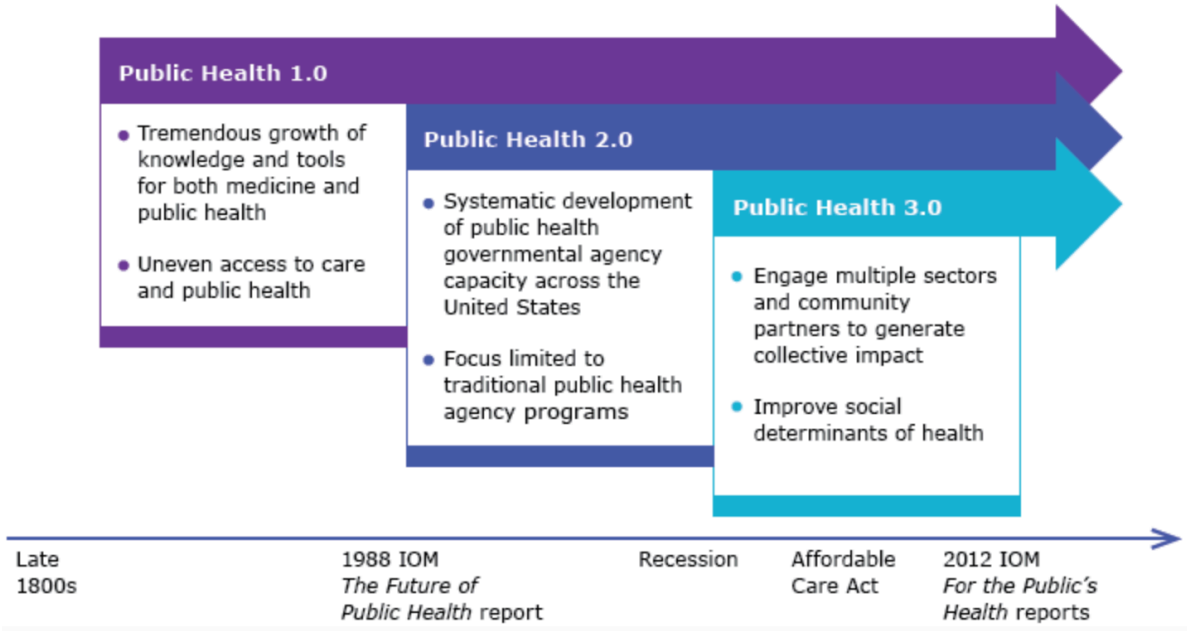
The World Health Organization (WHO) offers several key strategies to achieve health equity through action on the social determinants of health, including: pursuing structural as well as intermediary determinants of health; intersectoral action; and social participation and empowerment.[4] Under the Affordable Care Act (ACA), the US healthcare system has aspirations to transform from one focused on costly, fragmented care to one that is affordable, coordinated, and integrated into allied community efforts.[1] More hospitals and health care systems are transitioning from retrospective fee-for-service models to prospective value-based purchasing and alternative payment models that could better facilitate realigning incentives to community need. More health care systems are also shifting from reactive care focused on treating acute

illness toward proactive care centered on preventing chronic conditions. In addition, health care systems can focus their community benefit dollars on long-term strategies to promote health equity, including multisectoral efforts in housing and food security.[14,15]

However, healthcare systems alone cannot address all the root causes of health and health inequities; thus, a complementary evolution in governmental public health is needed. While public health of the late 19th century through much of the 20th century met the demands of communicable disease control and public health of the second half of the 20th century focused on developing and implementing performance standards for governmental public health agencies, today's public health system requires an enhanced and broadened practice that goes beyond traditional public department functions and programs to respond to increasingly complex public health problems.[1]

Transformation of the public health system has been conceptualized nationally as "Public Health 3.0" and emphasizes multisector partnerships and community engagement to address the social determinants of health (**Figure 1.1**).[1] Recommendations to achieve Public Health 3.0 include training the public health workforce and students on the "upstream" social determinants of health; engaging public and private sector community stakeholders in "vibrant, structured" cross-sector partnerships to foster shared vision, funding, services, governance and collective action; ensuring more granular (i.e., subcounty), real-time, and reliable population health data are accessible to communities for local decision-making; developing clear metrics of success for prevention initiatives that target social determinants of health and enhance equity; and exploring innovative funding models, like blending and braiding funds from multiple sources, rather than being constrained by siloed, categorical funding.[1]

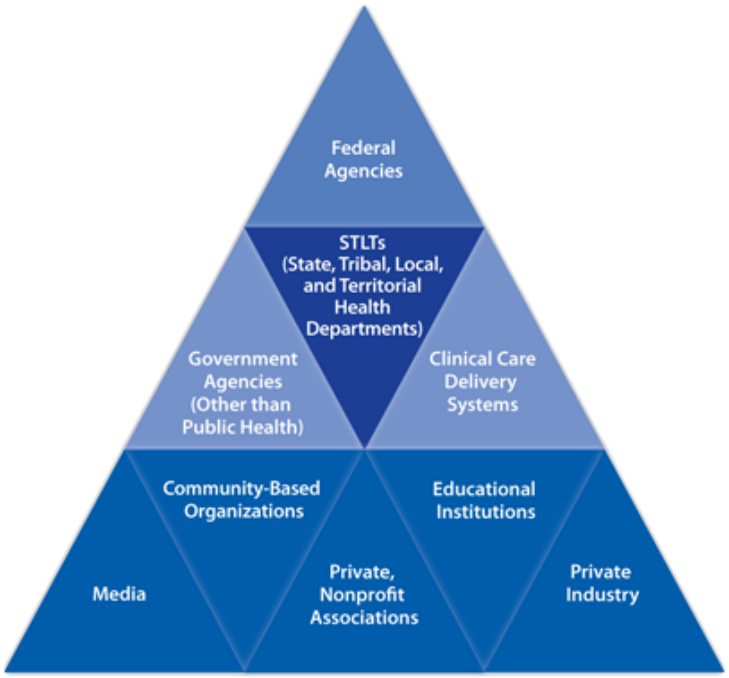
Figure 1.1. Evolution of public health practices[1]



Public health systems are commonly defined as all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.[16] Entities within these local networks can have different roles, relationships, and interactions depending on the jurisdiction. The US public health system is typically a network of government agencies, clinical care delivery systems, community-based organizations (CBOs), educational institutions, private businesses, and other organizations working together to support the health and well-being of those residing in the US. (**Figure 1.2**).[17] The governmental role in public health consists of three functions: assessment, policy development, and assurance, as defined by the 10 Essential Public Health Services.[18] The *assessment* function includes monitoring population health; and investigating, diagnosing, and addressing health hazards and root causes of health. The *policy development* function includes communicating effectively to inform and educate the general public; strengthening, supporting, and mobilizing communities and partnerships; creating,

championing, and implementing policies, plans and laws; and utilizing legal and regulatory actions. Lastly, the *assurance* function includes enabling equitable access to public health services; building a diverse and skilled workforce; improving and innovating through evaluation, research, and quality improvement; and building and maintaining a strong organizational infrastructure for public health.[18]

Figure 1.2. Components of the public health system[17]



These functions are carried out under a "federalist" system of government in which states delegate specific powers to the national government and reserve others for local implementation, often through local governments such as counties, municipalities, and townships.[19] Ideally, the relationships between federal, state, and local governments are not hierarchical, but rather highly interdependent and rely on shared power.[16] State and local health department governance ranges from centralized structures, in which local health units are primarily led by employees of the

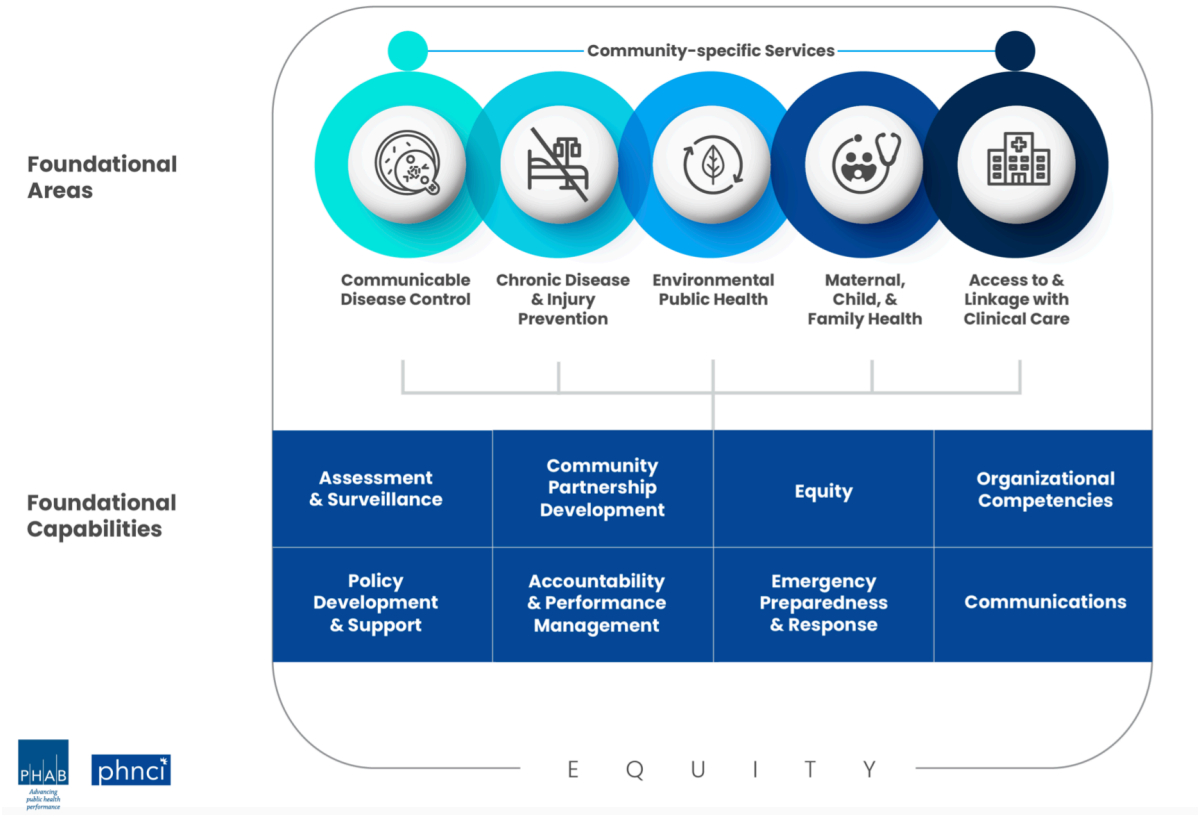
state, to decentralized structures, in which local health units are primarily led by employees of local governments.[20] For example, Oregon has a decentralized public health system, meaning that fiscal, administrative, ownership and authority of public health lies with local public health departments rather than the state.[21] There are 33 Local Public Health Authorities (LPHAs) in Oregon, which includes 27 county-based public health departments, 1 district health authority, and 5 public-private partnerships that provide subcontracted services for the LPHA.[21]

Public Health Modernization in Oregon

The state of Oregon has conceptualized Public Health 3.0 as a process of "modernization" focused on the adoption of the Foundational Public Health Services (FPHS) framework.[22,23] The FPHS framework was developed in 2013 in response to recommendations from the Institute of Medicine (now known as the National Academy of Medicine) that the governmental public health system consider its structure, functions, and financing in the context of the ACA.[24] Complementary to the ACA defining minimum essential healthcare coverage, the FPHS framework specifies a "minimum package" of public health programs and workforce capabilities[1] that should be present in every community (**Figure 1.3**).[25] In Oregon, the FPHS framework was enshrined in law as Public Health Modernization (referred to as "Modernization" hereafter) in 2015 with the passage of House Bill 3100, and operationalized in a Public Health Modernization Manual in 2017 (referred to as "Modernization Manual" hereafter).[26,27]

[1] Equity was added to the FPHS framework as a stand-alone workforce capability in 2022 to reflect its critical role in ensuring community health and well-being.[23]

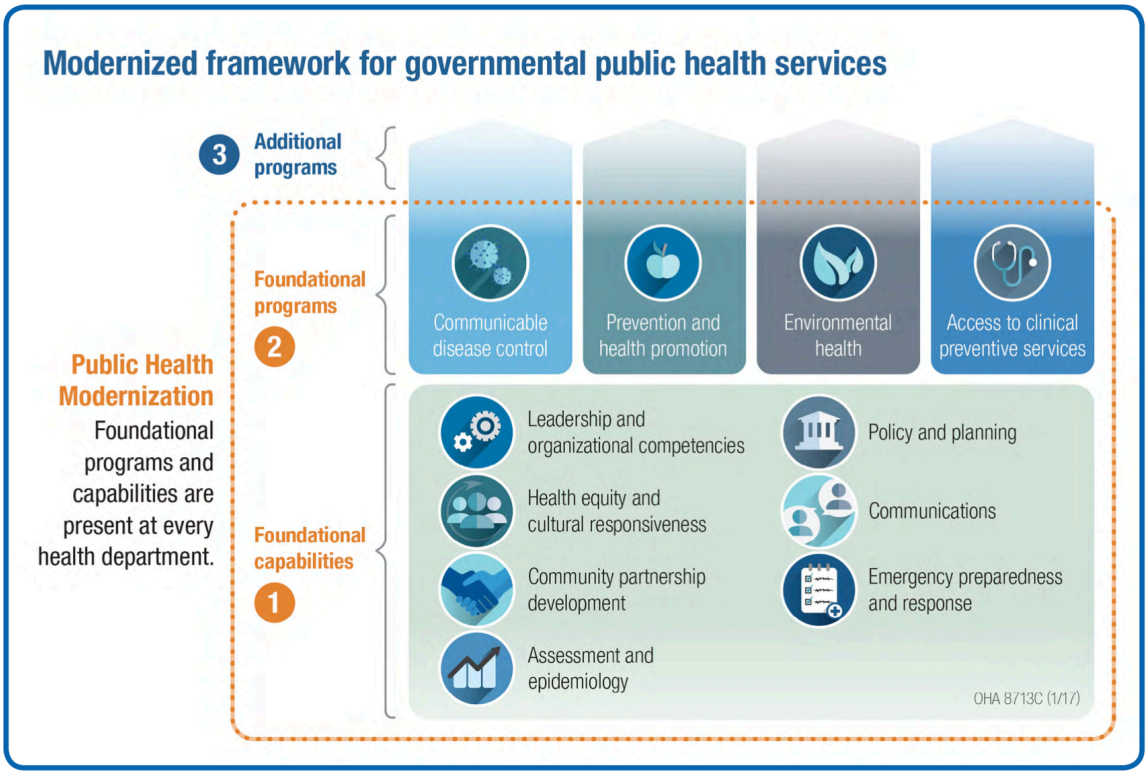
Figure 1.3. Foundational Public Health Services framework[25]



The Modernization Manual specifies distinct but complementary "roles" for state and local governmental public health agencies in the foundational program areas of communicable disease control, prevention and health promotion, environmental health, and access to clinical preventive services. The Modernization Manual also articulates the knowledge, skills, and abilities (termed "foundational capabilities") needed to successfully implement foundational programs.[26] Foundational capabilities include leadership and organizational competencies; assessment and epidemiology; policy and planning; communications; emergency preparedness and response; community partnership development; and health equity and cultural responsiveness (**Figure 1.4**).[26] For example, one role for state and local health departments in the health equity and cultural responsiveness capability area is to "promote a common understanding

of cultural responsiveness," while another role to fulfill the community partnership development capability requires governmental public health to "ensure participation of community partners in local and state health planning efforts."[26] Of note, there are 51 roles and deliverables in the health equity and cultural responsiveness capability area alone. A readiness assessment conducted in 2015 by the Oregon Health Authority Public Health Division (OHA-PHD) and LPHAs in Oregon found that foundational capabilities are not consistently present in every community, especially capacity and expertise to advance health equity and develop community partnerships.[28]

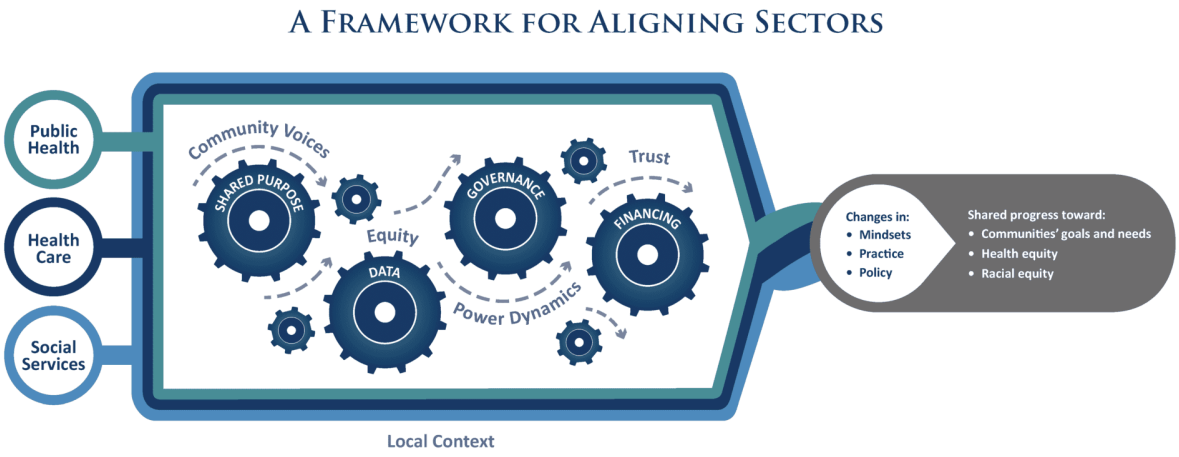
Figure 1.4. Oregon Public Health Modernization framework[26]



Cross-Sector Alignment for Health Equity

The successful integration of health equity as a foundational capability in public health will require the field to "abandon silos and practice in a common space with other sectors" to collectively address social and structural factors that contribute to health inequities.[3] Consequently, modern public health practice aims to encompass a "complex, loosely coupled system of actors" that includes governmental entities at the international, national, regional, and local levels; diverse non-governmental organizations, such as advocacy groups, medical systems, and businesses; and the general public.[1] Landers et al. offer a Framework for Aligning Sectors that specifies four critical components and four factors as necessary to the successful systems alignment (**Figure 1.5**).[29] The framework also specifies short-term and intermediate outcomes of cross-sector alignment, such as changes in mindsets or behavior among alignment members, changes in practice like shifts in the flows of funds, and changes in policy relevant to the cross-sector initiative's goals.[29]

Figure 1.5. A Framework for Aligning Sectors[29]



The first critical component of the framework is *shared purpose* and includes establishing shared areas of focus and outcomes in partnership with people most affected by inequitable systems.[29] Cross-sector efforts to develop a shared focus on equity and the social determinants of health face a value acceptability problem related to political economy and public administration legacies. First, neoliberal approaches to policymaking in the 1980s were translated within the health sector as market-oriented reforms that emphasized efficiency and productivity over relationship-building and equity as system goals. These reforms led to reductions in government programs comprising the social safety net and the devolution of state public health functions and services to other actors such as non-profit and for-profit organizations. [4,30] This contraction of the welfare state occurred despite an increasingly robust evidence base linking welfare regimes with population health outcomes; for example, in Europe, North America and the Asia-Pacific region, 20% of the differences in infant mortality rate among countries can be explained by the type of welfare state.[31]

Also during this time, New Public Management (NPM) public administration models followed a neoliberal logic and ushered in a market orientation to the public health field that brought decentralization and privatization of programs and services. These models also increased emphasis of programming on efficiency and accountability realized through rigid performance monitoring systems.[32] These movements toward privatization and efficiency stand in stark contrast to the core of the population health agenda which is "a philosophy of social justice and equity in which ideas lean towards collective good."[33] A shared focus on SDH reflects a collectivist response to socially produced conditions and calls for a redistribution of resources that conflicts with Western cultural values of individualism, neoliberal economic policies that privatize risk, and NPM administrative models that prioritize efficiency and productivity.

The second critical component of cross-sector alignment is developing a *shared data system* that is meaningful to all partners and allows for measurement of shared progress.[29] Kegler et al. note the difficulty of documenting whether complex multisector community change leads to population-level health outcomes and the added value of a coalition approach over other approaches to creating community change.[34] While social determinants of health data can be difficult to collect and share, epidemiological studies over the last several decades have successfully identified proximal, intermediary determinants of major disease (e.g., tobacco use, diet, and exercise), that are potentially controllable at the individual level and resonate with Western neoliberal cultural values that promote individual control and responsibility over health.[13] The focus on intermediate determinants is particularly concerning given calls to reconsider "damage-centered" research that documents peoples' health deficits and contributes to an overly-simplistic notion of people and communities as "depleted, ruined, and hopeless."[35] Instead, collaborations whose mission is to improve health and well-being can approach issues of power, decision-making, and justice in data initiatives by minimizing narratives that blame individuals or groups for their own "problems" and ensuring co-creation by communities and/or people with lived experience to center their values, needs, and priorities.[36]

The lack of viable SDH indicators and prominence of intermediary determinants is further compounded by the evidence-based policymaking (EBPM) agenda. EBPM strives to gather the "best" evidence on health interventions based on a hierarchy of methods with randomized controlled trials at the top, despite studies showing that RCTs are often not representative of those who experience systematic oppression,[37] and to ensure that this empirical evidence has a direct impact on practice.[38] While policymaking has always been informed by social scientific knowledge, the EBPM movement is distinct in the "breadth and primacy" given

to the role of rational, positivist, and quantitative knowledge in policy setting and implementation.[39] In establishing a hierarchy of methods, EBPM marginalizes and delegitimizes qualitative and community-based approaches to inquiry that elevate lived experiences, which is reinforced by government agencies through funding of rational, empirical research and the internal collection and reporting of mostly proximate risk factor data.[40]

Existing performance monitoring may also serve as a barrier if not updated to reflect and incentivize health equity as a multi-sector goal. When an organization cannot hope to show improvement on all relevant dimensions of performance monitoring, it seeks to show improvement on those of interest and most visible to stakeholders on which the organization is most dependent.[41] For governmental public health departments, and likely government agencies generally, the organization may be driven to show improvement on traditional dimensions of efficiency and productivity to local and state policymakers to which they are accountable and from which they receive funding. This focus potentially comes at the expense of newer dimensions of performance – like health equity – that may be perceived as beyond the organization's control. In addition, improvements to health equity may not be realized in the shorter timeframe required for performance reporting given the need to dismantle entrenched structures and cultures that perpetuate inequities.

The third critical component of cross-sector alignment is *shared financing*, which is focused on sustainable financing with appropriate incentives and shared accountability.[29] Strategic partnerships are created by the needs of all organizations to acquire or share scarce resources.[42,43] Cross-sector collaboration may be driven by a need to demonstrate progress on or commitment to health equity for funders, legislators, and the public to secure resources. Organizations can also be motivated to collaborate across sectors through explicit financial

incentives. Indeed, a multi-stakeholder group of healthcare experts convened by the National Quality Forum recommended the use of health equity performance measures to incentivize the reduction of health disparities and achieve health equity.[14] In practice, the rise in the use of quality measurement tied to payment and public reporting in the healthcare system has not expanded the use of measures that directly target disparities reduction, and major payment programs such as the Hospital Value-Based Purchasing Program and the Merit-Based Incentive Payment System do not include equity as a domain of performance measurement.[14] For governmental public health in Oregon, local public health departments are subject to accountability metrics, but there is neither a health equity metric nor a budget to which the metrics are tied.[44] Furthermore, there is weak evidence supporting the effectiveness of "carrot-or-stick" approaches to quality improvement.[45] For example, findings from a review of pay-for-performance programs to improve healthcare quality suggest a "more judicious use" of monetary incentives with greater focus placed on fostering the "intrinsic motivation" of professionals.[45] The review further highlighted how financial incentives alone "are a poor substitute" for providing practitioners with the resources, skills, and time to improve quality.[45]

Organizations in cross-sectoral collaborations must demonstrate their capacity to reduce uncertainty through a commitment of resource exchange.[41] This may prove difficult for governmental public health given that funding is often siloed, determined by state legislatures on relatively short budget cycles, and coupled with specific performance monitoring requirements that may contradict an equity focus.[46] Indeed, the Public Health Accreditation Board Center for Innovation (formerly the Public Health National Center for Innovation) Cross-sector Innovation Initiative funded 10 communities for two years to support public health, health care, and social services sector alignment and found that only five of ten sites worked on developing

collaborative financing models, compared to eight of the ten sites working on shared vision and data systems, and nine of the ten sites working on shared governance.[47]

The fourth and final critical component is *shared governance*, which focuses on the development of robust decision-making structures that include and elevate local representation and voice.[29] The WHO Commission on Social Determinants of Health affirms the focus on shared decision-making by asserting that health politics relies on "a configuration of cooperative relationships between citizens and institutions" and that the state is responsible for developing "real" participation opportunities for the public.[4] However, public participation can have a wide range of meanings from informing (providing balanced and objective information) to advising (soliciting feedback on services and programming) to power-sharing (sharing or redistributing power for final decision-making).[48,49] Historically, community empowerment interventions that go beyond narrow forms of consultation have been undermined by perceptions of relatively weak evidence that directly links community participation to improved health status.[50] Studies comprising the evidence lacked standard definitions for "community" and "participation" and the few links identified were deemed situation-specific and lacking generalizability.[51] More recently, systematic review evidence shows positive associations between community engagement interventions and a range of health outcomes[52,53] and establishes the importance of social relationships on good health and the detrimental effects of social isolation.[50] Civic engagement, the degree to which individuals participate in their communities, has been recognized as a social determinant of health in its own right.[54]

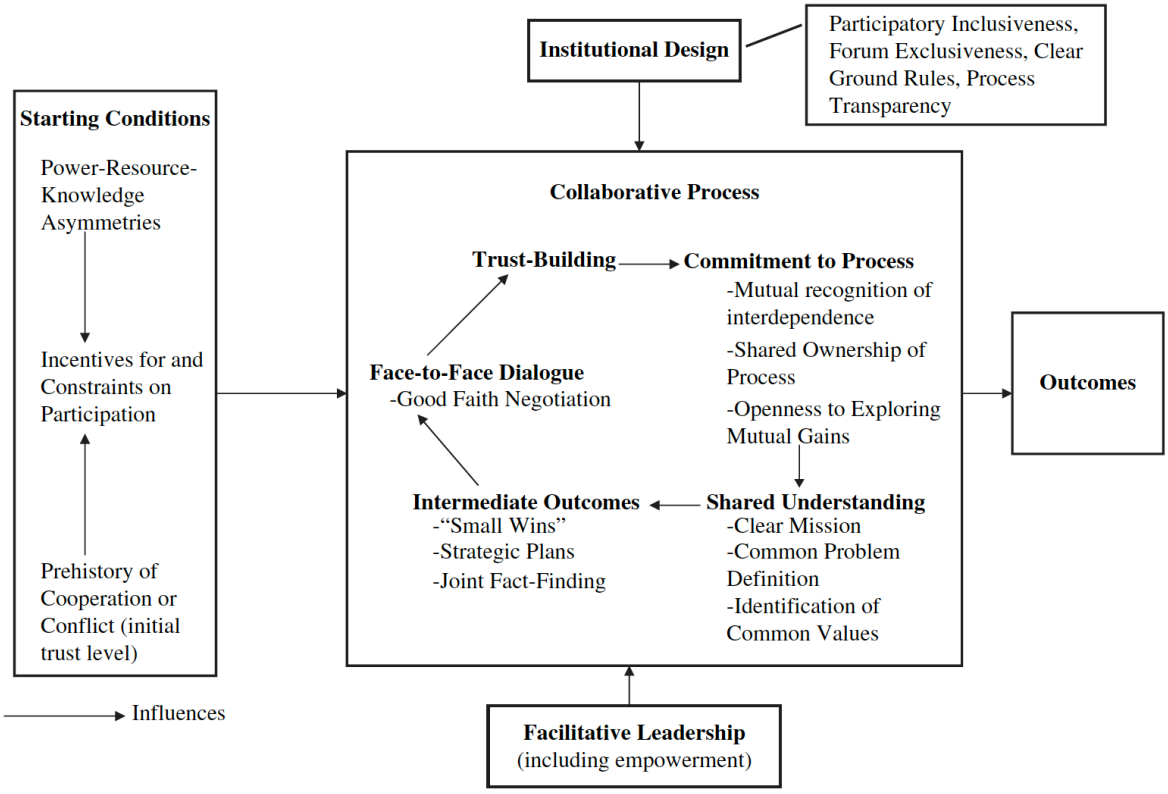
Notably, concepts of empowerment have been depoliticized by more conservative policymakers to emphasize existing social capital/power in communities and to absolve the state from redistributing resources or acknowledging the role of state structures in local problems.[4]

Community-centered prevention approaches require practitioners to shift from deficit-based models that focus exclusively on unhealthy behaviors toward an asset-based approach that affirms the resources and strengths within communities.[50] However, civic engagement by definition requires community members to work with state and local institutions to promote "meaningful actions, movements, and relationships" within a community,[54] so calls to empower communities may run the risk of absolving public administrators from accountability and decision-making responsibilities.[53] The "new public service" model of public administration acknowledges the increasingly important role of the public servant to help community members articulate and meet their shared interests, rather than to attempt to control or steer society in new directions.[32] Consequently, cross-sector alignment activities should work towards the highest form of participation that includes ceding "power to" communities for decision-making and generating "power with" community through collaborative processes and outcomes.[4]

Models of collaborative governance further specify preconditions for authentic public engagement, including acknowledging the history (and sometimes ongoing state) of conflict or cooperation (e.g., the role of state policies in creating and maintaining institutional discrimination), appropriately incentivizing participation and reducing constraints (e.g., paying stipends for participation; providing meals, transportation, childcare) and mitigating asymmetries in resources or knowledge (**Figure 1.6**).[55] International studies of public participation offer several challenges for consideration: engagement may contribute to a greater sense of exclusion if new spaces reinforce old hierarchies;[56] participation being linked to a sense of tokenism if not backed by outcomes;[56] and policy experts and civil servants perceiving citizens as lacking the necessary knowledge to participate.[57,58] In addition, previous public policies exist that paint harmful narratives of target populations experiencing health inequities as "deviants" and not

deserving of redistributive policy efforts (e.g., work requirements for food stamp recipients).[59] These are the same populations that should be engaged in public participation, but the stigma assigned to them through past policy decisions may be a significant barriers from being seen as legitimate participants in venues for shared decision-making. Fortunately, the process to develop Oregon's 2020-2024 state health improvement plan (SHIP) offers an example of how government engagement of cross-sector stakeholders can effectively support a statewide focus on equity. In 2018, a workgroup composed of members of academia, public health practice, and CBOs recommended a shift away from intermediary determinants of health, like tobacco use and obesity, to new social-structural priorities, including institutional bias, trauma, and economic drivers.[60]

Figure 1.6. A Model of Collaborative Governance[55]



The four factors identified by the Landers et al. framework as necessary for successful systems alignment include ensuring that priorities and solutions are *community driven*; embedding concepts of *equity* in processes to establish the four critical components; shifting *power dynamics* to ensure underrepresented voices drive change; and working with community in transparent and honest ways that build *trust*.[29] The inclusion of power dynamics in the framework is both unique and important, as powerlessness can be seen as a structural barrier to advancing health equity.[61] Vaidya et al. define community power as "the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity."[61] Community power is about building a sense of collective agency among those most impacted by structural inequities to disrupt these patterns, including Black, Indigenous and people of color; people who are lesbian, gay, bisexual, transgender and/or gender expansive, queer and/or questioning, intersex, asexual, and two-spirit; people with disabilities; people who are immigrants or refugees; people who are undocumented; people who experience classism; and others who experience systemic oppression. While leaders in public health have long valued the concept of community engagement, the concept of community power is less familiar and potentially less comfortable as it implies a ceding of the state's decision-making authority.

Disrupting the Status Quo

In reflecting on the "woefully inadequate" public health infrastructure and workforce during the 2020 response to the COVID-19 pandemic, Chudgar et al. ask, "What would it look like to

design systems that exist outside of the current structures and institutions that were designed to oppress? How do we truly transform?"[62] This question is particularly salient in the context of a public policymaking process that is structured for incremental rather than wholesale change.[63] That is, given limited time and information to examine more than a few policy options, policy makers focus on alternatives that differ only marginally from previous approaches. This narrow focus limits policy discussion to options that are well understood and politically feasible, typically those that emphasize solutions to concrete problems (e.g., tobacco use, diabetes) rather than the pursuit of more abstract or complex ideals such as social justice.[64] Policy feedback effects can also reinforce the status quo. For example, policies can be self-reinforcing due to high setup, learning and coordination costs of policy alternatives; when the benefits of a policy accrue to a dominant constituency that reinforces a sense of entitlement and strengthens the constituency's capacity to defend against the threat of policy alternatives; and when targets of a policy are viewed as deserving of the benefits (and alternatively when the targets of a competing policy alternative are viewed as not deserving).[65]

Although infrequent, major "punctuations" in policy change are possible when external pressure, such as widespread public attention on a problem, reaches a tipping point to overcome the conservatism of decision makers. This external pressure for policy innovation can be driven by "focusing events," which are typically crises or disasters that occur suddenly, tend to be rare, are often large in scale, and are known to policymakers and the public at the same time.[63] Examples of focusing events include natural disasters such as Hurricane Katrina in New Orleans and humanmade crises such as the Deep Water Horizon oil leak in the Gulf of Mexico. Longer-duration events, such as novel pandemics, rising sea levels, or economic recessions, can also evolve into large-scale crises that similarly pressure decision makers for policy innovation. The

aggregation of hazardous events and related learnings from an enduring crisis can open multiple windows of opportunity to address policy problems revealed over time.[66]

Focusing events and enduring crises may disrupt the relative stability of issue-specific policy subsystems to change problem definitions (e.g., shifting focus from intermediary to social-structural determinants), distribution of resources, and fundamental sociocultural values.[63] Political feasibility of health equity policies and practices may be improved through focusing events that shift national mood in favor of public responses to the social and structural conditions that create health inequities. In addition, equity-oriented interest groups that benefit from shifts in resources/power from focusing events may have increased influence on decision-makers' acceptability of approaches that center health equity.[63]

At an organizational/institutional level, dynamic conditions that change the balance of power provide an opportunity for "path-breaking" that deviates from institutional norms and structures.[67] Path breaking behavior depends on the presence of "institutional entrepreneurs" willing and able to bring along reluctant implementers and form political networks to gain legitimacy for institution-building or institution-dismantling projects. While an actor's agency is "embedded" within existing institutions and therefore constrained by related practices and structures,[68] social movements within an organizational field may enable institutional entrepreneurship.[67] The police killings of Black Americans and related resurgence of the Black Lives Matter movement, as well as visible racial/ethnic inequities in COVID-19 testing rates, mortality rates, and vaccination rates brought conversations of public health's responsibility for dismantling racism and other forms of institutional oppression to the fore.[69] Public and political pressure could drive governmental public health to prioritize more collaborative forms of

governance in order to maintain legitimacy and empower entrepreneurs within governmental public health to subvert institutional practices that ignore inequities.[41,70]

Some evidence exists that transformational change may be occurring both nationally and locally in both government and philanthropy in response to the enduring crises of racial inequities in both COVID-19 and policing. Nationally, a 2020 update to the 10 Essential Public Health Services framework newly placed equity at its core and indicated that public health must seek to remove systemic and structural barriers that have resulted in health inequities by mobilizing communities.[18] In addition, Healthy People 2030 includes social determinants of health among the subset of 23 high-priority population health indicators alongside more typical goals related to health conditions (e.g., persons who know their HIV status) and health behaviors (e.g., current use of any tobacco products among adolescents).[71] Lastly, the Robert Wood Johnson Foundation (RWJF) funded the Lead Local initiative in 2022 that brought together community power-building leaders and practitioners in the fields of community organizing, advocacy, public health, and science over the course of 18-months to document how power is built in low-income communities and Communities of Color, how it shifts over time, the factors that contribute to that shift, and how grassroots organizations do the work to build community power to improve social and economic conditions that advance health, equity, and well-being.[72]

In Oregon, OHA adopted the strategic goal to eliminate health inequities in the state by the year 2030.[73] In addition, the state legislature significantly increased funding for Modernization from $5 million in 2017-2019 to $30 million in 2021-2023, and specified CBOs as public health system partners to be funded.[74] As a precursor to this legislative investment, OHA-PHD funded more than 170 CBOs through the 2021 CARES Act to support culturally- and linguistically-responsive services as a part of the state's COVID-19 response.[75] OHA-PHD also

created a Community Engagement Team comprised of state staff who serve as regional and community-specific liaisons to newly-funded CBOs. Recognizing that COVID-19 response funding would not be sustained indefinitely, programs in OHA-PHD collaborated on a new grant opportunity for CBOs that would be sustained over time by pooling funding for commercial tobacco prevention, HIV prevention and treatment, overdose prevention, adolescent and school health, breast and cervical cancer screening, and Modernization (specifically for communicable disease control, emergency preparedness and response, and environmental health). The new funding opportunity was released December 2021 and allocated $33.1 million to 147 CBOs across the state.[76] To ensure adequate infrastructure for the new coordinated grant program, OHA-PHD also invested Modernization funds in a permanent Community Engagement Team to support funded CBOs.

Problem Statement

Modernization is being promoted in Oregon as a critical public health system transformation effort to address persistent health inequities through the provision of foundational public health services with an emphasis on equity. State and local jurisdictions have been described as "laboratories of democracy" for testing new policies and programs, with the most effective approaches emulated by other states or adopted nationally.[63] Policy and program ideas may be developed and diffused through professional state organizations like the National Governors' Association, the National Conference of State Legislatures, and the Association of State and Territorial Health Officers.[77] Examples in which states have led public health system innovations include regional health planning, children's health insurance, organization and financing of care for AIDS patients, restrictions on the sale of handguns, and indoor smoking bans.[77] However,

more complex or controversial innovations do not readily diffuse to other jurisdictions and federalism tends to produce wide variation in policies and programs to address a common problem.[77] In addition, state-level variations in political, financial, and technical support for federal policies, or calls to action like Public Health 3.0, can significantly impair the effectiveness of uptake and implementation.[77]

Indeed, public health system transformation initiatives are in their relative infancy and implementation models – especially those that center collaboration with community partners – do not yet exist to diffuse and scale throughout the governmental public health field. Since 2015, the Public Health Accreditation Board Center for Innovation has convened the 21st Century Learning Community, a group of states focused on public health system transformation via the FPHS framework.[78] However, case studies of states early to adopt the FPHS framework have provided limited details regarding local implementation.[78] In addition, published research describing transformation efforts in Washington and Ohio – two leaders on FPHS implementation – focused exclusively on regionalization of chronic disease prevention and methods for costing out full implementation of the FPHS framework, respectively.[79] No research to date has focused on governmental public health's capacity to collaborate with community organizations on the provision of foundational public health services with an emphasis on health equity – a model for implementation most closely aligned with Public Health 3.0. Oregon serves as a unique environment in which to study public health system transformation, given it is one of only two states to enshrine the FPHS framework in law; receive dedicated funding from the state legislature for FPHS implementation; operationalize the FPHS framework in a detailed Modernization Manual; adapt the FPHS framework to add a standalone health equity and cultural responsiveness workforce capability (prior to the national FPHS framework update in

2022 to add equity as a capability), and fund CBOs to advance the foundational public health services with governmental public health.

While early Modernization funding was allocated to county governments with expectations for community partnership development, the inequitable response to the COVID-19 pandemic in Oregon and nationally demonstrated that state and local public health departments are ill-equipped to reach culturally-specific communities without support from CBOs and other community leaders.[69] As a result, OHA-PHD now funds CBOs directly to support culturally-specific outreach and education for public health programs. New state funding to CBOs was implemented largely without input from county governments. Given Oregon's decentralized public health system – in which fiscal, administrative, ownership, and authority for public health lies with local public health departments rather than the state – OHA-PHD's direct funding to CBOs may be perceived by local public health departments as overreach.

However, some CBOs may advocate for the independence to implement programs without local government involvement, due to past and ongoing experiences of exclusion and tokenism. At the same time, governmental public health staff may view this approach as too diffuse – not supporting systems alignment – and therefore limiting collaboration on health equity. The governmental public health perspective may also perpetuate either/or thinking, characteristic of white supremacist organizations, rather than both/and thinking where the field can both uplift the autonomy of CBOs and simultaneously work to repair mistrust between CBOs and government to eventually work collaboratively on public health priorities.[80] These tensions raise the question of how state and local governmental public health agencies effectively collaborate with CBOs to provide foundational public health services and advance health equity. Furthermore, a recent evaluation of the 2021-2023 legislative investment in Modernization

recommended several areas for inquiry that guided dissertation research. Recommendations included: 1) examining when, where, and how collaboration between state and local governmental public health and CBOs is most relevant and beneficial to populations served; 2) assessing whether there is a common understanding of key terms to describe the public health system and related measurement; and 3) understanding the strengths and contributions of government and non-government partners in each foundational capability.[81]

Study Purpose

The purpose of this study was to characterize alignment between state and local public health departments and CBOs in Oregon to advance the FPHS framework with an emphasis on health equity. Modernization has historically been an endeavor of governmental public health, so the inclusion of CBOs as funded partners requires careful consideration of how public health agencies can effectively collaborate with community.

Research Question and Aims

The research question for this study is "What factors of cross-sector alignment impede or facilitate collaboration among state and local governmental public health and communities to advance health equity?"

This research question will be addressed through three specific aims:

1) Characterize the degree to which factors of cross-sector alignment are currently fulfilled;
2) Compare similarities and differences in how partners perceive factors of cross-sector alignment; and

3) Explore perceived roles of each partner in advancing health equity.

Theories in Use

The Framework for Aligning Sectors will provide the basis for semi-structured interview and focus group questions and a priori analytic themes.[29] In addition, a combination of network theory and policy feedback theory will be used to explain the mechanisms underlying the facilitators and barriers to collaboration identified from qualitative data analysis. Briefly, network theory posits that organizations will make strategic choices to become part of a cooperative network when it appears that the advantages of such an arrangement, such as acquiring resources or information, outweigh the costs of maintaining the relationship, particularly the potential loss of autonomy.[42,82,83,84] These networked relationships are embedded in larger social, political, and economic structures that can serve as sources for competing values and institutional logics among collaborative partners.[68] Policy feedback theory proposes that policy legacies and related institutions "feed forward" to shape the politics of new decision-making opportunities.[33] These policy legacies tend to maintain the status quo and are unlikely to change without an event that disrupts the system. These theories will be described in more detail in Chapter 2.

Anticipated Implications

There are several anticipated implications of the proposed research for public health practice. The research will inform how the OHA-PHD and LPHAs improve alignment with CBOs to advance foundational public health services with an emphasis on health equity. The research will also elucidate the distinct but complementary roles of governmental and community partners in

Modernization implementation. Furthermore, the research will inform similar efforts by other Divisions in OHA and other state agencies in Oregon to directly fund CBOs for culturally-specific outreach and education. For example, research findings could inform ongoing implementation of Ballot Measure 110 funding for community behavioral health services[85] and Oregon Department of Transportation's Innovative Mobility Program grants focused on culturally-specific active transportation needs in local communities.[86] Nationally, the research will inform state-led Public Health 3.0-style transformation initiatives across the country focused on cross-sector partnerships and community empowerment to advance health equity. The research will also inform FPHS framework implementation across the US, particularly for state health departments that are leading in this effort and participating in the PHAB Center for Innovation's 21st Century Learning Community. The research will also support refinements to existing frameworks. Given the Framework for Aligning Sectors is relatively new, study findings could help operationalize more opaque factors like power dynamics and trust for research in a public health practice context. Lastly, the research will test hypotheses from institutional theory, social movement theory, and network theory in a governmental public health context, including the potential for "path-breaking" behavior that deviates from institutional norms and structures.

Conclusion

Persistent inequities in population health outcomes have culminated in a call to action for the public health system to work across sectors – and specifically to partner with communities – to advance health equity. No research to date has focused on state governmental public health's capacity to collaborate with community partners to advance health equity through the foundational public health services. As described in this chapter, the Framework for Aligning

Sectors provides a lens through which to explore the collaborative implementation of public health system transformation. Organizational and policy process theories suggest that state-led initiatives will contend with network factors and policy legacies that maintain the status quo. These issues will be explored in focus groups and key informant interviews with staff in governmental public health agencies and CBOs implementing Modernization. Chapter 2 reviews the foundational literature relevant to the research topic, including the knowledge that exists and the gaps. Chapter 3 outlines the design of the research, explains methods used, addresses methodological challenges, describes data sources, and explains methods of data collection and analysis. Chapter 4 presents the primary results of the research. Chapter 5 synthesizes study findings and offers implications for theory, practice, and policy, discusses study limitations, and suggests future research.

Chapter 2. Review of the Literature

Introduction

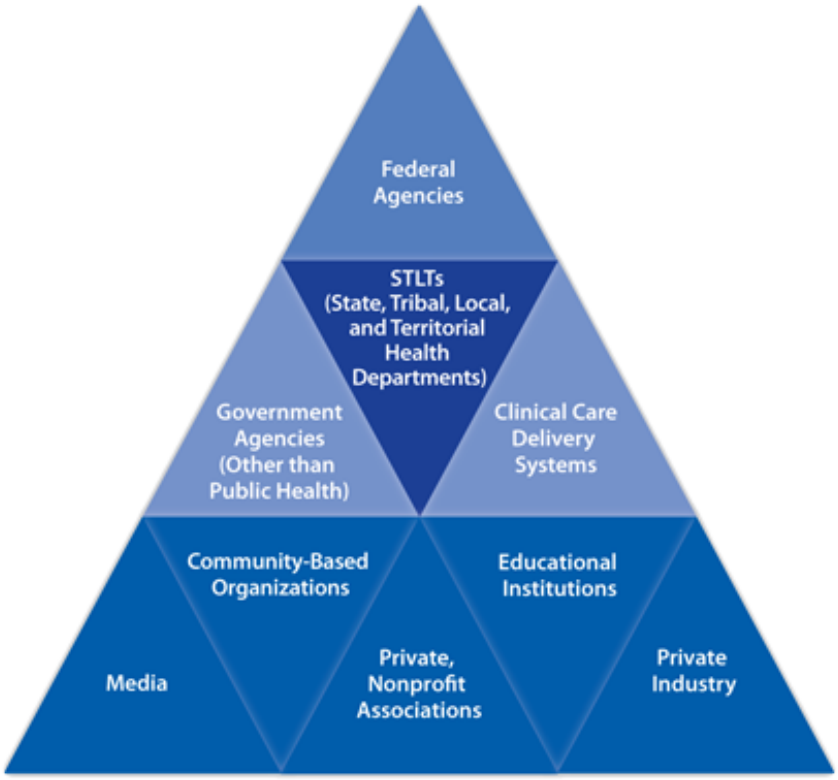
The purpose of Chapter 2 is to review and synthesize the foundational literature relevant to the dissertation topic, including identification of gaps in existing knowledge. First, the chapter will describe the population health approach and components of the public health system with a particular focus on the role of governmental public health. The chapter will also describe foundational frameworks that have guided governmental public health practice to date. Next, the chapter will describe inequities in population health outcomes and introduce the World Health Organization's Commission on Social Determinants of Health Framework to describe the root causes of health inequities. The chapter will then describe national and local public health transformation initiatives to address population health inequities that call for cross-sector collaboration, including Oregon's Public Health Modernization initiative (referred to as "Modernization" hereafter) which serves as the focus of this dissertation research.

Next, the chapter will provide an overview of cross-sector collaboration outcomes, facilitators, and barriers, as well as introduce the Framework for Aligning Sectors (FAS), which serves as the guiding framework for the dissertation research. The chapter will then describe each "core component" and "adaptive factor" of the FAS in detail, including potential implementation challenges and related antidotes. The "shared governance" core component and "power dynamics" adaptive factor of the FAS will be described in more detail than other components and factors, given the central role of power and shared decision-making in cross-sector collaborations that center equity. The chapter will conclude with organizational and policy process theories that explain governmental public health's tendency to maintain the status quo, as well as precursors to "pathbreaking" behavior that may support systems transformation efforts.

Population Health and the Public Health System

This section describes the population health approach, the composition of the public health system, and the distinct roles of governmental public health in advancing population health and well-being. Population health is defined as health outcomes and their distribution in a population.[2] Whereas many interventions focus exclusively on individuals, the population health approach aims to improve the health of the entire population and recognizes that health is influenced by factors beyond healthcare, including political, social, and economic factors and the physical environment.[33] Geoffrey Rose, in his seminal article "Sick individuals and sick populations," contrasts these approaches as the "high-risk" strategy that identifies and offers some protection to high-risk susceptible individuals and the "population strategy" that attempts to shift the whole distribution of exposure in a favorable direction through environmental control efforts.[87] Public health systems are commonly defined as all public, private, and voluntary entities that contribute to the delivery of public health services within a jurisdiction.[16] The US public health system is typically a network of government agencies, clinical care delivery systems, community-based organizations (CBOs), educational institutions, private businesses, and other organizations working together to support the health and well-being of those residing in the US (**Figure 2.1**).[17]

Figure 2.1. Components of the public health system[17]



The governmental public health system, residing at the state, territorial, and local levels, is where most public health policy is enacted and where decisions are made about the stewardship and allocation of federal funds.[88] The governmental role in public health is guided by the 10 Essential Public Health Services (EPHS) framework, which defines governmental public health as the three functions of assessment, policy development, and assurance.[18] The *assessment* function includes monitoring population health, as well as investigating, diagnosing, and addressing health hazards and root causes of health. The *policy development* function includes communicating effectively to inform and educate the general public; strengthening, supporting, and mobilizing communities and partnerships; creating, championing, and implementing policies, plans and laws; and utilizing legal and regulatory actions. Lastly, the

assurance function includes enabling equitable access to public health services; building a diverse and skilled workforce; improving and innovating through evaluation, research, and quality improvement; and building and maintaining a strong organizational infrastructure for public health.[18]

These functions of governmental public health are carried out under a "federalist" system of government in which states delegate specific powers to the national government and reserve others for local implementation, often through local governments such as counties, municipalities, and townships.[89] In order to function effectively, the relationships between federal, state, and local governments are not hierarchical, but rather highly interdependent and rely on shared power.[89] State and local health department governance ranges from centralized structures, in which local health units are primarily led by employees of the state, to decentralized structures, in which local health units are primarily led by employees of local governments.[20] Oregon has a decentralized public health system, meaning that fiscal, administrative, ownership and authority of public health lies with local public health departments rather than the state.[90] There are 33 Local Public Health Authorities (LPHAs) in Oregon, which includes 27 county-based public health departments, 1 district health authority, and 5 public-private partnerships that provide subcontracted services for the LPHA.[21]

Public Health Practice Frameworks

This section describes historical efforts to define the purpose and roles of the governmental public health system, including foundational public health practice frameworks. These frameworks define the core capabilities of governmental public health and will serve as a point of comparison for descriptions of public health system transformation to come in later sections of

this chapter. In the 1998 report "The Future of Public Health," the Institute of Medicine (IOM)[2] found a lack of consensus on the role of governmental public health and found significant disparities in services available and level of service provision across jurisdictions.[91] The public health infrastructure was not well understood by the general public and key partner groups like the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) maintained different lists of core governmental public health functions.[91] A working group, composed of federal public health agencies and other major public health organizations and led by the Director of the CDC and Deputy Assistant Secretary for Disease Prevention and Health, was convened in spring 1994 to develop a consensus list of essential public health services.[91] In fall 1994, the workgroup adopted the Public Health in America Statement, which included public health's vision and mission, a description of what public health does, and the EPHS framework.[91] The EPHS framework reflected several significant shifts in public health practice, including shifting focus from treating disease to sustaining health and from an individual's needs to a broader perspective on the health of populations.[91] The framework also supported a shift in strategy from reactively treating illness to proactively promoting prevention and focusing on community assets and opportunities rather than needs and problems.[91]

The EPHS framework also supported setting expectations for outcomes and accountability for governmental public health practice. To this end, in 1998, the CDC collaborated with NACCHO, the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), and the Public Health Foundation (PHF) to develop a national set of

[2] Note: The Institute of Medicine is now the National Academies of Sciences, Engineering, and Medicine.

performance standards to measure the capacity of the public health system to deliver the EPHS.[91] This collaboration resulted in the National Public Health Performance Standards Program (NPHPSP), which represented a "gold standard" of public health services against which state and local health departments could measure their level of service provision.[91]

The EPHS have also been included in the Healthy People initiatives, which began in 1979 with the landmark Surgeon General report "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention" and is now in its fifth iteration of setting measurable 10-year objectives for improving health and well-being in the US.[91] In particular, Healthy People 2010 included the focus area of public health infrastructure with the goal to "ensure that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively" and references the NPHPSP.[91] The EPHS is also embedded in the education of the public health workforce; the Council on Education for Public Health (CEPH), which accredits public health schools and programs, requires that schools and programs of public health include the EPHS as a core component of the curricula.[91]

In addition to these nationwide initiatives, the EPHS and NPHPSP have guided state and local public health practice. Based on a scan of state laws published in 2016, 19 states incorporated the EPHS framework, either partially or in full, in their public health laws or statutes.[91] The EPHS have also guided state health department program evaluations. For example, local health departments have used the EPHS to develop and evaluate obesity prevention programs and services to demonstrate areas of program success and needed improvements.[91] The EPHS has also been recommended as a framework for approaching emerging public health issues. For example, the EPHS has been suggested as a model to develop a response to climate change by listing out climate change-focused activities by each essential

service (e.g., communicate effectively to educate, strengthen, and mobilize communities and partnerships).[91]

In the 2003 report "The Future of the Public's Health in the 21st Century," the IOM recommended the exploration of a national accreditation program that built upon existing frameworks, such as the NPHPSP, to improve performance and accountability for governmental public health departments.[92] In 2005, the Robert Wood Johnson Foundation (RWJF) and the CDC funded the "Exploring Accreditation Project" to investigate the desirability and feasibility of accreditation for governmental public health departments.[92] Ultimately, the Project steering committee recommended that a national voluntary public health accreditation program be put in place to: 1) promote high performance and continuous quality improvement; 2) recognize high performers that meet nationally accepted standards of quality; 3) clarify the public's expectations of state and local health departments; and 4) increase the visibility and public awareness of governmental public health.[92]

The Public Health Accreditation Board (PHAB) was incorporated in May 2007 as the nonprofit organization to administer the national public health accrediting body for the approximately 2,500 governmental public health departments in the United States.[92] In July 2011, PHAB released the first version of the standards and measures against which health departments' performance would be assessed.[92] The standards and measures were organized into 12 domains, the first 10 of which addressed the EPHS and two other domains focused on administration and governance.[92] In 2013, PHAB conducted an evaluation of the accreditation program, which included surveys to health departments one year after receiving accreditation.[93] The foremost benefit of accreditation reported by health departments was the increased use of quality improvement information in decision-making and in supporting a stronger culture of

quality improvement.[93] Health departments also reported improved communication with governing entities and the identification and use of evidence-based strategies/programs and metrics because of accreditation.[93] These findings may be expected given domain 9 of the PHAB standards calls for health departments to "[e]valuate and continuously improve health department processes, programs, and interventions," and because accreditation was predicated on a foundation of quality improvement to drive performance improvement.[94] In addition to advancing a culture of quality improvement, accreditation is also believed to support an enhanced focus on community engagement within local public health practice.[93] For example, completing certain accreditation prerequisites, such as conducting a community health assessment and developing a community health improvement plan, seemingly necessitate the development of authentic and sustained community partnerships.[92] Currently, 368 public health departments (41 state health departments, 321 local health departments, and 6 tribal health agencies) have been accredited through PHAB, covering 90% of the US population.[95]

Disparities in Public Health Outcomes and the Social Determinants of Health

This section describes ongoing inequities in population health outcomes and introduces a framework to describe the influence of social and structural determinants on population health and related recommendations to advance health equity. In the United States, public health interventions and high-quality clinical care have significantly improved the health of the general population, including a 10-year increase in life expectancy at birth since the 1950s.[1] These improvements, however, have not equally benefitted all groups within the population. For example, racial and ethnic inequities persist across many health outcomes and factors that increase the risk for developing disease, including life expectancy, infant mortality, and exposure

to environmental pollutants.[1] In addition, life expectancy between people with the highest and lowest incomes has been found to differ by as much as 20 years in neighborhoods just a few miles apart.[1] Health *inequality* refers to differences in the health of individuals and groups, as in rank, amount, or quality.[2] In contrast, health *inequity* contextualizes those inequalities as stemming from unjust policies, practices or institutions and are therefore avoidable and unnecessary.[2] Health inequities are health differences that are "socially produced, systematic in their distribution across the population, and unfair," which implies not an objective description of health status, but rather an appeal to ethical norms and values.[2] Taken together, health equity is "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[3,4]

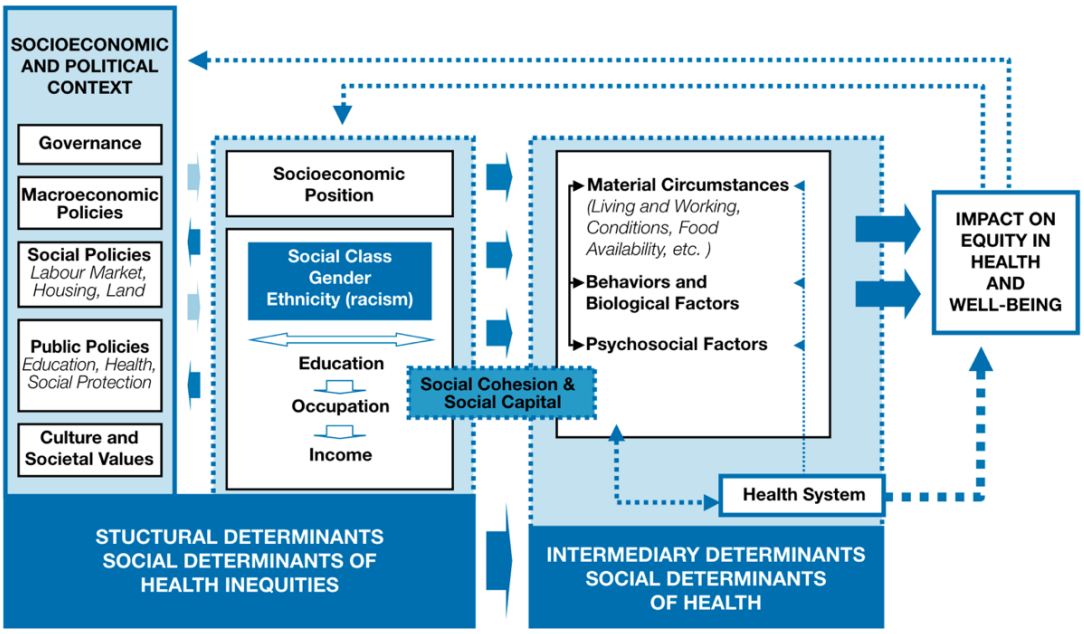
Advancing health equity requires not only equitable access to healthcare, but also efforts outside of the healthcare system to address broader social well-being. The social determinants of health are the non-medical factors that influence health outcomes, including educational attainment, employment, access to transportation, food security, housing stability, and social cohesion.[4,5] In 2005, the Commission on Social Determinants of Health (CSDH) was established by the World Health Organization (WHO) to summarize the available evidence on how society is structured to affect population health and offer recommendations to governments and other public health system partners on approaches to address these inequitable structures.[4] The CSDH's purpose was, in part, to reinvigorate and center the understanding of health as a social phenomenon that requires more complex forms of intersectoral action.[4]

To ground the work of the CSDH, the WHO developed a single conceptual framework for "action on the social determinants of health" by synthesizing several extant frameworks (**Figure 2.2**).[4] The CSDH framework reflects specific theories of the social production of health,

including psychosocial approaches, social production of disease/political economy of health, and eco-social frameworks.[4] These theoretical traditions share the same pathways/mechanisms of causation, including social selection or social mobility, social causation, and life course perspectives.[4] Common to each of these causation explanations is the role of social position in the social determinants of health inequities. Based on Diderichsen's model of "mechanisms of health inequality," the CSDH framework illustrates how social, economic, and political mechanisms create socioeconomic positions whereby populations are stratified according to income, education, occupation, gender, race/ethnicity, and other factors.[4,96] This social stratification contributes to differential exposure to health-damaging conditions (e.g., exposure to environmental pollutants), differential vulnerability through health conditions and availability of material resources, and differential economic and social consequences of ill health.[4]

The "context" that engenders social stratification is broadly defined within the framework as the social and political mechanisms that "generate, configure and maintain social hierarchies," and include the labor market, educational system, political institutions, and other cultural and societal values.[4] Among these contextual factors, the framework positions the welfare state and the presence or absence of redistributive policies as most significantly affecting population health. These institutions of the social and political context comprise the structural mechanisms by which social stratification is generated and individual socioeconomic position is defined within hierarchies of power, prestige, and access to resources.[4]

Figure 2.2. Commission on Social Determinants of Health framework[4]



Taken together, the context, structural mechanisms, and resulting socioeconomic position of individuals serve as the "social determinants of health inequities" and operate through "intermediary determinants of health" to affect health outcomes.[4] Intermediary determinants are differentially distributed across social groups and include material circumstances (e.g., housing and neighborhood quality, financial means to buy food and other essentials, physical work environment); psychosocial circumstances (e.g., psychosocial stressors, stressful living circumstances, social support); behavioral factors (e.g., nutrition, physical activity, tobacco consumption); and biological factors (i.e., genetics).[4] Importantly, policy solutions can be defined differently depending on whether the aim is to address determinants of health or determinants of health inequities.[4] Conflating the social determinants of health and the social processes that shape the unequal distribution of these determinants can mislead policy solutions.[4]

Consequently, the CSDH argues that policies to reduce health inequities must eschew a singular focus on intermediary determinants to address the social mechanisms that systematically reproduce an inequitable distribution of health determinants across populations. For example, policy objectives for intermediary determinants are likely to focus on reducing overall exposure to health-damaging factors (e.g., reduce rates of smoking), whereas policies targeting structural mechanisms are likely to focus on "leveling up" the distribution of health determinants by narrowing the gap (e.g., housing standards in poorest group are brought closer to the average) or lifting the level of health determinants across society towards levels in the highest socioeconomic group (e.g., earned income tax credit).[4] The CSDH also emphasizes the central role of power in generating health inequities and advances the concept of power as positive and based in collective action rather than classical notions of power as domination.[4] With this understanding, addressing the social determinants of health inequities is inherently and necessarily political process that engages both the agency of oppressed communities and the responsibility of the state to support the expression of communities' collective social power. The CSDH recommended three key strategic directions for policy work to address the social determinants of health inequities, including 1) the need for strategies to address context; 2) intersectoral action; and 3) social participation and empowerment.[4]

Public Health System Transformation

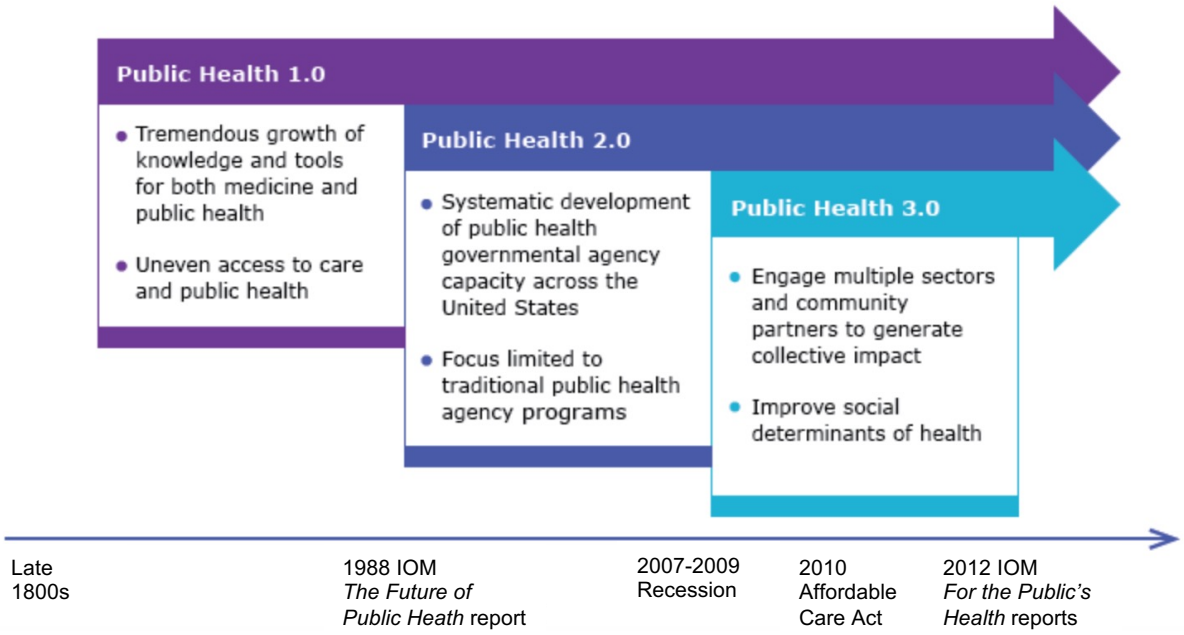
This section describes the call to action for governmental public health transformation in response to ongoing population health inequities and situates this next phase of public health practice along an evolutionary pathway dating back to the late 19th century. This section also describes early state-level transformation initiatives, including in Oregon which serves as the

study site for this dissertation research. Given the health care system alone cannot address the social determinants of health inequities, a complementary evolution in governmental public health is needed. Transformation of the public health system has been conceptualized nationally as "Public Health 3.0" and, in alignment with the WHO CSDH, emphasizes multisector partnerships and community engagement to address the social determinants of health.[1] Public Health 3.0 builds on past eras of public health practice with each reflecting a particular understanding of government's role in supporting population health and well-being (**Figure 2.3**).[1] "Public Health 1.0" refers to the period from the late 19th century through much of the 20th century in which specialized federal, state, local, and tribal public health agencies systematized sanitation, improved food and water safety, expanded understanding of diseases, developed prevention and treatment tools such as vaccines and antibiotics, and expanded capability in epidemiology and laboratory science.[1] This era is characterized by scientific and organizational progress to provide comprehensive public health protection – from primary prevention through science-based medical treatments and tertiary prevention – for the general population.[1]

"Public Health 2.0" began in the second half of the 20th century and was heavily informed by the 1988 IOM report "The Future of Public Health," which argued that public health agencies were hindered by the demands of providing safety-net clinical care at the cost of being unprepared to address the rising burden of chronic diseases and emerging threats such as the HIV/AIDS epidemic.[1] As a result, the IOM defined a common set of core functions for governmental public health and public health practitioners subsequently developed target capacities and performance standards for governmental public health agencies at every level.[1]

Consequently, governmental public health agencies became increasingly professionalized and standardized in the era of Public Health 2.0.

Figure 2.3. Evolution of public health practices[1]

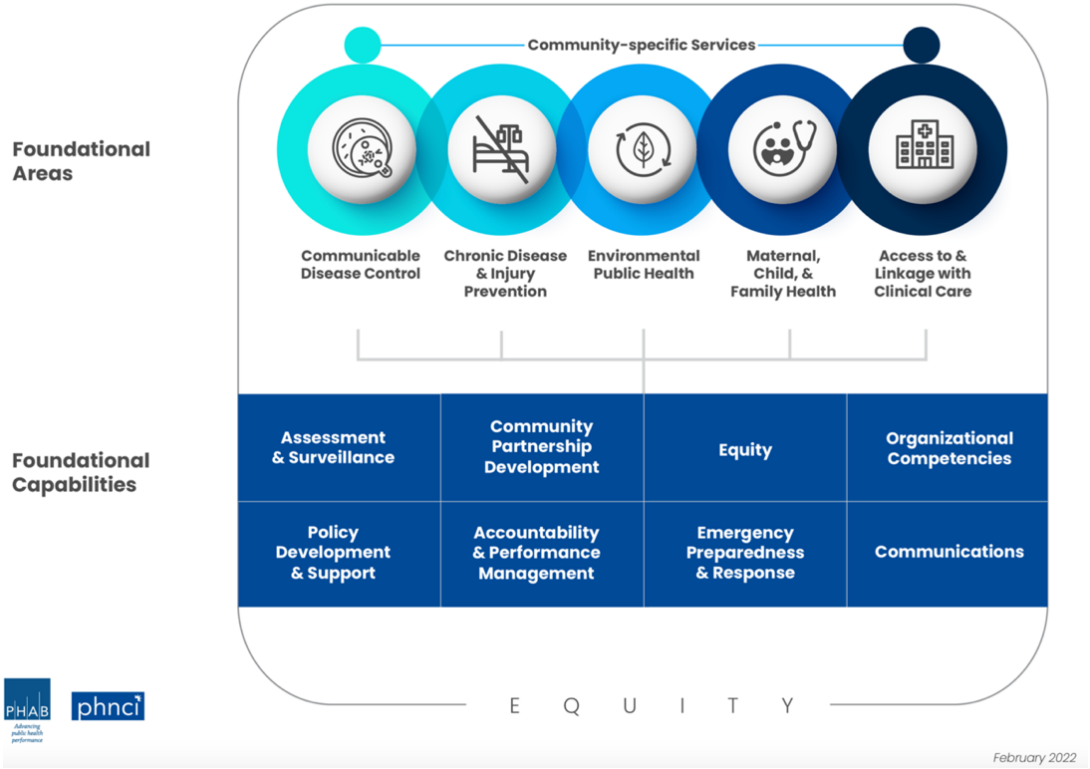


Recommendations for Public Health 3.0 reflect a broadened scope of practice that goes beyond traditional public department functions and programs to respond to increasingly complex public health problems.[1] These recommendations include 1) training the public health workforce and students on the "upstream" social determinants of health; 2) engaging public and private sector community stakeholders in "vibrant, structured" cross-sector partnerships to foster shared vision, funding, services, governance and collective action; 3) ensuring more granular (i.e., sub-county), real-time, and reliable population health data are accessible to communities for local decision-making; 4) developing clear metrics of success for prevention initiatives that target social determinants of health and enhance equity; and 5) exploring innovative funding models,

like blending and braiding funds from multiple sources, rather than being constrained by siloed, categorical funding.[1]

Complementary to the call for Public Health 3.0 was the development of a framework to define the capabilities of governmental public health in a "modern" public health system. Beginning in 2009, an IOM committee convened to consider the structure, functions, and financing of the governmental public health system and recommended a "minimum package of public health programs and services" to complement and reinforce the minimum package of clinical health care services created by the Affordable Care Act.[24] Subsequently, the Public Health Accreditation Board Center for Innovation developed the Foundational Public Health Services (FPHS) framework in 2013 which specifies a core set of public health services and workforce capabilities that should be present in every community (**Figure 2.4**).[25]

Figure 2.4. Foundational Public Health Services framework[25]



The FPHS framework reflects the public health protections provided by health departments, such as preventing the spread of communicable disease and supporting maternal and child health, and the cross-cutting skills and capacities needed to provide these protections, such as policy development and communications expertise.[24] Public health programs focused on certain diseases or public health threats are described as "foundational areas" in the FPHS framework, while elements of public health infrastructure are "foundational capabilities" of the governmental public health workforce and infrastructure.[24] The FPHS framework not only describes a "minimum package" of public health programs and services, but also describes how governmental public health may fulfill each foundational area and capability.[24]

In 2013 – the same year in which the FPHS framework was released – Leider et al. conducted 50 interviews with senior leadership at state and local health departments to determine awareness of the term "foundational capabilities."[97] Nearly half of those interviewed (21/50) had not heard of the term, but the concept of foundational workforce capabilities resonated generally. In addition, a small number of respondents identified competencies they considered missing from the FPHS framework, including those related to governance, health equity, and procurement practices.[97] Leider et al. concluded that the use of foundational capabilities was variable across respondents and recommended that jurisdictions determine the degree to which they can implement foundational capabilities without dedicated funding and identify optimal levels of the various capabilities.

While early awareness of the foundational capabilities was variable across jurisdictions, several states have since adopted and implemented the FPHS framework. Ohio, Washington, and Oregon led the field in early adoption and implementation of the FPHS framework and serve as examples of the varied pathways for statewide FPHS adoption. As described by case studies

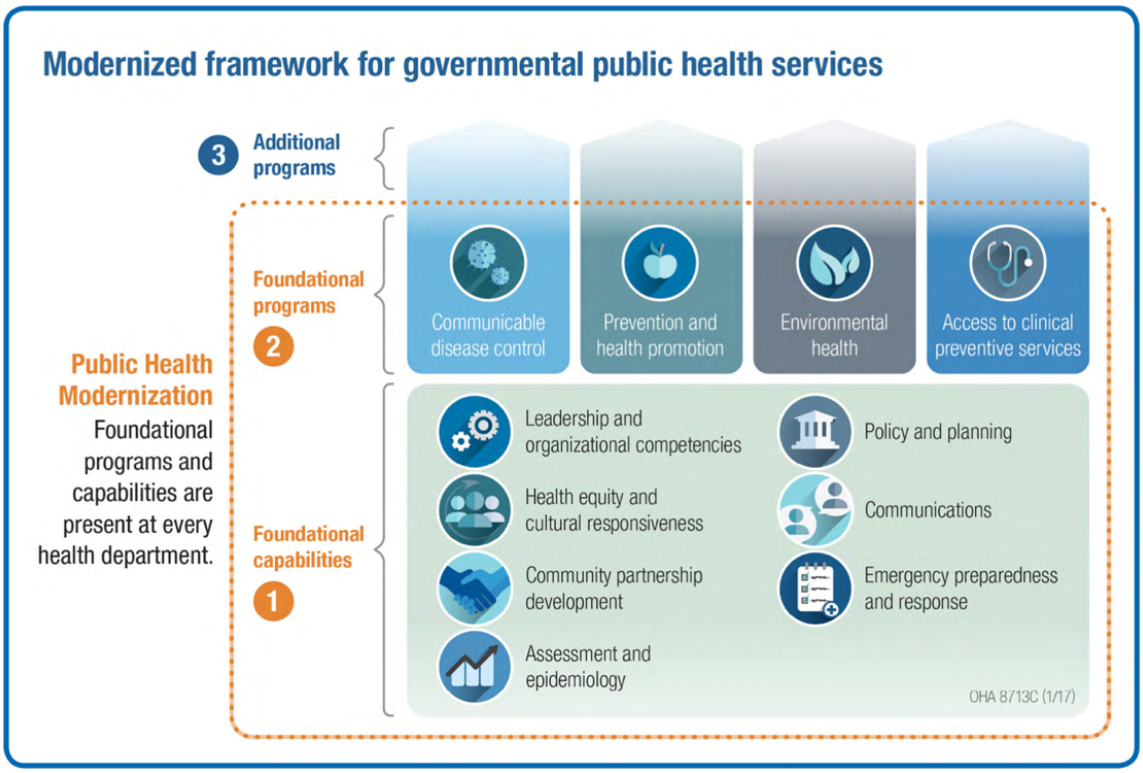
developed in 2018, early adoption efforts in Ohio included legislation requiring all local health departments to apply for and successfully become accredited by 2020; a shared services survey to assess where state programs and services would be placed in the FPHS model; and a costing tool to identify the level of FPHS being provided and what it would cost to fully implement FPHS.[98] Washington defined a state-specific package of core public health services for which the governmental public health system is responsible; supported a Tribal-led process to define public health for sovereign tribal nations; launched the "Public Health is Essential" media campaign to increase public awareness of inadequate public health funding; and initiated three shared service demonstration projects to test new service delivery models.[99]

As another early implementer of the FPHS framework, Oregon will serve as the study site for this dissertation research. In 2015, the state legislature passed House Bill 3100, which established the FPHS model in Oregon law.[100] This law also updated the composition of Oregon's Public Health Advisory Board (PHAB) and mandated a Public Health Modernization assessment and statewide plan.[100] In 2016, the Oregon Health Authority Public Health Division (OHA-PHD) worked with a consultant to assess the degree to which all 33 LPHAs and the OHA-PHD were providing FPHS and to estimate the costs of fully implementing FPHS.[100] Results were published in the "Public Health Modernization Assessment Report" and showed that foundational capabilities were not consistently present in every community, especially capacity and expertise to advance health equity and develop community partnerships.[28] In 2017, the legislature allocated $5 million to OHA-PHD for Modernization in the 2017–2019 biennium.[100] OHA-PHD allocated $3.9 million of the legislative investment to eight regional partnerships of LPHAs that covered 33 of Oregon's 36 counties for regional communicable disease control strategies with a focus on eliminating disparities among priority populations.[100,101] In addition to

the regional local grant program, the PHAB adopted accountability metrics to track progress toward Modernization and OHA-PHD would later publish the baseline "Public Health Accountability Metrics Report" in early 2018.[100,102]

In 2017, OHA-PHD also developed the Public Health Modernization framework to guide transformation efforts (**Figure 2.5**).[26] Similar to the FPHS framework on which it was based, Oregon's Modernization framework includes the foundational programs of communicable disease control, environmental health, and access to clinical preventive services, as well as the foundational capabilities of leadership and organizational competencies, assessment and epidemiology, policy and planning, communications, emergency preparedness and response, community partnership development, and health equity and cultural responsiveness.[26] Of note, the original FPHS framework did not include an "equity" foundational capability, although this was added in a 2022 update to the framework.[25] In a slight departure from the FPHS framework, Oregon's Modernization framework combines the original two foundational programs "Maternal, Child and Family Health" and "Chronic Disease and Injury Prevention" into one "Prevention and Health Promotion" foundational program. Also unlike the FPHS framework, the Modernization framework was operationalized by OHA-PHD in a 162-page "Public Health Modernization Manual" that specified "roles" for state and local governmental public health agencies in each foundational program and capability.[26] For example, one role for state and local health departments to fulfill the health equity and cultural responsiveness capability is to "promote a common understanding of cultural responsiveness," while another role for the community partnership development capability requires governmental public health to "ensure participation of community partners in local and state health planning efforts."[26] There are 51 roles for the health equity and cultural responsiveness capability alone.[26]

Figure 2.5. Oregon Public Health Modernization framework[26]



Cross-Sector Collaboration and Public Participation

This section describes the research on outcomes of cross-sector collaboration and public participation in governmental public health decision-making and related facilitators and barriers. This emphasis is driven by recommendations for intersectoral action and social participation and empowerment in the transformative public health practice frameworks described earlier. Public Health 3.0 and related local initiatives, such as Oregon's Public Health Modernization, reflect a systems change approach to address the root causes of population health inequities rather than the symptoms. Given there is no single answer to complex public health problems, systems change cannot be achieved by individual actors, but instead requires collaboration of actors across sectors, disciplines, and social groups toward a common goal. Indeed, the vast majority of

state and local public health department leaders interviewed in 2017 viewed collaboration with community partners and elected officials as a fundamental component of the political power necessary for improving health equity.[46] Consequently, modern public health practice must aim to "abandon silos and practice in a common space" with non-governmental organizations, such as advocacy groups, medical systems, and businesses, as well as the general public.[3,1]

Organizations required for multisector approaches to health equity are likely not in contractual, market-oriented relationships or part of a common hierarchy of top-down coordination, so integration is best achieved through "loosely coupled" network modes of governance with coordination characterized by informal social systems rather than bureaucratic structures.[103] Collaboration occurs when a group of autonomous allies engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain.[104] Intersectoral or cross-sector collaboration involves the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately.[68] For example, participants in Canada's Multi-sectoral Partnerships Initiative in public health reported increased resources, including increased access to people with different skills and expertise.[105] Intersectoral collaboration assumes a high degree of horizontal integration through voluntary agreements and mutual adjustments and is based on a willingness to work together rather than through mandated or other coercive forms of collaboration.[103]

Collaboration introduces organizations to new, unknown relationships that require new skill development and/or abandonment of old skills or norms,[104] so organizations will make strategic choices to become part of a cooperative network when it appears that the advantages of such an arrangement (e.g., enhanced survival capacity) outweigh the costs of maintaining the

relationship, particularly the potential loss of autonomy.[83,84] Agranoff describes six general cost categories that frustrate progress within collaborative networks: 1) general time and opportunity costs of being involved in a network; 2) time and energy costs from protracted decision-making process due to nonhierarchical, multiorganizational, multicultural decision-making processes; 3) lack of agreement due to exertion of organizational power or withholding of power; 4) network tendency towards consensus-based, risk-aversive decisions; 5) agencies' failure or unwillingness to contribute needed resources; and 6) collaborative decisions frustrated by barriers embedded in legislation and policy makers' unwillingness to make needed changes.[106]

Reviews of large-scale community coalition evaluations further suggest that involving a broad array of institutions is limited by the concept of "community" being loosely defined; the presence of many organizations leading to unclear decision-making processes; the difficulty of organizations with different sizes and institutional affiliations working together; the narratives of past failed interventions contributing to unproductive conversations on current problems; and attempting to address local problems that have regional, state, national, and international roots.[107] International studies of public participation offer several additional challenges for consideration: community engagement may contribute to a greater sense of exclusion if new spaces reinforce old hierarchies;[56] participation being linked to a sense of tokenism if not backed by outcomes;[56,108] and policy experts and civil servants perceiving citizens as lacking the necessary knowledge to participate.[57,58]

Baciu et al. contend that much of the existing research on the effectiveness of collaborative efforts to improve community health has been of "limited usefulness."[15] Research findings have been mixed or negative on the effectiveness of partnerships, with insufficient study duration being one challenge.[15] In addition, research has primarily focused on the "low-hanging

fruits," such as individual level interventions, single interventions, and interventions implemented under highly controlled conditions not generalizable to socio-culturally diverse communities.[15] A Cochrane Collaboration systematic review and meta-analysis by Hayes and colleagues in 2012 examined 16 studies with a total of 28,212 participants "comparing local collaborative partnerships between health and government agencies with standard working arrangements" and found only two good-quality studies: one showed no health improvement while the other showed modest benefit.[109] In contrast to the Haynes et al. study, a 2018 study of local health departments in the US found that collaboration with local multisector organizations was critical to providing evidence-based interventions for obesity and diabetes prevention given few interventions were delivered directly by the local health department.[105] Local multisector initiatives have also resulted in increased percentages of hypertensive patients with controlled blood pressure.[105] In addition, multisector cancer collaborations have demonstrated increased use of evidence-based approaches to facilitate cancer screening and increased cancer screening rates.[105]

Despite mixed evidence of effectiveness for community health improvement, a meta-analysis of 100 case studies of citizen participation in 20 countries proposes four types of democratic and developmental outcomes,[56] which are particularly salient in the context WHO CSDH recommendations for social participation and empowerment. The first category of outcomes relates to the construction of citizenship[3]. Democratic theorists, such as Mansbridge[110] and Pateman,[111] contend that citizen participation can help to create "better citizens" through increased political knowledge, confidence, and sense of citizenship through involvement in

[3] Note: In this dissertation, the term "citizenship" refers to the relationship between an individual and a state to which the individual owes allegiance and in turn is entitled to its protection, and does not exclude those who are undocumented or pursuing documentation.

democratic life.[56] However, where some case studies showed contributions to the construction of active citizenship, other cases showed citizen participation may lead to a sense of disempowerment and a reduced sense of agency, or to new knowledge hierarchies.[56] The second outcome category is strengthening practices of participation. Participation and democratic theorists argue that citizen engagement may strengthen the efficacy and sustainability of individual and collective citizen action.[56] Gaventa and Barrett confirm in their meta-case study analysis that citizen engagement can lead to increased capacities for action, to new forms of participation on new issues or in other issue arenas, and to deepening citizen engagement networks. While engagement can support a strengthened practice of participation, it may also be perceived as meaningless, tokenistic, or manipulative depending on the process and outcomes.[56] Some cases emphasized that engagement could contribute to new skills and alliances used for *non-positive* ends or primarily benefitting "policy elites."[56]

The third outcome type relates to strengthening the responsive and accountable state. Gaventa and Barrett identified several examples in which participation contributed to access to development resources through increased government attention to issues that may have been previously ignored; the achievement of rights by increasing capacity to claim existing rights and supporting legal or constitutional change to establish new rights; and increased state accountability through new institutionalized mechanisms for engagement that support greater transparency and right to information.[56] Although engagement can support a more responsive state, at other times it may not penetrate bureaucratic "brick walls" and fail to implement or sustain policy gains.[56] In other cases, participation may lead to retaliation against those who challenge the status quo.[56] The fourth and last outcome category is the development of inclusive and cohesive societies. Gaventa and Barrett found that citizen participation can foster a sense of

individual recognition, social identity, and dignity, which are essential to a sense of inclusion.[56] In addition, citizen engagement can support social cohesion in communities experiencing inequalities by creating space for new voices and issues in the public sphere.[56] Conversely, participation may foster a sense of exclusion when new spaces reinforce old hierarchies based on gender, class, or race.[56] Participation may also contribute to competition and conflict among groups who compete for recognition and resources in new ways.[56]

Most studies on public health collaboration focus on smaller-scale partnerships between local health departments and agencies while less is known about how state health departments collaboration with organizations outside the health sector.[105] Tsai et al. contend that state health departments may be uniquely positioned to serve as a "bridging hub" for state and local multisector collaborations to advance health equity given the central role in supporting state health policy development and managing relationships with diverse partner organizations.[105] Given the potential for state health departments to serve as a coordinating point for cross-sector collaboration, governmental public health must consider network theoretical barriers and facilitators of effective collaboration. First, network performance is influenced by the type of inception: mandated or voluntary.[112] Transaction costs of entering or exiting a network are highest with collaborative arrangements mandated through governmental authority and lowest with arrangements based on voluntary relationships and social constraints.[113] In addition, mandated networks are likely to have external legitimacy conferred by the governmental authority, but tend to lack in internal legitimacy among network actors which can serve as a barrier to collective action.[112] While mandating cross-sector collaboration (e.g., through grant funding or contracting) may generate collaborative networks in the near-term, governmental

public health will also need to facilitate more organic, voluntary collaborations for sustained networked governance.

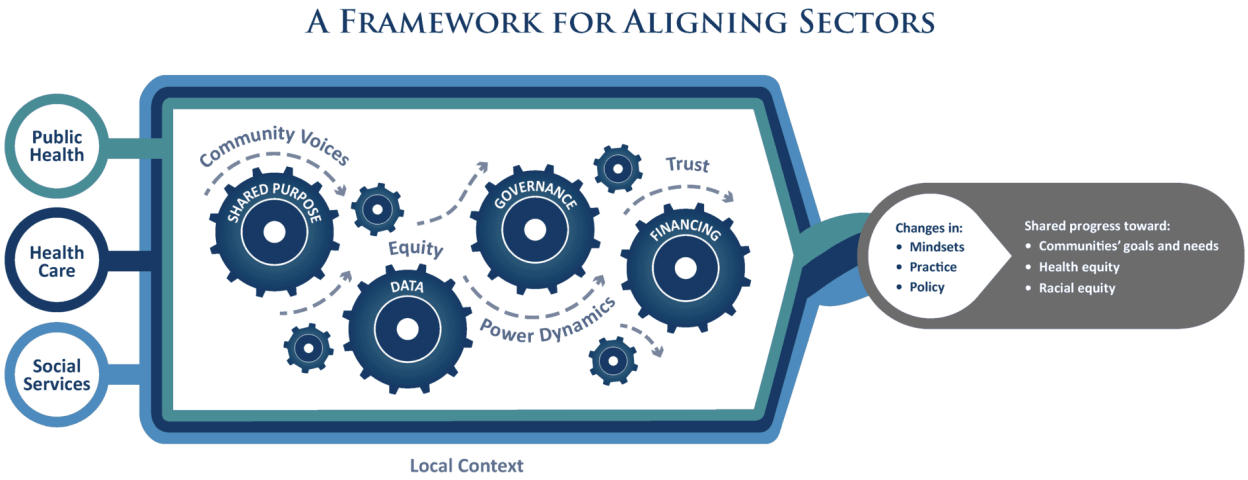
Network theorists also describe how intergovernmental relationships are embedded in larger social, political, and economic structures and that this "social embeddedness" can serve as a source of conflicting values and competing institutional logics among collaborative partners.[68] These competing logics can contribute to diverging perceptions of network performance among actors where different organizations might refer to different criteria when assessing the network.[112] This collaborative frustration is only intensified in large, diverse networks where it is difficult to reach consensus or create ties with other members, and allies are more likely to perceive the network as poorly performing due to a broader range of diverse evaluation criteria.[112] However, a breadth and diversity of network partners is required for (and perhaps a hallmark of) cross-sector collaboration, so associated barriers point to the need for coordinating mechanisms, including: a shared vision and set of priority outcomes; shared data and measurement system; sustainable financing; and robust governance structures.[113]

Cross-Sector Alignment Framework

This section describes a framework for cross-sector alignment that conceptually grounds this dissertation research, including the methods and analytic approach to be described in Chapter 3. Aligning Systems for Health is a national initiative led by the Georgia Health Policy Center and RWJF that supported 21 research grants to better understanding how to align sectors for health equity improvements.[29] The initiative is guided by the Framework for Aligning Sectors (FAS) (**Figure 2.6**), which emphasizes four core components: shared purpose, data, governance, and financing.[29,114] The FAS also includes four "adaptive factors" deemed necessary to successfully

align sectors to jointly address complex public health problems that matter to community members: community voices, equity, power dynamics, and trust.[29] The centrality of these factors is the primary differentiating point from other cross-sector alignment frameworks, including the popular Collective Impact (CI) model from Kania and Kramer.[29,115]

Figure 2.6. A Framework for Aligning Sectors[29]



Prior to describing the FAS in detail, critique of the CI model will be addressed given the model's wide use in public health research and practice. While the CDC, the Health Resources and Services Administration (HRSA), and several philanthropic funders have incorporated CI into their calls for proposals,[116] Wolff et al. assert that the use of CI was driven by a desire to conceptually simplify the process for largescale social change through multisector collaboration compared to existing, more sophisticated collaborative models, such as Butterfoss and Kegler's Community Coalition Action Theory,[117] Wolff's Power of Collaborative Solution Model,[118] and Foster Fishman and Watson's ABLe Change Framework.[119] Wolff and colleagues also describe the rapid adoption and endorsement of CI despite being introduced in a six-page essay without

pilot testing or evaluation, misrepresenting the study of a few case examples as "research," and early available research on CI that calls into question its contribution to coalition effectiveness.[120]

Literature critical of CI highlights the model's top-down business-consulting orientation rather than a community building and development approach, termed "trickle-down community engagement" by nonprofit sector leader Vu Le.[120] Critics also note the lack of a social justice core that exists in many coalitions and promoting an "illusion of inclusion" by failing to engage those most affected in the community as partners with equal power.[120] Lastly, the model fails to directly address the causes of social problems and their political, racial, and economic contexts and cite advocacy and systems change as core strategies.[120] In addition to these limitations, Wolff et al. also describe how CI assumes that most coalitions can obtain resources for a well-funded backbone organization and misses "building leadership" as a key role of the backbone organization.[120] While the CI model has evolved since its inception to include new conditions, such as "community aspiration" and "movement building," Wolff et al. contend that the lack of meaningful evaluation of the old or newer versions of the model continues to be problematic and CI's top-down collaborative model cannot be reengineered after the fact for inclusion and equity.[120]

In response to perceived flaws in the CI model, Wolff et al. developed six principles of Collaborating for Equity and Justice to facilitate successful cross-sector collaboration for social change based on "decades of multi-disciplinary research, organizing, and experience."[120] These guiding principles encourage collaboratives to 1) explicitly address issues of social and economic injustice and structural racism; 2) employ a community development approach in which residents have equal power in determining the agenda and resource allocation; 3) employ community

organizing as an intentional strategy and as part of the process; 4) focus on policy, systems, and structural change; 5) build on the extensive community-engaged scholarship and research over the last four decades; and 6) construct core functions for the collaborative based on equity and justice that provide basic facilitating structures and build member ownership and leadership.[120] Recognizing that no single model or methodology can thoroughly address structural inequities and injustice, the principles are linked to web-based tools that can be incorporated into existing and emerging models and methods, including the FAS.[120] The following sections describe the core components and adaptive factors of the FAS, as well as Wolff's principles of Collaborating for Equity and Justice in the context of governmental public health system transformation to advance health equity. Each core component and adaptive factor of the FAS will be described in detail, including potential barriers to achieving the component or factor and possible antidotes.

Shared Purpose

The first core component of the FAS is *shared purpose*, which includes establishing shared areas of focus and outcomes in partnership with people who experience the worst effects of inequities.[29] Wolff et al. contend that shared purpose must explicitly address issues of social and economic injustice and structural racism because initiatives that fail to directly address these inequities and injustices may perpetuate them.[120] Furthermore, collaborations focused on equity and justice should advance policy, systems, and structural change.[120] This orientation not only acknowledges that fundamental societal transformation requires changes in laws, policies, regulations, and practices, but also implies the need for collaboratives to develop a joint advocacy agenda and the advocacy and political skills and relationships to effectively implement the shared agenda.[120] These principles may be especially important for multisector collaborations

in which participating organizations, like state governments, are complicit in maintaining existing power dynamics that perpetuate racial and other forms of inequity and injustice. In a 2016 review of initiatives to address social determinants of health, commissioned by the National Academy of Medicine (NAM), only some focused on achieving health equity and none explicitly named addressing the role of structural racism as a mechanism through which they would achieve their shared goal.[120] Wolff et al. further note that the authors of the review did not mention structural racism or other forms of structural inequities in their conclusions and conclude that well-intentioned research to address the social determinants of health may perpetuate an ignorance of structural racism.[120]

The equity adaptive factor of the FAS is particularly salient within the context of a collaborative's shared purpose. Lynn et al. contend that initiatives with strong equity capacity have an explicit and shared lens of social justice to guide action and target interventions to address the greatest need.[121] Equity-centered initiatives also shift power from systems leaders to community partners such that their voices, assets, and solutions drive change.[121] Strong equity initiatives are also intentional about representation, inclusion, and empowerment.[121] Unfortunately, a recent environmental scan of governmental public health's capacity to advance equity identified several barriers that may inform the development of an equity-centered shared purpose.[122] First, there are many different definitions of health equity being used by public health agencies, and while some definitions are highly cited, no single definition of health equity is considered the "gold standard."[122] In addition, the conceptually distinct terms health disparities, health equity, and social determinants of health are used interchangeably, suggesting a need to clarify these concepts.[122] Second, the scan found that while many practitioners view advancing equity as a critical role for public health, the capacity to do so is limited when equity is not an

explicit mandate, when there are competing priorities or mandates, and when there is not a specified funding source.[122] In addition, some practitioners believe that it is not feasible for public health agencies to lead work on equity and should instead opt for a "supporting role."[122]

Brunton and Smedley recommend internal and external strategies for public health departments to build capacity to advance health equity.[122] Internal strategies include incorporating equity principles into the agency's mission, vision, and formal mandate; embed principles of diversity, equity, and inclusion in hiring practices; and support individual staff to develop critical skills in leadership, communication, system thinking, and partnership building (i.e., skills that may fall outside a traditional public health curriculum).[122] External strategies are approached in partnership with communities and other agencies and include building and maintaining strong relationships with partners in other governmental agencies, businesses, nonprofits, health systems, and communities; engage with thought leaders nationally to share knowledge and strategies and build political will for racial equity; acknowledge and shift power imbalances between community and decision makers; and develop a shared narrative of equity with community "at the table and in the lead."[122]

In addition to capacity building strategies, Health in All Policies (HiAP) has become a popular approach to public policy that promotes cross-sector integration and could inform the shared purpose of public health collaboratives.[123] HiAP is defined by the WHO as an approach that "systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity."[123] HiAP has five key elements for sustainable impact, including: 1) promoting health and equity by embedding these values into policies, programs, and processes; 2) facilitating intersectoral collaboration by convening multi-sector stakeholders to recognize the

connections between health and other policy issue areas, break down policy silos, and build partnerships; 3) ensuring policy and program goals of public health and government agencies in other sectors are synergistic and derive benefit to multiple partnerships; 4) engaging stakeholders beyond government partners such as community members, policy experts, advocates, the private sector, and funders; and 5) creating structural or procedural change on how government works by embedding health and equity into all levels of government decision-making.[123]

HiAP was first popularized in Finland in the mid-2000s as an approach to increase multisectoral coordination across European Union countries.[123] In the United States, the NAM has highlighted HiAP in reports and discussion papers, NACCHO became the first national association to adopt a position statement on HiAP in 2012, and the CDC promoted the HiAP approach as one way to achieve the National Prevention Strategy and Healthy People 2020 goals.[123] The HiAP Program has facilitated multi-agency problem solving, capacity building, and action on topics such as embedding equity in government practices; healthy transportation; land use and health; access to parks and urban forestry; housing siting and air quality; healthy and sustainable food procurement; and childhood trauma prevention. For example, California's government embedded health and equity criteria in over $5 billion of state grants serving over 350 communities in 49 counties as a result of a HiAP Program.[123]

Despite the promise of a HiAP approach, a 2017 survey of the governmental public health workforce in the US found relatively low awareness of "health in all policies" (60%) and "multisector collaboration" (67%) compared to concepts like "evidence-based public health" (80%) and "fostering a culture of quality improvement" (81%).[124] In addition, practitioners of the HiAP approach introduce equity "selectively and strategically" depending on the political environment. In instances where HiAP faced ideological barriers, practitioners described

avoiding the use of terms such as "equity" or "race" and argued that framing the discussion around income and disease-specific indicators was "more productive."[123] Consequently, the degree to which HiAP can be used to explicitly promote a shared purpose that advances health equity policy interventions appears to depend on political values. Similarly, while laws using the term "HiAP" or containing HiAP elements have been increasingly passed in jurisdictions in the United States, differences exist on the explicit mention of the emphasis on health equity.[123]

In addition to advancing health equity broadly, COVID-19 pandemic inequities, the 2020 uprisings for Black liberation, and increasing state and local voting restrictions illuminate how particularly high the stakes are for Black, Indigenous, and other people of color. Indeed, Farhang and Morales emphasize that previously quiet conversations about advancing health equity and "moving upstream" have evolved into more public debates about the need to center racial equity in institutional efforts to achieve health equity.[125] For example, as of October 2021, the American Public Health Association tracked more than 220 jurisdictions that had named racism a public health crisis, and organizations across various sectors are making visible commitments to transform their practices, programs, and policies to achieve racial equity.[125] Acknowledging the centrality of racism – particularly structural racism – in racial differences in morbidity and mortality patterns, rather than individual genetic or behavioral factors, shifts the narrative frame from people to institutional policies and practices and reconceives the public health problem and potential solutions that form the basis of a shared purpose and outcomes.[69]

Centering racism as a public health crisis has led many organizations to approach health equity initiatives with a "lead with race" approach. For example, Human Impact Partners (HIP) leads explicitly, though not exclusively, with race because racism is "baked into the creation and ongoing policies of government, media, and other institutions" unless otherwise countered.[126]

HIP also leads with race because inequities based on other dimensions of identity – income, gender, sexuality, education, ability, age, citizenship, and geography – are compounded by racial identity.[126] HIP contends that while advancing health equity requires addressing "all areas of marginalization and understanding the interconnected nature of oppression," governments will be better equipped to transform systems and institutions impacting other marginalized groups by deepening their ability to eliminate racial inequities.[126] HIP offers several examples of local health departments that are leading with race. The Boston Public Health Commission in Massachusetts developed an Anti-Racism Advisory Committee, requires all staff to participate in racial justice and health equity training, and created accountability mechanisms to ensure that their workforce reflects the city's population.[126] In addition, Cuyahoga County in Ohio commissioned a report to examine how racial differences in neighborhood opportunities and health outcomes today were created by institutional racism in past housing policy and created an *Eliminating Structural Racism Subcommittee* in their Community Health Improvement Plan consortium.[126]

These local examples are complemented by national efforts to convene and elevate organizations that are leading with a race-centered approach to advancing equity. First, the Government Alliance on Race and Equity (GARE) is a national network of governmental jurisdictions that have committed to achieving racial equity, focusing on the power and influence of their own institutions, and working in partnership with one another.[127] GARE supports a cohort of jurisdictions and provides best practices, tools, and resources to build a national movement for racial equity; developed a "pathway for entry" into racial equity work for new jurisdictions that may lack the leadership and/or infrastructure to address racial inequities; and supports and builds local and regional collaborations that are broadly inclusive and focus on

achieving racial equity.[127] In addition to GARE, the Public Health Institute (PHI) works in collaboration with state, philanthropic, and training partners to offer the Capitol Collaborative on Race & Equity (CCORE) initiative.[128] CCORE's anticipated outcomes are for state governments to establish Racial Equity Action Plans and develop organizational leadership to implement the plans; increase transparency around racial equity commitments and progress; and pursue resources to advance racial equity.[128]

Given the principles of Collaborating for Equity and Justice include a focus on systems change,[120] collaboratives may employ a systems thinking orientation to ensure their shared purpose addresses the 'whole' system rather than focusing exclusively on individual components.[129] In addition, systems science methods can be used by collaborators to visualize the relationships between public health inequities and systems and structures. This approach to developing shared purpose may support a shift from acute care and epidemiological models that focus on isolating independent causes to viewing health as "long-term, evolving, contextually embedded" and molded by "interconnected forces" at multiple levels.[130] For example, a public health-led community health improvement planning process in Cuyahoga County, Ohio engaged a cross-sector consortium to create causal loop diagrams of structural racism.[131] The group model building process centered the lived experience of those most affected by structural racism and led to a shared understanding and language of the systems underlying racism and identification of potential leverage points for systemic change in the areas of criminal justice, education and economic opportunity, health and health care, quality of life, and racial trauma and healing.[131] The systems thinking approach not only enabled cross-sector partners to develop a shared understanding of the interconnected institutions enabling systemic racism and potential leverage points for change, but also nurtured the development of trust and community-driven solutions.

Similarly, Black Hawk County Public Health in Waterloo-Cedar Falls, Iowa engaged cross-sector partners in a participatory process of system mapping to develop a shared understanding of community conditions.[132] Collaborators developed a system map visualizing patterns driving inequitable outcomes, as well as bright spots and resiliencies experienced across the community. System mapping supported collaborators to describe not only needs and deficits in the community, a common practice in public health, but also community strengths and assets. The system map was also populated with local stories and data to represent a "theory of context" on which to base strategies to shift systems in support of a healthier community. Collaborators also co-created a "diagnosis of the current system" in the form of a challenge statement: "This system is perfectly functioning to maintain the status quo—reinforcing existing power and privilege while further harming large groups in our community, bringing forward a history of distrust and hopelessness, and creating an environment of conflict and polarization."[132] The system mapping process supported governmental public health to collaborate with nontraditional partners on a shared understanding of the context in which inequities are perpetuated and the community assets that may help address inequities.

In addition to practical challenges, such as learning other sectors' language and understanding embedded values and priorities,[108] developing a shared purpose that addresses the social determinants of health inequities and centers racism as a cause, is likely to be limited by the current neoliberal paradigm under which many public health organizations continue to operate. Neoliberal approaches in the health sector mandated market-oriented reforms that emphasized efficiency over equity as a system goal and reduced government programs comprising the social safety net.[4] This contraction of the welfare state occurred despite an increasingly robust evidence base linking public policy with key population health outcomes. For

example, Navarro et al. found that cumulative years of government by a pro–redistributive party and higher public health expenditures were significantly correlated with lower infant mortality (a key indicator of population health overall).[133] Neoliberalism's influence on social policy is exemplified in welfare reforms where the receding boundaries of the welfare state that were once staked on the basis of need, legal right, and family status became conditional on individual contribution to the market economy (e.g., income benefits conditional on work).[134] This conception of social policy stands in stark contrast to Beland and Katapally's description of the population health agenda as "a politically-charged science that lean[s] towards collective good, rather than neo-liberal, free market capitalism."[33] However, this ideology of market-driven efficiency and productivity has driven government reforms for decades and must be considered and counteracted in discussions of shared purpose with cross-sector collaborators.

Shared Governance

Shared governance is another core component of the FAS, which focuses on the development of robust decision-making and leadership structures that include and elevate local representation and voice.[29] Within the context of collective action, Ostrom describes governance as "jointly determined norms and rules" to regulate individual and group behavior.[135] Furthermore, governance arrangements support "a set of coordinating and monitoring activities" that enable the survival of collaborative partnerships.[135] Ansell and Gash center the state in defining collaborative governance as an "arrangement where one or more public agencies directly engage non-state interested parties in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets."[55] Other scholars have emphasized more emergent "cross-boundary" forms

of governance that extend beyond state-initiated arrangements, including public-private and private-social partnerships and community-based collaboratives.[135] However, Ansell and Gash's definition is particularly appropriate for this dissertation research given the focus on governmental public health's capacity for collaboration with CBOs.

Scholars have traced the roots of collaborative governance back to the study of intergovernmental cooperation in the 1960s and even back to American federalism generally as "the most enduring model of collaborative problem resolution."[135] Collaborative governance has been studied in several policy contexts, including law enforcement agencies, the Veteran's Health Administration, and the Department of Homeland Security, and applied to diverse research areas, including child and family service delivery, government contracting, local economic policy, crisis management, and on environmental issues such as the protection of open-spaces, natural resources management, and forest management.[135] Many public administration scholars view collaborative governance as a new paradigm for decision-making in democratic systems given declines in American civic institutions and voting behaviors.[135] In keeping with the WHO CSDH recommendation for social participation and empowerment,[4] new or enhanced forms of public engagement have been constructed as a "deliberative democracy movement" that promises opportunities for citizens to exercise voice and a more responsive government that embeds institutions with greater levels of transparency, accountability, and legitimacy.[135] Indeed, the National Academies of Science, Engineering, and Medicine convened a workshop in 2022 on civic engagement and civic infrastructure to advance health equity and confirmed democratic deliberation as "purpose-built for social questions that involve competing values and sensitive or contentious issues and where there may be low trust."[54]

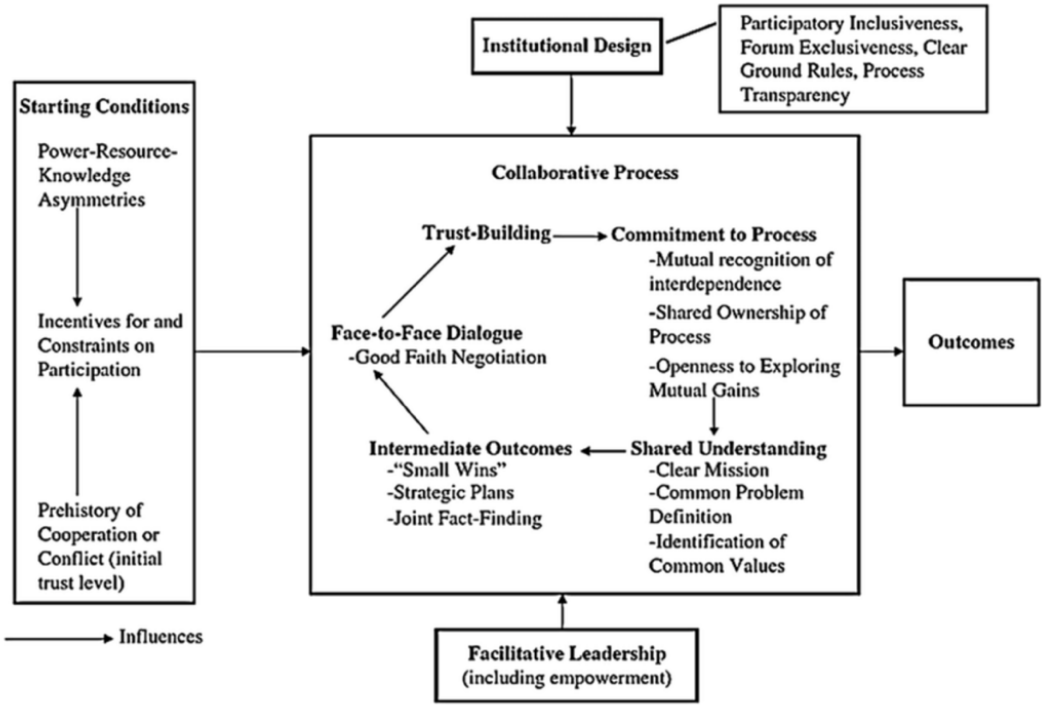
The WHO CSDH emphasizes the state's responsibility for developing "real" participation opportunities for the public given health politics relies on a cooperative relationship between citizens and institutions.[4] Indeed, Oregon's conception of a modern public health system relies on shared planning and decision-making with community members. For example, the "core system functions" of the health equity and community partnerships foundational capabilities require state and local public health departments to "earn and maintain the trust of community residents and engage them at the grassroots level…towards common goals and ensuring mutual benefits" and to "co-create objectives, milestones and outcome measures for resource allocations, funding allocations, work plans and implementation timelines with priority populations."[26]

Currently, centering community voice in governmental public health decision-making is often accomplished through state and local community health improvement planning required for public health department accreditation.[136] A state's health improvement plan (SHIP) describes how the health department and the community will work together to improve population health. The state health agency typically leads SHIP development and works with the community and other partners to set priorities, allocate resources, and develop and implement programs and policies using a process prescribed by Public Health Accreditation requirements.[136] The influence of community voice on shifting statewide public health priorities from intermediary to social determinants of health was observed in Oregon's 2020-2024 SHIP process. In 2018, a workgroup composed of members of academia, public health practice, and CBOs recommended a shift away from priorities like tobacco use and obesity, to new social-structural priorities, including institutional bias, trauma, and economic drivers.[60] However, this example may not reflect the outcome of most SHIP processes; an analysis in 2018 of all 44 SHIPs by ASTHO

revealed tobacco use and chronic disease as the top 2 priorities areas, with health disparities/health equity in third.[136]

While community-oriented theories of post-liberal democracy reject the state as *the* unifying point for democratic empowerment,[137] the model of collaborative governance offered by Ansell and Gash may provide a path forward by placing the state as *one* unifying point for citizen engagement in shared decision-making.[55] In addition, Boswell et al. note that "invited spaces," or state-initiated arenas for public participation, have more direct influence on policy decisions and decision-making processes compared to "invented" participation spaces created by citizens.[138] Consequently, Pagatpatan and Ward conclude that it is essential to recognize and use state institutional support to sustain public participation spaces.[138] To this end, the Ansell and Gash Model of Collaborative Governance considers variables related to starting conditions, leadership, and institutional design that may influence the success of collaborations, as well as factors deemed crucial within the collaborative process itself (**Figure 2.7**).[55] The model was built on an analysis of 137 cases identified through a systematic review of literature on "comanagement," "public participation" and other related concepts from a range of disciplines, including public health, education, social welfare, and international relations.[55] The Model of Collaborative Governance will be described in detail since the model will be used in this dissertation research to operationalize the governance core component of the FAS.

Figure 2.7. A Model of Collaborative Governance[55]



Starting conditions variables set the basic level of trust, conflict, and social capital that become resources or liabilities during the collaboration and include acknowledging the history of conflict or cooperation; providing appropriate incentives for stakeholder participation; and recognizing and accounting for power, resource, and knowledge asymmetries.[55] Research on interorganizational collaborations, especially in health-related organizations, and community engagement identifies trust as essential to success and confirms its inclusion as an adaptive factor in the FAS.[139,140,135] Indeed, the extent to which network members trust and value their partners can determine levels of cooperation and higher trust has been associated with the number and diversity of resources in a network.[139] Unfortunately, a public opinion poll conducted by RWJF and Harvard in March 2021 found that only 44% of respondents trusted the recommendations of their local health department "a great deal" or "quite a lot" and 41% trusted those from their state

health department.[88] Given the government's historical and contemporary role in discrimination, from apartheid to disenfranchisement laws that disproportionately affect young Black men,[141,142] earning and maintaining the trust of community members for co-creation of shared public health goals will be difficult. In addition, residents who engage in participation opportunities may experience challenging power dynamics, a limited scope of the work, engagement strategies that are tokenizing, and a lack of sustained participation that further contribute to distrust.[108] Governmental public health must acknowledge its position in the state apparatus of exclusion while also differentiating itself as supporting empowerment of communities. Creating space within decision-making opportunities to acknowledge and discuss the state's role in producing and perpetuating inequities in the community may be an essential starting place from which to build trust and legitimacy.

While the collaborative governance framework does not apply an explicit racial equity lens to the starting conditions, the Praxis Project's Working Principles for Health Justice and Racial Equity affirm that organizations must "deliberatively and affirmatively" take stock of and address past injustices while working toward equitable opportunities for health and well-being.[143] The Working Principles also describe the need for historical repair and reparations for oppressed communities which may, in part, come from the redistribution of power, resources, and opportunity through participation in collaborative governance.[143] Furthermore, the W.K. Kellogg Foundation's Truth, Racial Health, and Transformation framework includes "acknowledging the wrongs of the past and addressing the consequences of those wrongs" as one of its five pillars to address the historic and contemporary effects of racism.[144]

Potential power, resource, and knowledge asymmetries must also be addressed prior to initiating collaborative governance arrangements. Ansell and Gash note that collaborations are

prone to "manipulation by stronger actors" when participants do not have the capacity, organization, status, or resources to participate on equal footing with other participants.[55] Consequently, governmental public health must implement "proactive strategies of mobilizing less well-represented stakeholders."[55] Younger organizations, in particular, may find it more difficult to engage in collaborative relationships given competing demands for their limited resources and shallower networks and connections compared to older, well-established organizations.[83] Lastly, power imbalances borne of asymmetric information may be mitigated by state provision of targeted technical assistance via trusted community groups and dedicating time in the collaborative forum to jointly process information.[55]

Facilitative leadership considers the essential role of mediation and facilitation in the collaborative process.[55] The model specifies a "steward of the process" who promotes broad and active participation, ensures broad-based influence and control, and facilitates productive group dynamics.[55] Feldman and Khademian's concept of the "inclusive public manager" may inform the leadership role of governmental public health staff in collaborative governance arrangements.[145] Participant deliberation and negotiation are supported (and perhaps enabled) by the *informational work* of the inclusive public manager who serves as a "broker, translator, and synthesizer" in the collaborative space.[145] As a broker, the public manager receives information reflecting different ways of knowing a policy issue and distributes the information across boundaries. As a translator, the public manager "reformulates" ways of knowing so the diverse information can be appreciated, or at least understood, across participant boundaries. As a synthesizer, the public manager identifies ways in which diverse information can be combined to create new ways of *shared* understanding.[145] Complementary to informational work, the

inclusive public manager also engages in *relational work* to "create connections between people in ways that develop the potential for empathy and legitimize different perspectives."[145]

Embodying the role of inclusive public manager will be hampered by historical public administration models that continue to influence practice. For example, the New Public Management (NPM) model of the 1980s ushered in a market orientation to the public health field that brought decentralization and privatization of programs and services and an increased emphasis on efficiency and accountability realized through performance monitoring systems.[32] Under NPM, public managers were urged to "steer, not row" their organizations (i.e., make policy, but utilize other actors to deliver public services) and were tasked with privatizing previously public functions, holding executive leadership accountable for performance goals, establishing new processes for measuring productivity and effectiveness, and reengineering departmental systems to reflect a strengthened commitment to accountability.[32] Government agencies were also urged to adopt private sector practices deemed useful for productivity and effectiveness, such as "scientific management" and "total quality management."[32] In addition to adopting the techniques of business administration, government under NPM also adopted certain business values as well, including productivity and effectiveness.[32] NPM became a normative model for public administration and management, exemplified by the period of Public Health 2.0 with its emphasis on professionalism, specialization, and development of target capacities and performance standards for governmental public health agencies.[1]

Proponents of NPM contrast it with the formal bureaucracies of Old Public Administration characterized by excessive rules, rigid budgeting and personnel systems, and a preoccupation with control.[32] Whereas NPM provides wide latitude to decentralized public organizations to progress entrepreneurial goals through market mechanisms, Old Public

Administration advances politically determined objectives through administrative officials in centralized public agencies working with limited discretion and top-down authority.[32] These traditional bureaucracies are described as "ignoring citizens, shunning innovation, and serving their own needs" with NPM's principles of entrepreneurship positioned as the clearly superior administrative form.[32] However, both of these public administration perspectives stand in stark contrast to the core of the population health agenda which is "a philosophy of social justice and equity" and the need for coordination in the public sector. [32,33]

Denhardt and Denhardt offer "New Public Service" as an alternative model of public administration that is grounded in theories of democratic citizenship and organization humanism, discourse theory, and models of community and civil society.[32] Whereas New Public Management championed a vision of public managers as the "entrepreneurs of a new, leaner, and increasingly privatized government," New Public Service acknowledges the increasingly important role of the public servant to help community members articulate and meet their shared interests rather than to control or steer society.[32] Denhardt and Denhardt offer seven principles of New Public Service to guide governmental public health participation in collaboratives.[32] The first principle is to "serve rather than steer," which includes supporting citizens to describe and meet shared interests rather than acting as a "catalyst to unleash market forces."[32] The second principle is that public interest is the aim rather than the by-product of public management.[32] Public administrators should focus on building a shared understanding of the public interest and shared responsibility to meet that interest rather than efficiently finding solutions driven by individual choices.

The third principle is to "think strategically and act democratically," implying that programs and policies can most effectively and responsibly meet public needs through

collaborative processes. The fourth principle is to "serve citizens, not customers."[32] This principle acknowledges that building a shared understanding of the public interest results from dialogue about shared values rather than the aggregation of individual self-interests (i.e., market-driven approaches to accountability). This distinction means that public servants do not respond to demands from "customers" but rather build relationships of trust and collaboration with citizens. The fifth principle states that "accountability is not simple" and public servants should be attentive to more than the market, including laws, community values, political norms, professional standards, and citizen interests.[32] The sixth principle is to value people, not just productivity, given public organizations and their professional networks are more likely to achieve long-term success if they operate through collaborative processes and shared leadership.[32] (This principle could be re-written as "value people *over* productivity" to better reflect the model's community centeredness.) The seventh principle is to value citizenship and public service above entrepreneurship.[32] This principle discourages entrepreneurial managers from acting as if public money were their own and asserts that democratic values should be paramount to our systems of decision-making. Overall, Denhardt and Denhardt contend that while market-driven values such as efficiency and productivity should not be lost, they should be placed within the context of democracy, community, and the public interest.[32]

Importantly, public managers will need to be incentivized to transition from old public administration models to New Public Service and inclusive public management. A 2006 study of 14 public management networks in the central US found that public managers were hesitant to give up agency authority and resources to nongovernmental organizations as a collaborative cost, because they "know best" how to carry out the agency's mission and programs.[106] Furthermore, public managers continued to advance most of their work within the agency hierarchy despite

network participation.[106] Agranoff concludes that while mutual dependency in networks leads to increases in horizontal relationships across boundaries, these connections seem to "overlay the hierarchy" rather than replace them.[106] A study of participatory policymaking projects in two municipalities in the Netherlands appears to confirm government's maintenance of power in public processes. The Dutch case studies found that citizen participation did not lead to a new division of roles between government and citizens. Rather, the projects were designed by local government to gather information and leave vertical government decision-making intact. Indeed, an internet survey of citizen participants found that 35% were critical of the "excessively dominant role" of civil servants in defining the outcome of participatory processes.[146]

The creativity and flexibility required of governmental public health practitioners to collaborate for joint problem solving may not currently be fostered or rewarded within the current workforce. The 2017 Public Health Workforce Interests and Needs Survey showed that while the majority of employees recognize that public health has a role in affecting health equity (85%) and social determinants of health, like the quality of housing (59%) and the built environment (55%), less than half felt creativity and innovation are rewarded.[124] Consequently, Sellers et al. recommend that public health agency leaders create workforce development plans that align with new staff training needs and highlight the supervisor's role in ensuring workers receive the training to develop skills such as systems thinking and relational coordination.[124]

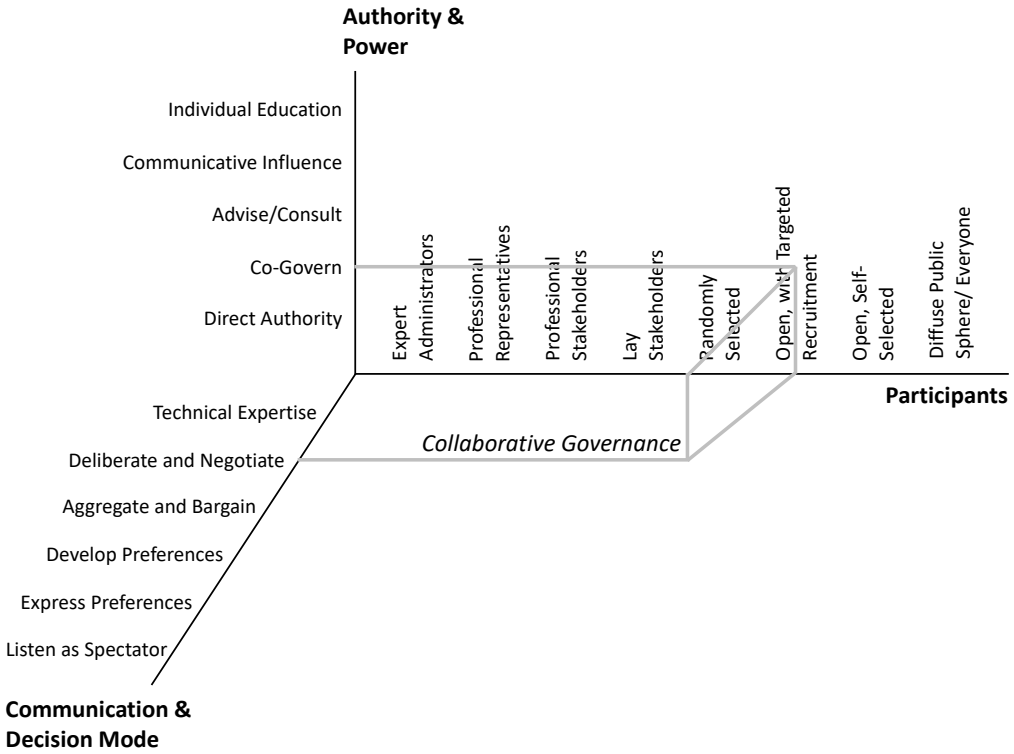
In addition, changes to hiring practices can complement new incentive structures for existing staff. In the report "Public Health Forward: Modernizing the U.S. Public Health System," the Bipartisan Policy Center provides several workforce recommendations in response to the "pervasive disparities" exposed by the COVID-19 pandemic.[88] First, organizations should focus on hiring people who are good at listening and observing, in addition to a typical focus on

subject matter expertise, to avoid an "overreliance on previous knowledge and to ensure that the voices of people 'on the ground' are heard."[88] In addition, organizations must expand opportunities and reduce barriers for Black and Indigenous communities, people of color, and people with differing abilities, all of whom are under-represented in governmental public health, particularly in leadership positions.[88] For example, organizations can formalize partnerships and programs with academic institutions, including Historically Black Colleges and Universities, local boards of health, and technical training programs to provide students of color and other marginalized groups with experiential opportunities in public health.[88] Organizations can also expand paid internships and fellowships, loan-repayment programs, and other career on-ramp programs with a focus on achieving equitable representation in the public health workforce.[88] Lastly, organizations can hire outreach workers who live in communities experiencing health inequities to assist with building trusting relationships and engaging community members.[88] The Minnesota Department of Health, for example, centered equity during the COVID-19 response by investing in several new workforce positions, including: a systems planner to partner closely with Communities of Color, American Indian, and LGBTQ+ communities; a disability systems planner and a digital accessibility coordinator to engage and serve the diverse needs and opportunities for those with disabilities and their families; and a diverse communication specialists to co-create culturally appropriate COVID-19 messaging and materials.[147]

Institutional design variables set the basic ground rules under which collaboration takes place, and include a forum that is initiated by the state, formally organized, and meets collectively; broad participation that is actively sought and includes nonstate participants; clear ground rules and process transparency that contribute to procedural legitimacy and trust-building; and realistic timetables for collaboration so as to not arbitrarily limit the discussion

scope and undercut ongoing collaboration.[55] Fung offers a framework for understanding the range of institutional designs for public participation,[49] which vary along three dimensions of participation, including 1) who participates; 2) how participants communicate with one another and make decisions together, and 3) how participation is linked to public policy and program outcomes. These dimensions represent decision points for "designers" of participation opportunities that reflect desired openness and inclusivity of the process. While Fung articulates a variety of institutional designs for public participation and contends that "modes of contemporary participation are, and should be, legion,"[49] applying the collaborative governance framework of Ansell and Gash to these designs reveals a more limited set of options for authentic public engagement in decision-making processes (**Figure 2.8**).

Figure 2.8. Collaborative governance on the Democracy Cube[49]



Fung notes that most public participation mechanisms use the least restrictive method of selecting participants as "they are open to all who wish to attend."[49] While this method of participant *self-selection* would appear to promote the open and inclusive processes emphasized by collaborative governance, the reality of self-selection finds that "individuals who are wealthier and better educated tend to participate more than those who lack these advantages."[49] Arnstein argues that "participation is valuable to the extent that it is the redistribution of power that enables the have-not citizens…to be deliberately included in the future."[49] Oregon's Modernization effort requires state and local health departments to co-create public health objectives with *priority* populations, specifically, and supports the technically more restrictive method of *selective recruitment* of participants from subgroups that are less likely to engage.[26] Importantly, selective recruitment of marginalized community members should be accompanied by structural incentives – including, but not limited to, compensation, transportation, child-care, translation services, meals, accessible meeting times, and observance of cultural and religious celebrations and holidays[143] – that mitigate potential resource and power asymmetries reflected in the starting conditions of the collaborative governance framework. Fung notes *random selection* of participants from the general population as "guaranteeing the best descriptive representatives."[49] While this method ensures *equal* participation, it may fail to produce *equitable* participation required by the Model of Collaborative Governance and Modernization.

Public managers may also engage *lay stakeholders* who are unpaid citizens with deep issue interest and substantial time and energy available to participate;[49] however, this selection method reinforces resource asymmetries and contradicts recommendations to pay community partners for their time and expertise in participation spaces. *Professional stakeholders* may also be selected for participation, but these paid representatives of organized interests likely maintain

the concentration of power in policy networks and may not represent the broader interests of affected communities.[49] Indeed, Wolff et al. contend that if the selection of key community leaders is ill defined, participation may result in the inclusion of hand-picked community leaders known to represent the status quo rather than the interests of community residents.[120] In addition, Chaskin contends that most community collaboration initiatives succeed in engaging only a small set of residents, typically those already involved in neighborhood affairs.[148] Consequently, residents who do not typically participate in the governance of collaboratives may begin with the disadvantage of being a relatively small proportion of the group, less comfortable with the established mode of planning and decision-making, and less confident of their knowledge and contribution than professionals who sit in similar capacities on several boards and committees.[148] Conveners must also consider how ongoing requests for participation in community-driven work may tax already overburdened residents.[108]

These considerations may require collaboratives to build community capacity to participate in shared governance. Capacity building is the "the process of building and strengthening the systems, structures, cultures, skills, resources, and power that organizations need to serve their communities," and broadly includes the existence of resources, networks of relationships, leadership, and support for a process of participation in collective problem solving.[149] Unfortunately, opportunities for capacity building have been largely inaccessible to nonprofit organizations of color, which is especially problematic if more selective strategies for recruitment target organizations serving communities experiencing structural oppression.[149] Nishimura et al. describe how conventional capacity building opportunities often rely on tools, workshops, and resources designed by white consultants for white-led, mainstream nonprofits.[149] Organizations of color are often encouraged to assimilate to standards rooted in white

professionalism that emphasize "values of individualism, technical solutions, worship of the written word, and effectiveness" that may not resonate with values driving nonprofits of color.[149] Building culturally resonant relationships requires capacity builders to understand and engage with local organizations through their specific communities' cultural lens and practices.[149] Culturally resonant approaches to capacity building may also engender the "deep trust" – a firm belief in the reliability, integrity, and discernment of those one works with – required for collaboratives to address complex issues together."[149]

While selective recruitment supports equitable access to public decision-making spaces, institutional design choices about how participants' preferences are integrated into the process and how those preferences are linked to policy and program decisions are essential considerations of meaningful public engagement. While the *aggregation and bargaining* mode of decision-making develops a collective choice by amassing known participant preferences, it can be mediated by the influence that participants bring into the process and thus maintains external power imbalances.[49] In addition, participants from marginalized communities may not enter the process with pre-formed preferences due to information asymmetries. An institutional design that emphasizes *deliberation and negotiation* may remedy these asymmetries as it allows participants to "absorb educational background materials and exchange perspectives, experiences, and reasons with one another to develop their views and discover their interests."[49] Several tools exist to help define the public's role in participation processes, including Arnstein's "ladder of participation,"[150] the CDC's "continuum of community engagement,"[151] and the International Association for Public Participation (IAP2) "public participation spectrum."[48]

These forms of public participation speak to the *depth* of participation or the extent to which participation "enables residents to have any control over decisions and actions that

impinge on their lives."[152] The IAP2 public participation spectrum, for example, contrasts *consult* forms of public participation in which the goal is to "obtain public feedback on analysis, alternatives, and/or decisions" to *collaborate* forms that seek to "partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solutions."[48] Lewis et al. contend that depth of participation requires that conveners consider the range of opportunities for participation and allow residents to engage in ways that work for them as individuals.[152] For example, Neshkova and Guo identified seven strategies of seeking citizen input and situated each strategy within the IAP2 spectrum, ranging from telephone hotlines and citizen surveys that support public *consultation* to citizen advisory boards and commissions that support *collaboration* with the public.[153] Research shows that citizens have clear preferences for two-way communication and find participation more beneficial when there is opportunity to discuss issues with professional administrators and develop in-depth knowledge. Citizen advisory boards and commissions most closely meet this preference.[153]

The last area of the collaborative governance framework considers *process* variables deemed crucial to successful collaborations, including face-to-face dialogue; building trust among stakeholders; commitment to the process through shared ownership, mutual recognition of interdependence and openness to exploring gains; shared understanding through a clear mission, common problem definition, and common values; and critical process outcomes essential to building momentum, including small wins, strategic planning, and joint fact finding.[55] Wolff et al. posit that facilitating structures within collaborative processes must be vigilant of the power dynamics among collaborative members and have the "capacity to identify and name practices and processes that intentionally or unintentionally contribute to power imbalances."[120] This is especially true for collaborative governance approaches that selectively

recruit citizens who have historically been excluded from decision-making. For example, this could require white members of the collaborative to engage in "careful self-examination" on the presence of white privilege and systematic racism inside and outside of the collaborative.[120]

This approach can feel contentious, while also surfacing conscious and unconscious racial (and other) biases that "threaten the privilege and power of some individuals and institutions."[120] Enabling self-examination within collaborative processes may prove difficult in the context of Victor Ray's Theory of Racialized Organizations, which positions organizations as "key actors in connecting the rules of racial interaction to social and material resources."[154] Under Ray's theory, governmental public health agencies that convene collaborative processes are far from "race-neutral bureaucracies," but rather reproduce racial inequality through the distribution of social and emotional resources and filtering state policy and individual attitudes along racial lines.[154] Racialized organizations diminish (or enhance) the agency of racial groups; legitimate the unequal distribution of resources; position whiteness as a credential; and decouple formal rules from organizational practice based on race.[154] Governmental public health will need to acknowledge and dismantle these practices of racialized organizations to ensure equitable collaboration processes.

In addition to organization-level barriers, the extent to which collaborative governance processes support the empowerment of communities for decision-making may also be limited by the insular nature of "policy communities" and the social construction of oppressed communities as "deserving" of participation opportunities. A policy community is comprised of networks and advocacy coalitions with actors who share a common policy focus and knowledge of a policy area and who seek to use the rules, budgets and personnel of public organizations to achieve policy goals.[155,63] These expert policy communities may be unlikely to accept such a dramatic

shift as public participation in their techno-rational process. In addition, population health and health equity encompass a range of disciplines and sectors and thus need both an overarching advocacy group, as well as issue specific leaders to serve as policy entrepreneurs who will advance health equity policy alternatives.[12] The intersectoral nature of health equity policy alternatives makes an issue-specific coalition unlikely, and cooperation between issue-specific coalitions is difficult given they are semi-independent and compete for issue dominance and related resources.[63] Furthermore, it should not be assumed that sector-specific coalitions outside of public health will have health equity as a primary policy or a value for public participation.[4]

Collaborative processes may also be hindered by the negative social construction of populations that experience health inequities and "feed-forward" effects of past policy designs. Ingram's "Target Population Proposition" posits that the allocation of benefits and burdens to target groups in public policy depends on their political power and social construction as deserving or undeserving.[59] Target populations who are "advantaged" have a relatively high amount of power and are positively constructed as deserving a disproportionate share of benefits and few burdens, whereas "deviants" have relatively low power and are negatively constructed as undeserving so receive limited to no benefits and a disproportionate share of burdens.[59] Schneider and Ingram's "Feed-Forward Proposition" contends that past and contemporary policy designs "…shap[e] institutions and broader culture through both the instrumental (resource) effects of policy and the rhetorical/symbolic (interpretive) effects."[59,63] These effects shape the social construction of a policy's target population and create differential opportunity structures for populations constructed as "deviant." A negative social construction can influence behavior toward the target population and even an understanding of self by targeted populations.[59]

Unfortunately, policy legacies exist that construct target populations experiencing health inequities as deviants and not deserving of redistributive policy efforts (e.g., work requirements for food stamp recipients).[59] These are the same populations that should be engaged in public participation, but the stigma assigned to them through past policy decisions may preclude them from being seen as legitimate participants in collaborative governance arrangements. This stigma can also have enduring negative effects on the political orientation and participation patterns of target populations.[59] Nickel and Eikenberry note that barring lived experience from public debate writes socially constructed identities as "natural" and maintains the oppression of these groups through the "the denial that subjugation is political."[156]

Shared Data System and Financing

Another core component of the FAS is developing a *shared data system* that is meaningful to all partners and allows for measurement of shared progress.[29] Wolff et al. caution that approaches to developing shared metrics often privileges traditional data collection "for and by those in positions of power" and controls for the contextual variables (e.g., through regression modeling) that are often part of the public health problem.[120] The RWJF National Commission to Transform Public Health Data Systems serves as an example of how public health data systems can be reimagined to improve health equity.[157] The Commission used a health equity and racial healing framework to examine the systems and data needed to ensure public health information works for all, including "who the data we collect elevates, who is being centered in our data, who is being excluded, and why."[157] The Commission offers three overarching recommendations as a "blueprint for change." First, the Commission recommends centering health equity and well-being in narrative change.[157] This is accomplished by increasing data literacy for interested

parties, including the importance of equity considerations in data systems, and by challenging perceptions about what constitutes public health data and who has (and should have) access. Second, the Commission recommends prioritizing equitable data governance and community engagement in developing and maintaining shared data systems.[157] Data governance is particularly important for equitable data systems as it involves how the rights of people, communities, and organizations to access and use data are operationalized and enforced.

The third Commission recommendation contends that public health must ensure measurement of structural racism and other inequities, including accurate community-level data that supports small-area estimates.[157] Public Health 3.0 similarly emphasizes shared data systems that ensure the timely collection of granular public health data to guide decision-making. Similar to the Commission recommendation, data collection under Public Health 3.0 should consistently include age, race, ethnicity, disability status, and other indicators that characterize populations experiencing health inequities.[1] State-level policies in Oregon offer an example of Public Health 3.0-style data initiatives; in 2013, the state Legislature passed a bill instructing the Department of Human Services and OHA to collaborate on the adoption of uniform standards for data on race, ethnicity, preferred spoken and written languages, and disability status (termed "REALD") for all programs that use demographic data.[158] The REALD example in Oregon aligns with the Commission's specific call to action for state governmental public health to ensure that state policies for public health data collection and analysis are equity driven with robust indicators of existing inequities in health.[157] The Commission further recommends that local governments can ensure local voice is represented in public health data and in positions of authority responsible for making sense of the data and informing decisions.[157]

Data sharing across sectors to drive health equity is still an emerging concept in public health practice and research, so the extent to which public health entities engage in multisector data sharing is underexplored.[36] The RWJF Data Across Sectors for Health (DASH) initiative seeks to promote and support data sharing systems in service to community health equity.[36] In 2021, RWJF administered the All In National Inventory survey to inform the DASH initiative, which documented progress and challenges of data sharing in public health.[36] Survey findings highlighted four key considerations for equitable data infrastructure. The first recommendation is to ensure that all partners engaged in cross-sector data sharing are involved in ongoing analysis of risks and benefits of data sharing. The second recommendation is to advance a holistic, comprehensive view of public health data that minimizes narratives that blame individuals or groups by collecting information on disparities in health outcomes *and* underlying causes.[36]

To expand on this second recommendation, Indigenous researcher Eve Tuck calls on communities and researchers to institute a moratorium on "damage-centered research" that documents peoples' "pain and brokenness" to hold those in power accountable for their oppression.[35] Tuck asserts that damage-centered research operates from a flawed, albeit benevolent, theory of change in which data on marginalized communities are used to leverage reparations for those communities while simultaneously reinforcing a "one dimensional notion of these people as depleted, ruined, and hopeless."[35] Tuck contends that Native communities, Communities of Color, and other disenfranchised communities tolerate damage-centered data collection because there is an implicit and sometimes explicit assurance that "stories of damage" pay off in material, sovereign, and political wins.[35] Tuck questions whether these wins are worth the long-term costs of communities thinking of themselves as damaged and recommends that community health research begins to capture community *desire* rather than damage.[35]

The third recommendation from the All In National Inventory survey is ensuring a shared understanding of the data lifecycle and access to data that holds systems, like public health agencies, accountable to all potential users.[36] The fourth and final recommendation is to co-create equitable data systems with communities.[36] This recommendation aligns with the principles of Collaborating for Equity and Justice, which requires that indicators, outputs, and outcomes are developed and generated by the local community.[120] Community power-building "learning circles" hosted by the Praxis Project with 50 community organizations across the US, offer complementary recommendations for developing shared measurement systems with communities. First, collaboratives must promote respect of community knowledge and expertise to "uplift healing."[159] Shared measurement systems should reflect existing, shared, and increased community knowledge and center healing as the "other side" of trauma-informed efforts to improve health equity.[159]

Learning circle participants also recommended that both quantitative and qualitative methods are considered in a shared data system.[159] This recommendation recognizes that qualitative approaches, such as stories, focus groups, and interviews, are a powerful complement to numbers and offer the context in which policy and systems change strategies are being advanced. In addition, local organizers can be trained and supported to help determine and collect the information needed to demonstrate the collaborative's impacts.[159] Fourth, the learning circle recommended measuring the "social infrastructure" that is built to expand communities' voices.[159] For example, changes in influence and decision-making power and participation in local policy processes (e.g., parents attending school board meetings or city council meetings) could serve as indicators.[159] Lastly, the learning circle recommended a participatory evaluation approach with data sovereignty by organizers and communities. This approach promotes the co-

development of shared measurement methods and protocols with community members, ensures co-ownership of the resulting data and information, and promises that stories of "health victories" are defined by the community members who are organizing.[159]

Wolff et al. further suggest that a good collaborative evaluation design will include frameworks to monitor the partnership's membership and internal dynamics, in addition to more typical indicators like activity outputs and outcomes.[120] Fortunately, frameworks, tools, and practice recommendations exist to support shared measurement of internal factors in a collaborative. First, the Wilder Collaboration Factors Inventory is a free self-assessment to determine the extent to which a collaborative meets 20 "research-tested" success factors, most of which align with core components of the FAS.[160] For example, respondents indicate level of agreement with factors relating to shared vision and unique purpose (shared purpose), history of collaboration or cooperation in the community (shared governance), evaluation and continuous learning (shared measurement); and sufficient funds (shared financing).[160] In 2020, the Wilder Collaboration Factors Inventory was used by sites participating in the Cross-Sector Innovation Initiative – a RWJF grant program to support public health, health care, and social services sector alignment and community engagement – to identify models for governance structures and decision-making systems with cross-sector partners.[47]

While the Wilder Inventory supports assessment of readiness for cross-sector collaboration generally, the Praxis Project offers a complementary organizational self-assessment that supports reflection on the ways in which health justice and racial equity principles are embodied by organizations.[143] The self-assessment is based on Praxis' Working Principles for Health Justice and Racial Equity and includes indicators for each of the five working principles: act with care; inclusivity; authentic community collaboration; sustainable solutions; and

commitment to transformation.[143] For example, indicators for the "act with care" principle ask organizations to consider whether their timelines enable relationship building and trust with community partners. Other example indicators include members of impacted communities leading decision-making processes for the "inclusivity" principle; decision-making processes valuing lived experience as much or greater than professional experience for the "authentic community engagement" principle; solutions addressing the root causes of issues facing the community (rather than behavior change) for the "sustainable solutions" principle; and establishing accessible channels for feedback for the "commitment to transformation" principle.[143]

While a shared measurement system can enable the learning and adaptation of a collaborative, "performance" of collaboratives can be difficult to measure. For example, Provan and Milward found that networks of mental health delivery organizations were differentially "effective" depending on whether they were assessed by clients, clients' case managers, or clients' families.[84] Thus, the criteria by which network performance is determined should be made explicit. In addition, Kenis and Provan contend that while any criterion is normatively as legitimate as any other to assess network performance, not every criterion may be equally appropriate or reasonable for evaluating a network.[112] For example, the form of network governance makes certain performance criteria more or less appropriate than others: efficiency is not an appropriate effectiveness criterion for a shared governance form just as high levels of multiorganizational collaboration would not be expected from a governance form with a lead organization.[112] In addition, the developmental stage of the network will inform appropriate evaluation criteria. For example, a criterion of "goal attainment" may be problematic for a newly emergent network that lacks clear processes for collaboration, whereas a mature network could

be expected to attain network-level goals and efficient operations.[112] Kenis and Provan suggest that if exogenous factors – like governance form and evolutionary stage – are regarded as the cause of underperformance, responsibility would lie outside the network and underperformance would be attributable to the use of inappropriate performance criteria.[112]

Kenis and Provan further highlight several potential conflicts in selecting network performance criteria that may inform a cross-sector collaborative's planning for shared data and evaluation. First, there may be conflict in selecting criteria given different perceptions of what constitutes performance among collaborative partners.[112] For example, performance may mean efficiency to one partner and goal attainment to another. Second, there can be conflict about the norms and values driving criteria selection.[112] For example, should the collaborative's effectiveness be based on efficiency or the inclusiveness of decision-making processes. Third, there may be conflict between what the assessing party expects and what the party assessed can realistically achieve.[112] For example, the British National Health Service argued in a 2016 report titled "What is Productivity" that they should not be assessed on the oft-imposed criterion of productivity, but rather on contribution to quality of care, which is more consistent with their mission.[112] Lastly, Kenis and Provan posit that networks with more partners are more likely to be perceived as underperforming, assuming that having more partners equates to a broader range of diverse evaluation criteria on which performance is evaluated.[112] This is particularly salient for collaboratives committed to co-creation of shared data systems with community.

Furthermore, a 2019 environmental scan of the Cross-Sector Innovation Initiative highlighted the difficulty of measuring the contribution of collaboration on population-level improvements given inconsistency in how collaborations evaluate their impact and the infancy of many collaborations.[161] The scan also noted that documenting population health improvements

takes time and improvements may not be demonstrable during the early stages of a collaboration.[161] In addition, the 2020 report "Embracing Complexity" for funders of systems change initiatives noted the difficulty of measuring progress and impact in traditional ways given cross-sector initiatives may use evolving approaches as systems adapt to disruptions.[162] The report also describes how the traditional focus on scaling efforts to demonstrate impact may be less applicable to cross-sector collaborations given "the scale of an organization [...] does not necessarily equal the scale of its impact."[162]

Understanding and proactively addressing these potential conflicts in selecting network performance criteria is particularly important for the sustainability of cross-sector collaboration given the mutual dependence between the shared measurement and shared financing components of the FAS. The *shared financing* core component requires organizations to create or access long-term financing supports, including appropriate incentives and shared accountability structures.[29] Resource dependency theory posits that organizational survival relies on the ability to secure critical resources from the external environment, and that interorganizational dependencies (i.e., strategic partnerships) are created by the needs of all organizations to acquire or share scarce resources.[42,43] Consequently, intersectoral collaboration may be driven by a need to demonstrate progress on or commitment to health equity for funders, legislators, and the public to secure resources.[83] For example, Robert Wood Johnson Foundation's Building a Culture of Health initiative includes several equity-focused funding opportunities such as "Evidence for Action: Innovative Research to Advance Racial Equity,"[163] and Oregon's Modernization grants to local public health departments require engagement of community partners in formal governance structures.[101]

Although national and state funding opportunities may incentivize cross-sector collaboration, related performance monitoring systems must similarly reflect and incentivize health equity as a system goal. When an organization cannot hope to show improvement on all relevant dimensions of performance monitoring, it tends to prioritize and show progress on dimensions that are of interest and most visible to those on which the organization is most dependent.[41] Consequently, governmental public health may be driven to show improvement on traditional dimensions of efficiency and productivity to the policymakers on which they are reliant for funding. This focus may come at the expense of newer dimensions of performance related to health equity, like trust developed or a sense of shared purpose across sectors, that may be perceived as beyond the organization's control and may not show improvement in the shorter-term required for performance reporting. Indeed, lessons from the healthcare sector show the rise of quality measurement tied to payment and public reporting has not expanded the use of measures that directly target disparities reduction, and major payment programs such as the Hospital Value-Based Purchasing Program and the Merit-Based Incentive Payment System do not include equity as a domain of performance measurement.[14] Similarly, local public health departments in Oregon are subject to accountability metrics for Modernization funding, but there is neither a health equity metric nor a budget to which the metrics are tied.[44] There is also weak evidence supporting the effectiveness of "carrot-or-stick" approaches to quality improvement.[45]

Furthermore, Moynihan notes that legislators promote performance management to display values of government accountability during their reelection efforts and rarely use performance information for decision-making.[164] Despite calls for outcomes-oriented approaches to public budgeting, Moynihan contends that decision makers generally ascribe to incremental policy making that relies on past decisions rather than current performance data and suffer from

confirmation bias that filters out information failing to conform to current beliefs on a problem and its policy solution.[164] The unfortunate consequence of rigid performance measurement is that outcome benchmarks, the pressures of competition, the prospects of incurring rewards and penalties, and the awareness that one is being monitored effectively reshape agencies.[164] Soss et al. describe the "hidden costs" of organizational adaptations to meet the demands of performance management, including time- and cost-shifting that may come at the expense of changes to meet health equity and racial justice commitments.[134] To recenter *public* transparency and accountability in performance management systems, Moynihan proposes agencies convene "learning forums" that support the co-production of performance management meaning and related priority setting through interactive dialogue, which is currently lacking.[164] Indeed, Preskill et al. contend that "you cannot be accountable if you do not learn" and assert that accountability (and related funding) must "shift from achieving predetermined results on a predetermined plan to demonstrating the capacity to achieve results in dynamic environments."[165]

In addition to a learning orientation, principles of trust-based philanthropy may support a different conception of accountability that drives shared financing models to support health equity. Trust-based philanthropy is rooted in shifting power and building mutually accountable relationships.[166] The Trust-Based Philanthropy Project describes the practice as recognizing the racial, economic, and political inequities in which funders operate and taking explicit anti-racist approaches to change practices and behaviors. Trust-based philanthropy centers on six practice recommendations that were developed after more than 60 interviews with funders and systems change leaders, as well as a survey of over 110 systems change leaders.[166] The first practice recommendation is to provide multi-year unrestricted funding given half (55%) of systems

change leaders surveyed indicated that funding opportunities support short-term projects with clear, measurable results rather than collaborative, evolving approaches to create lasting change.[166] Respondents further highlighted the mismatch between short funding horizons and systems change strategies that need more than five years to come to fruition. Indeed, semi-structured interviews with leaders in US state and local health departments confirm funding sustainability as a significant barrier to engaging in and maintaining health equity efforts.[46] Consequently, funders should prepare for long-term engagement, set realistic expectations for achieving systems change goals, and support evolving paths to systems change.[166]

The short time horizon is compounded by restrictions on funding; the majority (72%) of respondents indicated receiving less than 25 percent unrestricted funding.[166] Funders are encouraged to trust that leaders will allocate resources to where they are most needed and provide unrestricted funding in line with a jointly agreed-upon theory of change. More flexible funding could also support cross-sector partnership development by enabling coalitions to work on a range of issues specific to their communities' health and wellbeing rather than current funding practices that are often disease-specific.[88] Interviews with US state and local health department leaders confirm that ongoing compartmentalization of government grants hinder nonprofit organizations from "building up more intensive, organization-boundary-spanning collaborations" given requirements to meet distinct documentary requirements of siloed grant programs.[46] Lastly, 87% of respondents reported needing to adapt their initiative to comply with funder requirements, which was viewed as hampering innovative approaches. Funders are encouraged to tie funding to jointly developed milestones or outcomes rather than to specific activities, which allows recipients to determine how to best reach agreed-upon goals.[166]

The second practice of trust-based philanthropy is for funders to proactively identify prospective grantees to save non-profit organizations time in the early vetting process.[166] The third practice is to simplify and streamline paperwork associated with grant funding such that applying for funding does not distract community organizations from mission-critical work. The fourth practice encourages funders to be honest and transparent in their communications to grantees, which requires funders to model vulnerability and power consciousness. The fifth practice is to solicit and act on feedback from grantees and communities. The sixth practice is to provide grantees with non-monetary supports that bolster organizational leadership and capacity.[166]

Complementing trust-based philanthropy recommendations for grantmaking, participatory budgeting may also offer a counterpoint to funding models informed by performance management. The Participatory Budgeting Project defines participatory budgeting (PB) as "a democratic process in which community members decide how to spend part of a public budget…giv[ing] people real power over real money."[167] PB began in Porto Alegre, Brazil, in 1989, as an anti-poverty measure to help reduce child mortality but has since spread to more than 7,000 cities around the world to decide budgets from states, counties, cities, housing authorities, schools, and other institutions.[167] PB processes typically last about a year and consist of five phases, including community-led design of the process, idea generation, proposal development, voting, and implementation.[167]

The Participatory Budgeting Project offers several considerations for state and local health jurisdictions implementing PB, including moving beyond the "usual suspects" for participation to center the perspectives of community members experiencing health inequities.[167] Jurisdictions must also ensure budgets for participatory decision-making feel meaningful enough

to bring community members to the table; lower the barrier to participation by providing compensation, transportation, food, internet connectivity, and childcare; and offer compensation to participating community members that is commensurate with public health staff managing the process to mitigate potential resource and power imbalances.[167] Furthermore, jurisdictions should ensure that a high level of commitment and trust exists among leadership, staff, partners, and funders to share power for budget allocation decisions. Jurisdictions must also understand that PB is time intensive and requires a "high degree of cultural competence in a wide variety of settings." Finally, jurisdictions may start with more traditional participatory planning process (e.g., codesign) to lay the foundation for PB.[167]

Equitable approaches to shared measurement and financing that require trust and power-sharing may be hampered by current evidence-based practice models that tend to favor behavioral and lifestyle-focused interventions and related measures of intermediary determinants of health (e.g., individual behaviors). Historically, public health agendas have tended to oscillate between approaches relying on narrowly defined medical and public health interventions, and an understanding of health as a complex, social process that requires intersectoral policy action.[4] Current structures in governmental public health are heavily influenced by practice models that favor biomedicine, population-based clinical care, and behavioral and lifestyle-focused interventions that, in isolation, do not reach the whole person in their social context.[3] The rise and promotion of "evidence-based" orientations within government agencies is consistent with the public sector's increased interest in efficiency and effectiveness. Evidence-based policy making (EBPM), for example, is believed to answer key questions arising from a neoliberal, New Public Management orientation focused on how programs can be improved for greater

return-on-investment; how innovation and competition can be expanded to drive productivity; and how program managers can achieve specific "outcomes" for clients and partners.[39]

The evidence-based orientation can be traced back to the 1990s in which significant political shifts to address entrenched and interlinked health issues led to increased investment in central units for policy analysis and commissioning evidence-based consultancy reports. During this time, for example, the U.K. Labor Government adopted evidence-based policymaking as a core framework for evaluating policy ideas.[39] Responding to interlinked public health problems led to a rise in policy processes that were potentially less technocratic (i.e., limited to elite "technical experts") and more open to "network" approaches that included new feedback mechanisms variously described as community engagement, multi-stakeholder consultation, and partnering across sectors.[39] This period was also characterized by new technologies to support data gathering and analysis that focused on measuring the nature and extent of problems, assessing impacts of service systems, and providing benchmarks against which system performance could be judged (as observed in the era of Public Health 2.0).[39]

Unfortunately, the biomedical understanding of health and technocratic approaches to developing population health interventions often ignore a community's socioecological context as a point of intervention in favor of factors that can be more easily researched, measured, and reported, such as intermediary determinants.[39,168] Consequently, evidence-based approaches limit the types of knowledge that are considered legitimate in the construction of population health problem definitions and associated indicators. For example, Givens et al. describe how the influence of topics such as gerrymandering and the #MeToo movement on population health do not fall neatly within logic models for public health research or community health indicators.[8] Critics of EBPM question whether the persistence of complex social problems is truly

attributable to a lack of information or rather the need to reconcile different value perspectives to arrive at effective policy solutions.[39] Furthermore, critics conclude that EBPM assumes a mechanistic process that depoliticizes knowledge (i.e., assumes knowledge is value neutral) and ignores uncertainty and local context; underestimates the difficulty of determining a cause for complex problems and by extension "what works" as a potential solution; and ignores democratic deliberation of values as a fundamental requirement for decision-making.[39] Indeed, Ansell and Geyer contend that evidence is "diverse and contestable" and assert that simple technical solutions by "experts" are likely unavailable for complex public health problems that require different types of evidence for decision-making.[39] Furthermore, Liverani et al. raise concerns that public health's tendency to depoliticize knowledge may encourage the selective use of evidence by decision makers to support predetermined policy choices or ideological positions, and may delay decisions on contentious issues while less contentious topics with "clearer, uncontested evidence bases" are pursued.[168] Critics of EBPM are not necessarily arguing against the value of scientific knowledge, but rather the way it is used in top-down models of technocratic policymaking.[39]

Head asserts that while the traditional evidence base consists of knowledge generated by applied research, there are three forms of policy-relevant knowledge to consider. The first form of knowledge arises from "political know-how" or the analysis and judgement of political actors; the second form of knowledge is generated from rigorous scientific and technical analysis; and the third form of knowledge is derived from practical and professional field experience that reflects the "practical wisdom of professionals in their communities of practice."[40] Head contends that these forms of knowledge constitute the three "lenses" for policy analysis and for understanding the evidence-base(s) of policy debates. Conspicuously absent from these lenses is

the knowledge inherent to the lived experience of community members, particularly community members most affected by government and cross-sector policies and programs. Indeed, the Praxis Project suggests those most affected by inequities are in the best position to define the problem, design appropriate solutions, and define success, and therefore should "be at the table driving solutions from inception."[143] The Project warns that evidence-based approaches may displace or silence lived experience with academic or professional expertise.[143]

While trust-based philanthropy and participatory budgeting center community in grantmaking and budgeting (i.e., financing), community-based participatory research (CBPR) may support the development of a more diverse evidence base by emphasizing the "participation, influence, and control by non-academic researchers in the process of creating knowledge."[169] Indeed, a 2022 workshop hosted by the National Academies of Science, Engineering, and Medicine explored civic participation as a social driver of health and attendees strongly supported CBPR approaches given data collection in communities can be extractive or dehumanizing in some cases.[54] CBPR begins with a research topic of community importance and assumes an action-orientation to influence policy and practice for community health improvement and equity.[169] The co-creation of knowledge implies a different shared measurement practice in which academics enhance existing efforts of community organizations, provide insight on how to measure community-level impacts of these efforts, and shape research agendas based on community goals and priorities.[170] CBPR – in its most comprehensive form – also aims to build the research capacity of community members.

Complementary to knowledge generation is knowledge mobilization, which is defined as "the reciprocal and complementary flow and uptake of research knowledge between researchers, knowledge brokers and knowledge users…in such a way that may benefit users and create

positive impacts."[171] Worton et al. emphasize that knowledge mobilization in communities is limited by the assumption that community partners will have similar values and approaches to knowledge mobilization as academic "knowledge producers" and that implementation of an evidence-based program or practice is the end goal for community partners.[171] Rather, community partners are more often interested in holistic programs and ecological outcomes compared to researchers focused on targeted interventions and individual outcomes.[171] In addition, community partners may prioritize adapting existing programs using local knowledge rather than implementing external initiatives wholesale.[171]

Shared Communications

In addition to the core components of shared purpose, governance, data, and financing, the literature on effective cross-sector alignment suggests the addition of a fifth component: shared communications. Stone contends that *causal stories* are the primary means in politics for defining and contesting policy problems, and that most policy problems, including those to address the social determinants of health inequities, are defined through a narrative structure with "heroes and villains and innocent victims."[172] Welfare reform in the US offers an example of the consequences of disregarding causal stories. Lipsky describes how political and organizational strategies for welfare reform have been informed by a dominant conservative narrative that criticizes the role of government in private life.[134] While conservative politicians were advocating for smaller government on principle, welfare advocates "neither created institutions to articulate directly a liberal perspective on the state nor did they incorporate a rationale for the state."[134] Consequently, the welfare discussion was confined to debates about individual responsibility. The lack of a liberal counterweight allowed the "antigovernment perspective to

grow up relatively uncontested" and contributed to the taken-for-granted status of welfare reform.[134]

Stone's "causal stories" also link a new communications core component to the existing data core component of the FAS. The lack of social determinant of health indicators described earlier contributes to the inability for health inequities to be framed in manner that makes it a public problem viable for policy intervention. Effective issue framing relies on the "deliberate use of language and symbols that highlight the harms of current policy consequences in a causal way (i.e., causal stories)."[173] Framing health inequities as a public issue is challenging because causation is difficult to determine and possible solutions are often simplified to medically orientated, easier approaches.[5] In other words, the complexity of social-structural causes makes it difficult to frame health inequities as "actionable."[173] Furthermore, the insistence on certain types of evidence under evidence-based policy making cements existing framing/causal stories related to intermediary determinants. The primacy of scientific knowledge over professional and local knowledge enables a causal story in which health inequities are inadvertent, "harmful side effects of well-intentioned policy" with intractable social-structural causes.[5,173]

The Truth, Racial Healing and Transformation framework also supports a focus on shared communications. One of the framework's five pillars is *narrative change* and advocates for a transformation in how we communicate about our past, present, and future.[144] Specifically, narrative change within the Truth, Racial Healing and Transformation framework is the "process of disrupting dominant narratives that normalize inequity and uphold oppression and advancing new narratives from our communities and individuals in historically marginalized groups...[to] imagine a different future."[144] One example of institutionalizing narrative change is the more than 200 states and cities that have declared racism a public health crisis.[144] Eve Tuck's desire-

based framework for research also informs shared communications within cross-sector initiatives.[35] Shared storytelling of collaborative efforts should consider Tuck's call to resist stories that introduce or reinforce narratives of people who experience structural oppression as broken or damaged. These stories of "brokenness" may reinforce the social construction of oppressed communities as deviants and negatively impact opportunities for participation in collaborative spaces. Rather, shared stories can highlight a community's assets, opportunities, and desires.[35]

Power Dynamics

Power dynamics will be discussed separately from the other adaptive factors in the FAS given power differences (including powerlessness) is seen as a structural barrier, like racism and sexism, to advancing health equity.[61] Power is linked to core components of the FAS because it manifests in how decisions are made, the people and networks involved in how decisions are made, how problems and solutions are framed, what ideas are considered in the process, and how to measure success.[125] Power also determines access to resources and decision-making, alliances and networks, the capacity to organize and reproduce community power, and the dominant stories society chooses to tell about people in the US.[125] Shifting power dynamics in alignment efforts ensures underrepresented and/or minoritized voices drive change.[29]

Agranoff notes the four dimensions of power conferred to public agencies in network arrangements that may be levers for power sharing in collaboratives, including: 1) a visible public agency head serving as a "champion"; 2) a "political core" of departmental heads that often participate in shared governance; 3) a "technical core" of public agency staff with considerable knowledge about a particular topic area; and 4) paid public agency staff who

support the network infrastructure and therefore "have a foot in every phase of the operations."[106] These four dimensions create a deep power structure for public agencies participating in networked governance. Farhang and Morales emphasize that power hoarding has contributed to the systematic oppression of Communities of Color and a commitment to sharing power means widening and shifting the circle of people, communities, and networks making decisions.[125] While leaders in public health have long valued the concept of community engagement, the concept of community power is less familiar and potentially less comfortable as it implies a ceding of the state's decision-making authority.[61]

Vaidya et al. define community power as "the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity."[61] Community members also hold community power through mobilization efforts that hold organizations, academics, and policy makers accountable to desired changes. Community organizers note that community power-building is not a recent phenomenon but rather "has its roots in the struggles of our ancestors."[159] The impact of community power can be observed throughout history through social movements to abolish slavery and prisons, return and protect Indigenous lands, and defend human rights that relied on Communities of Color and Indigenous, LGBTQ+, disabled, low-income, and other communities to build power, mobilize, and act for collective change.[174]

Base building organizers in learning circles convened by the Praxis Project further describe motivations for building community power.[159] Organizers are motivated by the opportunity to heal communities and individuals through spaces in which "our stories, culture,

music, and wisdom can be expressed, to redress the past, to heal the wounds that our communities and ancestors have confronted."[159] Organizers also described sovereignty as a motivating factor in that building power will help "break through walls of oppression" and systems that take away wellness, opportunity, and excellence.[159] Power-building was also described as essential to creating a society in which "equity abounds" including regaining control and agency. Lastly, organizers want to build power to "form a voice that is not easily ignored" and enable communities to narrate their own stories.[159]

Organizers in learning circles also identified potential barriers to building community power, many of which align with core components of the FAS. First, organizers note that power-building is limited by resources, including both financial supports as well as basic needs – food, jobs, education, technology, childcare, transportation, organizational structure, space, and research – that comprise the "scaffolding" required to be able to engage (i.e., financing).[159] Second, organizers emphasize that a lack of community-led vision that reflects each community's unique input impairs power-building (i.e., shared purpose).[159] Furthermore, this lack of collective visioning and understanding produces fragmentation of community efforts, reinforces a lack of trust, and fosters a sense of individualism and apathy. Organizers also highlight past traumas experienced by community members as contributing to a fear of change, feelings of powerlessness, and lack of efficacy and agency. Existing institutional and systemic bias against people of color, the "cis-patriarchy (sexism, homophobia, transphobia)," elitism, ableism, capitalism, structural violence, and stigmas surrounding mental health and substance abuse also work against community power-building (i.e., governance).[159] In addition to systematic bias, the maintenance of institutional power and control over communities limits power-building. For example, police brutality, lack of access to legislators, and inequities in the

legal, financial, transportation, immigration, and education systems are major barriers to community power.[159] Lastly, the current media environment contributes to a lack of exposure for positive community power-building work and perpetuates a limited framing of community conditions that does not generate support. Communities lack of control over the telling of their own stories becomes disempowering (i.e., data and storytelling).[159]

Fortunately, more health institutions and funders, such as the Robert Wood Johnson Foundation, National Association for County and City Health Officials, and The California Endowment, are looking for opportunities to invest in community power-building as an outcome in and of itself (rather than a means to an end).[125] These funders are committed to recognizing power dynamics present in grantee relationships and are working to change them by conferring more decision-making authority to systems change leaders.[162] For example, RWJF funded the Lead Local initiative in 2022 that brought together community power-building leaders and practitioners in the fields of community organizing, advocacy, public health, and science over the course of 18-months to document how power is built in low-income communities and Communities of Color, how it shifts over time, the factors that contribute to that shift, and how grassroots organizations do the work to build community power to improve social and economic conditions that advance health, equity, and well-being.[72] Research and action groups participating in Lead Local were informed by theories of community power-building and aligned to the "north star" question, how does community power catalyze, create, and sustain conditions for healthy communities?[72] Broadly, the Initiative recognizes community members as experts of their own experiences and conditions and, as such, should drive the "design, implementation, and protection of policies and reforms."[170]

In 2018, Human Impact Partners launched Power-building Partnerships for Health (PPH), a pilot project to build relationships between community organizers and local health departments with a goal of building community power to improve community health.[174] PPH is guided by the philosophy that transformational health equity work must prioritize trust and relationship building as precursors for action.[174] For example, the PPH partnership between the Santa Barbara County Public Health Department and two grassroots organizations led to the launch of a Latinx Indigenous Migrant Health COVID-19 Task Force and to the passage of a novel Health Officer Order on safety in farmworker housing.[174] While this three-year collaboration has not been conflict-free, partners emphasize that early relationship and trust-building supported health department staff and organizers to work through conflict.[174] PPH highlights that greater community empowerment is not a quick technical fix, but rather a long-term process to bring awareness to and redress power imbalances within communities and between communities and public agencies.[50] Importantly, this process of community power-building relies on public agency leaders who are willing to take risks and share knowledge, power, and credit.[50]

Maintaining the Status Quo and Pathbreaking

Addressing issues of social and economic injustice and structural racism requires a fundamental transformation of laws, policies, regulations, practices, and cultural norms. As described earlier, transformation of institutions and systems is limited by a public policymaking process structured for incremental rather than wholesale change.[63] Given limited time and information to examine more than a few policy options, policy makers focus on policy alternatives that differ only marginally from previous policies.[63] This narrow focus limits policy discussion to options that are well understood and politically feasible, typically those that emphasize solutions to concrete

problems (e.g., tobacco use, diabetes) rather than the pursuit of more abstract or complex ideals, such as social justice.[64] In addition, policy feedback effects can reinforce the status quo. Policies can be self-reinforcing due to the high setup, learning and coordination costs of policy alternatives; dominant constituencies that have benefitted from policy legacies and have the capacity to defend against the threat of policy alternatives; and the social construction of target populations for policy alternatives as undeserving.[65]

Furthermore, institutional theory suggests that organizational behavior is "shaped, mediated, and channeled" by cognitive, normative, and regulative structures that are propagated by culture, structure, and routine.[83,43,175] Current professional norms in governmental public health practice have been informed by a decades-long focus on efficiency and effectiveness under the neoliberal and New Public Management paradigms. Despite environmental signals of potential reform, such as Public Health 3.0, New Public Management values and processes have become "institutionalized social facts" that serve as a template for action within governmental public health. The taken-for-granted status of NPM has contributed to "institutional isomorphism" with commonality of form (siloed bureaucracies) and function (top-down administration).[67] The governmental public health field is particularly susceptible to isomorphism because a greater dependency on a single source of vital resources (i.e., legislators and federal funders) tends to produce higher levels of isomorphism.[67] In contrast, Wooten and Hoffman reject isomorphism as inevitable and contend that fields are dynamic and evolve through "changes of interaction patterns and power balances."[67] These dynamic conditions provide an opportunity for "path-breaking" behavior that deviates from institutional norms and structures.[67]

Importantly, path breaking behavior depends on the presence of "institutional entrepreneurs" willing and able to bring along reluctant implementers and form political networks to gain legitimacy for institution-building or institution-dismantling projects.[67] While an actor's agency is "embedded" within existing institutions and therefor constrained by related practices and structures,[68] social movements within an organizational field may enable institutional entrepreneurship.[67] The structural strain theory suggests that any nascent social movement needs six factors to grow: people in a society experience some type of problem (deprivation); recognition by people of that society that this problem exists; an ideology purporting to be a solution for the problem develops and spreads its influence; an event or events transpire that convert this nascent movement into a bona fide social movement; the society (and its government) is open to change for the movement to be effective (if not, then the movement might die out); and mobilization of resources takes place as the movement develops further.[176] The police killings of Black Americans and related resurgence of the Black Lives Matter movement, as well as visible racial/ethnic inequities in COVID-19 testing rates, mortality rates, and vaccination rates brought conversations of public health's responsibility for dismantling racism and other forms of institutional oppression to the fore.[69] Public and political pressure could drive governmental public health to prioritize more collaborative forms of governance in order to maintain legitimacy and empower entrepreneurs within governmental public health to subvert institutional practices that ignore inequities.[70]

In addition to enabling entrepreneurs within institutions, the resurgence of the Black Lives Matter movement and visible racial/ethnic inequities during the COVID-19 pandemic may serve as "focusing events" to pressure decision makers for policy innovation.[69] Focusing events are typically crises or disasters that occur suddenly, tend to be rare, are often large in scale, and

are known to policymakers and the public at the same time.[63] Focusing events may disrupt the relative stability of issue-specific policy subsystems to change problem definitions (e.g., shifting focus from intermediary to social-structural determinants), distribution of resources, and fundamental sociocultural values in support of transformation.[63] Political feasibility of health equity policies and practices may be improved through focusing events that shift national mood in favor of public responses to the social and structural conditions that create health inequities. In addition, equity-oriented interest groups that benefit from shifts in resources/power from focusing events may have increased influence on decision-makers' acceptability of approaches that center health equity.[63]

Pervasive health inequities illuminate during the COVID-19 response have supported several changes to national public health system transformation frameworks that center equity and may support innovation and pathbreaking. First, the Bipartisan Policy Center collaborated with ASTHO, NACCHO, PHAB, the Big Cities Health Coalition, the CDC Foundation, the de Beaumont Foundation, the Kresge Foundation, Pew Charitable Trusts, and the Sunflower Foundation to release a five-year "roadmap" for public health, called "Public Health Forward: Modernizing the U.S. Public Health System."[88] The report offers recommendations for policymakers and public health leaders in the areas of financing, data and information technology, workforce, public health laws and governance, partnerships, and community engagement. While these broad categories are similar to those in preceding frameworks, such as the FPHS and Public Health 3.0, the roadmap explicitly includes "advancing health equity" as a core tenet and calls for the recruitment and retention of a diverse and inclusive governmental public health workforce; incentivizing partnerships between public health departments and other sectors; and investing in long-term partnership development with CBOs and residents.[88]

However, the Public Health Forward roadmap fails to explicitly center racial justice in recommendations for an equitable governmental public health practice.

In addition to new frameworks, such as Public Health Forward, for post-COVID-19 governmental public health practice, several existing frameworks have been updated to reflect a renewed focus on health equity and community partnerships. In 2020, the Public Health Accreditation Board Center for Innovation and the de Beaumont Foundation convened a 29-member "Task Force for The Futures Initiative" to revisit and refresh the 10 EPHS.[177] EPHS framework revisions were meant to not only describe the current public health practice landscape and functions, but also incorporate areas that support public health's movement towards a future vision (e.g., Public Health 3.0, Healthy People 2030). The Task Force noted that equity must be added to the EPHS framework as fundamental to the work of public health practice, acknowledged that advancing equity is both a process and an outcome, and that public health "should not shy away from statements that may not resonate with certain audiences or that may cause discomfort" (an important statement that runs counter to the typically risk-averse approaches of governmental public health).[177] As a result, the 2020 update to the EPHS framework placed equity at its core and indicated that public health must seek to remove systemic and structural barriers that have resulted in health inequities by mobilizing communities.[18]

In 2022, ten years after its creation, the FPHS framework was also refreshed to reflect the evolving nature of governmental public health practice post COVID-19 pandemic response. The revised framework added equity as a stand-alone foundational capability and provided greater definitional clarity on certain topics critical to public health transformation, including the social determinants of health.[23] While the addition of equity as a foundational capability is a

particularly positive evolution of the FPHS framework, there are existing foundational capabilities that may have similarly benefitted from a refresh. For example, the framework still promotes public health leaders as "health strategists" in their local communities (a recommendation from the Public Health 3.0 framework) but does not explicitly address power dynamics and the potential need for governmental public health staff to defer decision-making to trusted community leaders in the vein of New Public Service public administration. In addition, the framework continues to promote the development of "measurable benchmarks of progress" linked to accreditation without acknowledging that traditional metrics of efficiency and productivity may limit authentic community engagement and may not align with initiatives that center health equity and racial healing, such as the RWJF National Commission to Transform Public Health Data Systems.[23]

The Public Health Accreditation Board (PHAB) also took several steps to center health equity in public health department accreditation. In September 2020, PHAB adopted a strategic plan that included a priority to "create and implement a comprehensive anti-racism, diversity, equity, inclusion strategy to address structural racism and inequity within PHAB, public health departments, and the public health sector."[178] PHAB also convened a workgroup to ensure health equity was embedded in the 2022 iteration of accreditation standards and measures. Consequently, PHAB conducted a comprehensive and inclusive vetting process to ensure equity is reflected in all 10 accreditation domains, which were updated to align with the FPHS.[178]

Similar to these national examples, state and local governmental public health practice is evolving to prioritize equity. While the eighteen state public health departments participating in the 21st Century (21C) Learning Community are at various stages of systems transformation, many have embedded health equity into their practice. Kansas and Missouri incorporated health

equity in their state FPHS models to ensure an equity lens is applied to all public health services.[179] The Minnesota Legislature provided funding for local and Tribal public health projects to pilot new organizational models in health equity.[179] The state is also working to increase racial and ethnic diversity in the workforce. Missouri developed a facilitated workshop that guides public health professionals through a self-assessment of health equity practices within their agencies, culminating in the development of action plans to build individual and organizational capacity for advancing health equity.[179] Lastly, North Carolina implemented a Community Health Worker initiative across all 100 counties, as well as a public-private partnership with CBOs, to reach underserved populations.[179] The state also recruited external advisors from historically marginalized populations to contribute to the State Health Improvement Plan and Healthy North Carolina 2030 goals.

The first three 21C grantees – Ohio, Washington, and Oregon – also continue to approach the implementation of the FPHS framework post COVID-19 with an enhanced focus on health equity.[180] In Washington, House Bill 1152 was passed to include more community members on local boards of health and establish a Public Health Advisory Board with community representation.[181] In addition, Washington was selected to participate in Public Health Accreditation Board Center for Innovation's Equity in Data Systems Transformation Cohort,[182] a group of states focused on data modernization and implementing RWJF's National Commission to Transform Public Health Data Systems which "reimagine[s] how data are collected, shared, and used, and identify the investments needed to improve health equity."[183] In Ohio, the state department of health continues to host an Ohio Equity Institute and provides grants to a small number of local health departments that are increasingly adding dedicated health equity officers or similar positions.[184] In Oregon, OHA adopted the strategic goal to eliminate health inequities

in the state by the year 2030.[73] In addition, the state legislature significantly increased funding for Modernization implementation, from $5 million in 2017-2019 to $30 million in 2021-2023, and specified CBOs as public health system partners to be funded.[74] Consequently, OHA-PHD allocated $8.9 million to 75 culturally-specific CBOs to support Modernization implementation, especially the health equity and community partnership development foundational capabilities, and build on the network of 170 CBOs funded through the CARES Act to support outreach activities during the COVID-19 response.[185] In addition, OHA-PHD created a permanent Community Engagement Team comprised of 12 state public health staff who serve as regional and community-specific coordinators to support newly funded CBOs.

Conclusion

Persistent inequities in population health outcomes have led to governmental public health transformation initiatives focused on cross-sector collaboration to advance health equity. These transformation efforts are guided by several practice frameworks, including Public Health 3.0 and Foundational Public Health Services nationally and local equivalents like Oregon's Modernization effort. However, the extent to which these transformation frameworks explicitly center equity and community voice and address power dynamics is contestable. This gap is especially potent in the context of sociopolitical and public administration paradigms that continue to inform public health practice and emphasize accountability, efficiency, and effectiveness potentially at the cost of an equity and justice orientation. In addition, there is mixed evidence of the contributions of cross-sector collaboration and public participation on community health outcomes and much of the research considers community empowerment a means to an end rather than an outcome itself. Furthermore, inquiry on state governmental public

health transformation efforts in the US have been limited to program evaluations and single case studies that lack an organizing framework and suffered from disruption by the COVID-19 pandemic which required that transformation resources be diverted to response and recovery efforts. The Framework for Aligning Sectors offers an organizing framework that not only addresses coordinating mechanisms, such as shared governance and data, but also centers key factors like equity and power and can support the inclusion of Wolff's principles of Collaborating for Equity and Justice. Oregon also serves as a unique context in which to investigate governmental public health transformation given the state-specific implementation framework of Modernization, and the legislative investment in system transformation that dates back to 2017 and resulted in grant funding to local health departments and CBOs.

Chapter 3. Research Methods and Design

Introduction

Chapter 3 begins with a restatement of the research question, study aims, and anticipated implications. The chapter then describes the research paradigm, approach, and design. Next, the chapter describes the primary and secondary conceptual frameworks grounding the research. The chapter then outlines the data collection approach, including descriptions of data sources, anticipated challenges, and implications of researcher positionality. Next, the chapter explains data analysis methods, including operational definitions for study variables. Lastly, the chapter reflects on limitations of the research design and the timeline for dissertation completion.

Research Question and Aims

The research question for this study is "What factors of cross-sector alignment impede or facilitate collaboration among state and local governmental public health and communities to advance health equity?" This research question was addressed through three specific aims: 1) characterize the degree to which factors of cross-sector alignment are currently fulfilled; 2) compare similarities and differences in how partners perceive factors of cross-sector alignment; and 3) explore perceived roles of each partner in advancing health equity.

Anticipated Research Implications

There are several anticipated implications of the research for public health practice. The research informs how the Oregon Health Authority Public Health Division (OHA-PHD) and Local Public Health Authorities (LPHAs) improve alignment with community-based organizations (CBOs) to advance foundational public health services with an emphasis on health equity. The research also

elucidates the distinct but complementary roles of governmental and community partners in Modernization implementation. The research also informs similar efforts by other divisions in OHA and other state agencies in Oregon to directly fund CBOs for culturally-specific outreach and education. In addition, the research informs state-led Public Health 3.0-style initiatives across the country focused on cross-sector partnerships and community empowerment to address health equity. This includes the 24 states that are formally implementing the Foundational Public Health Services (FPHS) framework[25] and participating in the Public Health Accreditation Board Center for Innovation's 21st Century Learning Community.[179]

Having an assessment framework for FPHS implementation may also support state health departments to more clearly characterize and communicate the process and outcomes of investments in public health system transformation to policymakers, local implementers, and community members, which is essential to gaining and sustaining investment from legislatures and other funders. The research also supports refinements to existing frameworks and theories, such as the "power dynamics" adaptive factor of the Framework for Aligning Sectors (FAS) and "starting conditions" in the Model of Collaborative Governance.[29] Refining and better operationalizing FAS core components and adaptive factors may be especially important given the framework is relatively new and will benefit from application in a governmental public health context. The research also tests existing hypotheses from institutional theory, social movement theory, and network theory, including those related to cooperation in networked partnerships and the potential for "path breaking" behavior.

Research Paradigm

This study was guided by a pragmatic research paradigm. Pragmatism focuses on actions and consequences rather than antecedent conditions, and is concerned with application to practice (i.e., what works) and solutions to problems. Pragmatism is not committed to any one system of philosophy and reality (e.g., positivist or constructivist) and emphasizes freedom of choice in methods, techniques, and procedures of research that best meet needs and purpose.[186] While distinct from the transformative worldview, pragmatists agree that research always occurs in social, historical, political, and other contexts, and consequently may include a critical theoretical lens that is reflective of social justice and political aims. Given the research question and primary framework center on health equity and power in collaborative efforts, it will be important to uphold certain tenets of the transformative worldview, such as elevating the perspectives of people who experience systemic oppression; uncovering why problems of oppression and domination exist; and intertwining research inquiry with a social and political change agenda.

Research Approach

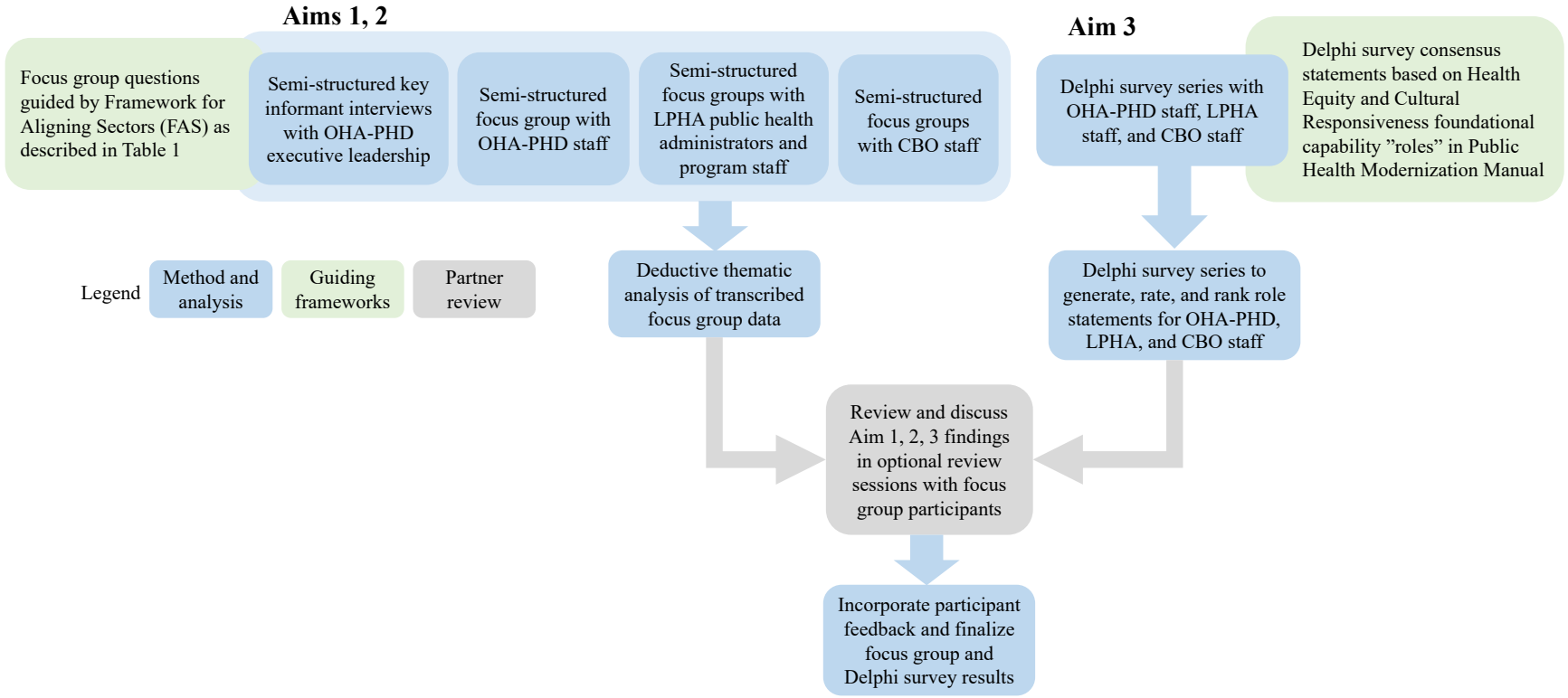
The study employed a mixed methods research approach, which involves collecting both qualitative and quantitative data and integrating the two forms of data during analysis and interpretation. The core assumption of the mixed methods approach is that the systematic integration of qualitative and quantitative data neutralizes the limitations of each form of data and yields additional insights beyond the information provided by either qualitative or quantitative data alone.[186] A mixed methods approach offers an advantage to studies of complex, multi-component interventions by drawing on both qualitative and quantitative data to support a more holistic understanding.[186] Challenges to mixed methods approaches include the need for

extensive data collection, the time-intensive nature of analyzing both qualitative and quantitative data, and the requirement for the researcher to be familiar with both quantitative and qualitative forms of research.[186]

Mixed Methods Design

The research question will be examined using a convergent mixed methods case study design (**Figure 3.1**). The intent of this design is to use the qualitative or quantitative data collection approach that best fits the study aim it is intended to address.[186] The first two study aims focus on the degree to which collaboration between governmental public health and CBOs reflects the FAS and how perspectives on alignment compare across partner types. Consequently, qualitative data collection methods were used to investigate individual and group experiences. The third study aim focuses on each partner type's role in advancing health equity – operationalized using pre-defined roles for the health equity and cultural responsiveness (HECR) foundational capability of the Public Health Modernization framework[26] – used quantitative survey methods better suited for efficiently collecting information from a large number of respondents and developing consensus. Qualitative and quantitative data were gathered concurrently in a convergent core design and results were merged together to answer the research question. The Institutional Review Board (IRB) at Portland State University approved the research proposal (IRB ID: 248406-18) on March 11, 2024. The IRB determined the study qualifies as exempt and the provisions for protecting the rights and welfare of all participants are adequate.

Figure 3.1. Visual of convergent mixed methods study design



Conceptual Frameworks

The FAS is the primary conceptual framework to ground dissertation methods (**Figure 3.2**).[29] Qualitative data collection and analysis reflected all core components and adaptive factors of the FAS, including shared purpose, data, governance, financing, community voices, equity, power dynamics, and trust. Shared communications was identified as another core component for effective collaboration in the Chapter 2 literature review and considered in data collection and analysis. **Table 3.1** below includes the operational descriptions of FAS core components and adaptive factors. The *context* and *outcomes* elements of the FAS will not be explicitly considered in focus groups and key informant interviews (i.e., there will not be questions related to these elements), but may come up organically during data collection and, if so, will be reported in results (Chapter 4) and recommendations (Chapter 5). Local context can include community factors like geography, external pressures like state policies, and organizational factors like leadership and workforce. The FAS defines short-term outcomes as changes in mindsets, practices, and policies and long-term outcomes as shared progress on community goals and needs, health equity, and racial equity.[29]

Figure 3.2. A Framework for Aligning Sectors[29]

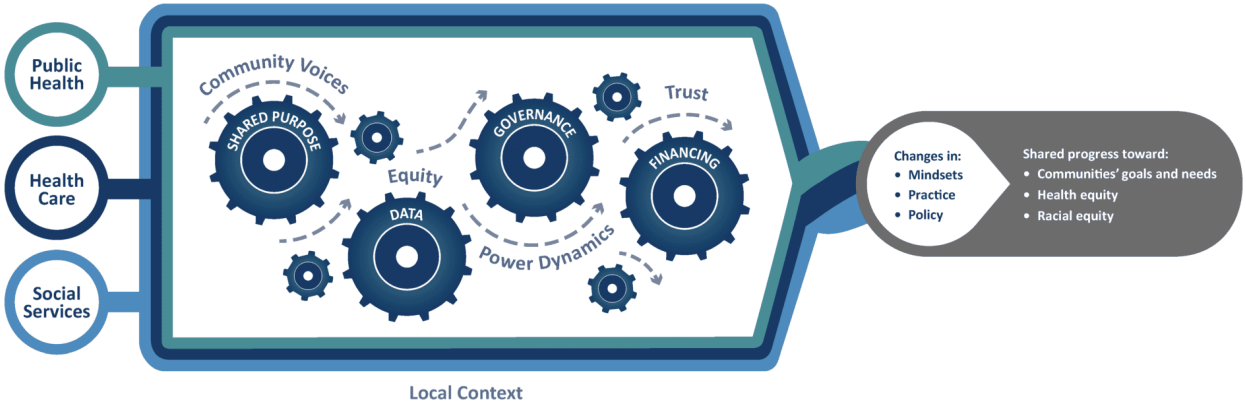


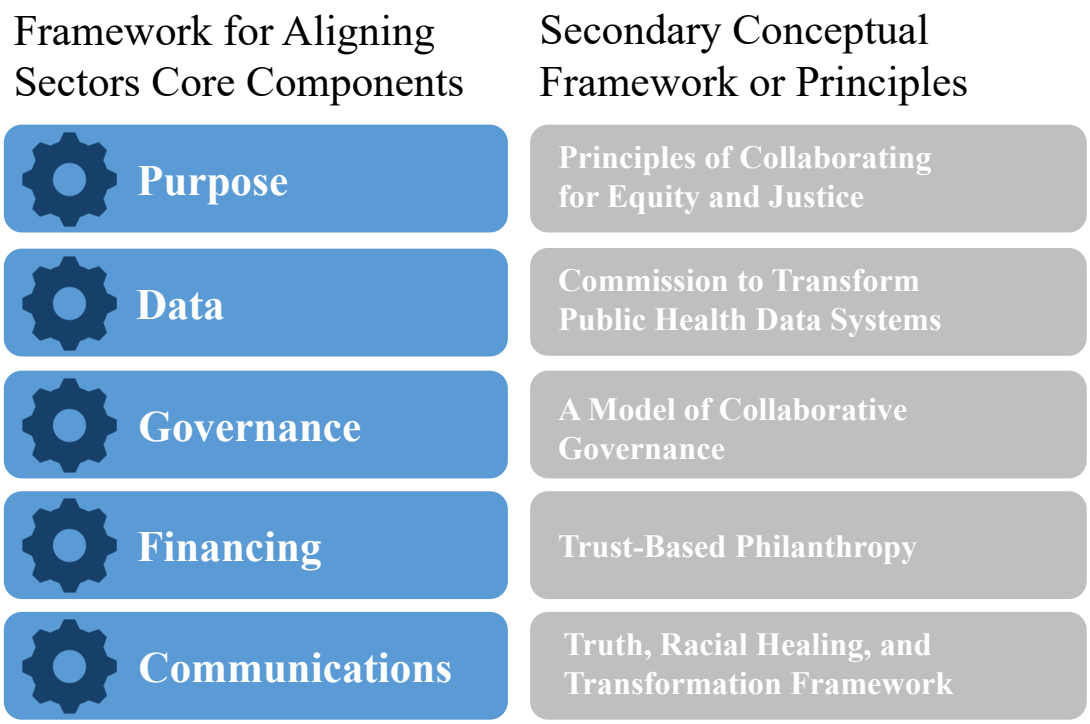
Table 3.1. Descriptions of Framework for Aligning Sectors core components and adaptive factors[29]

Framework elements	Description
Core components	
Shared purpose	A feature of aligned systems in which sectors share a mutual understanding and commitment to a vision and priority outcomes.
Shared data and measurement	A feature of aligned systems that enables sectors to collectively and systematically gather, organize, and share data between entities, and the process of using this information to track progress.
Shared governance	A feature of aligned systems in which infrastructure has leadership, appropriate roles, and defined relationships.
Shared financing	A feature of aligned systems characterized by sustainable methods with appropriate incentives and shared accountability.
Shared communications	A feature of aligned systems in which sectors have a shared communications strategy that centers community storytelling.
Adaptive factors	
Community voices	Active community engagement ensures that community members are heard and integrated at the beginning of the design process (e.g., co-creation). Elevation of community voices in the design of and decision-making for aligning efforts is deeply intertwined with building trust and shifting power dynamics.
Equity	The World Health Organization defines equity as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically." Equity encompasses both health equity and racial equity and includes both processes and outcomes. It is widely acknowledged that addressing equity is a critical goal of aligning across sectors and, ultimately, critical for improving community well-being.
Power dynamics	Aligning across sectors is challenging because of the inherent differences in dominance among sectors and between sectors and individuals. These differences in power can result from imbalances in resources, perceived value, historical practices, influence, or experience.
Trust	Both relational trust – earned through shared experiences and backgrounds – and transactional trust – earned through interactions and give-and-take – are necessary in collaborative efforts. Trust may need to be rebuilt or regularly renewed.

Several secondary conceptual frameworks and principles were used to further operationalize core components of the FAS and support interpretation of study findings (**Figure 3.3**). Secondary frameworks and principles were selected from the Chapter 2 literature review that reflect the intent of the FAS core components and adaptive factors, as well as center equity

considerations and elevate community voice. For example, the Robert Wood Johnson Foundation (RWJF) Commission to Transform Public Health Data Systems[183] broadly relates to the systematic gathering, organizing, and sharing of data between entities, but further recommends that shared data systems are developed and maintained with community and that data systems measure structural racism and other inequities. **Table 3.2** summarizes specific concepts from secondary frameworks and principles that will inform data interpretation and resulting recommendations. The Wolff et al. principles of Collaborating for Equity and Justice informed recommendations arising from *shared purpose* results, including guidance to focus on policy, systems, and structural change; explicitly address issues of social and economic injustice and structural racism; and employ community organizing as an intentional strategy.[120]

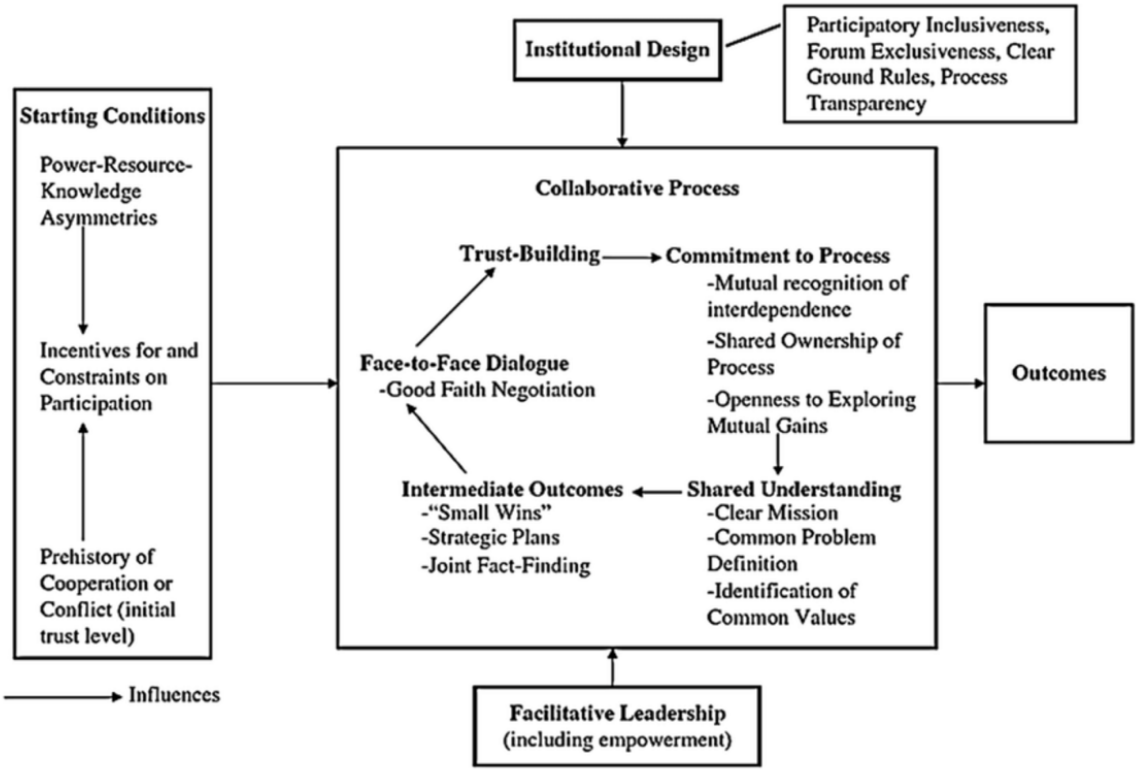
Figure 3.3. Secondary conceptual frameworks and principles to further operationalize Framework for Aligning Sectors core components



Recommendations arising from *shared data and measurement* findings were informed by the RWJF Commission to Transform Public Health Data Systems[183] and Data Across Sectors for Health initiatives,[36] including suggestions to center health equity and well-being in narrative change; develop and maintain shared data systems with community (equitable data governance); ensure measurement of structural racism and other inequities, including accurate community-level data that supports small-area estimates; ensure all partners engaged in cross-sector data sharing are involved in ongoing analysis of risks and benefits of data sharing; advance a holistic, comprehensive view of public health data that minimizes narratives that blame individuals or groups by collecting information on disparities in health outcomes *and* underlying causes; and ensure a shared understanding of the data lifecycle and access to data. In addition, the Wolff et al. principles of Collaborating for Equity and Justice specify that collaborations should build on the extensive community-engaged scholarship and research over the last four decades.[120]

Shared governance recommendations were informed by the Ansell and Gash Model of Collaborative Governance (**Figure 3.4**), including elements of the model focused on a collaboration's starting conditions, facilitative leadership, institutional design, and collaborative process.[55] The institutional design element of the Model of Collaborative Governance was further informed by Fung's three dimensions of public participation which specify selective recruitment of participants, deliberation and negotiation forms of decision-making, and co-governance forms of power and authority.[49] In addition, the facilitative leadership element was further informed by Feldman and Khademian's concept of the "inclusive public manager" and Denhardt and Denhardt's "New Public Service" model of public administration.[145,32]

Figure 3.4. A Model of Collaborative Governance[55]



Recommendations related to *shared financing* were informed by trust-based philanthropy, including the six practice recommendations to provide multi-year unrestricted funding; proactively identify prospective grantees to save non-profit organizations time in the early vetting process; simplify and streamline paperwork associated with grant funding; be honest and transparent in communications to grantees; solicit and act on feedback from grantees and communities; and provide grantees with non-monetary supports that bolster organizational leadership and capacity.[166] Finally, *shared communications* recommendations were informed by the "narrative change" pillar of the Truth, Racial Healing and Transformation framework, which specifies a "process of disrupting dominant narratives that normalize inequity and uphold oppression and advancing new narratives from our communities and individuals in historically marginalized groups...[to] imagine a different future."[144] *Shared communications*

recommendations were also informed by Eve Tuck's desire-based framework for research, which calls on collaborators to "resist stories that introduce or reinforce narratives of people who experience structural oppression as broken or damaged" and instead highlight a community's assets, opportunities, and desires.[35] The Oregon Modernization framework informed study aim 3 related to the perceived roles of each partner in fulfilling the HECR capability.[26] Specifically, state and local governmental public health "roles" for HECR that are described in the Modernization Manual served as the basis for exploring this aim (**Figure 3.5**).[26]

Figure 3.5. Oregon Public Health Modernization framework[26]

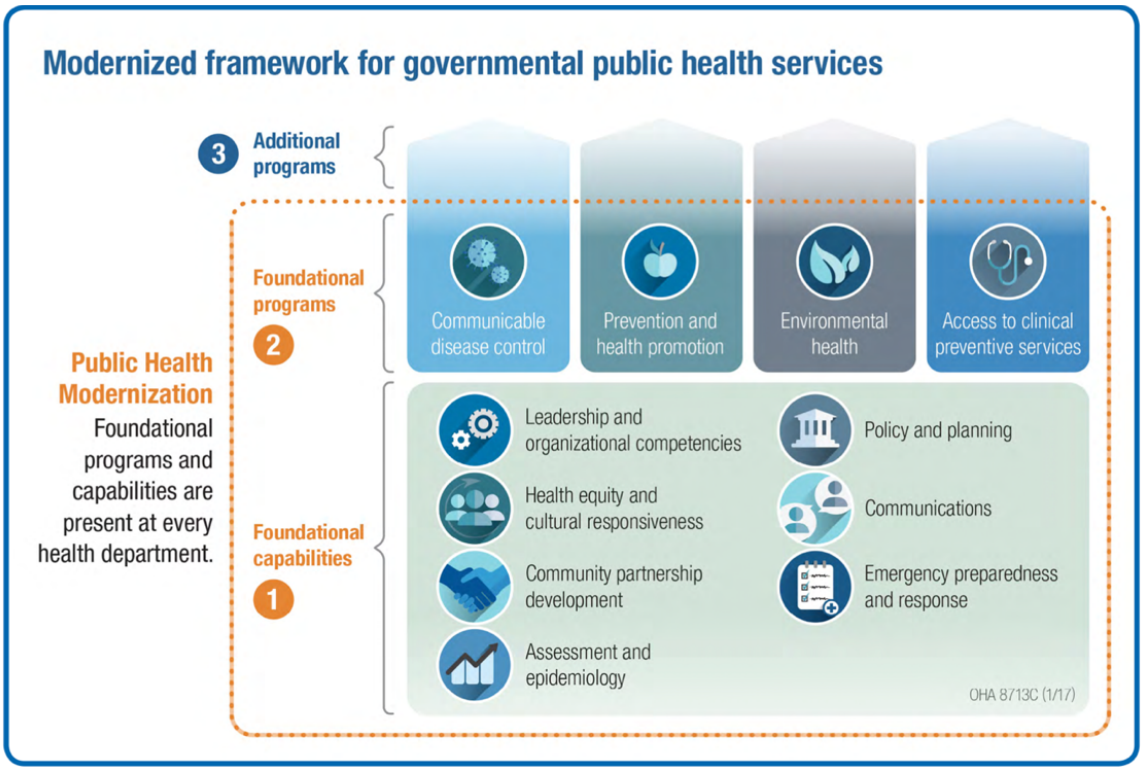


Table 3.2. Concepts from secondary conceptual frameworks and principles to further operationalize Framework for Aligning Sectors core components

Framework core component	Secondary framework	Secondary framework concepts
Shared purpose	Principles of Collaborating for Equity and Justice[120]	• Focus on policy, systems, structural change • Explicitly address social and economic injustice and structural racism • Employ community organizing as an intentional strategy and as part of process
Shared data and measurement	Commission to Transform Public Health Data Systems[183] Data Across Sectors for Health (DASH) initiative[36]5/15/25 8:52:00 AM	• Create equitable data systems with communities • Develop and maintain shared data systems with community (equitable data governance) • Measure structural racism and other inequities, including accurate community-level data • Ensure a shared understanding of the data lifecycle and access to data • Ensure all partners are involved in analysis of risks and benefits of data sharing • Advance holistic, comprehensive view of public health data by collecting information on disparities *and* underlying causes • Center health equity and well-being in narrative change and minimize narratives that blame individuals or groups • Build on existing community-engaged scholarship and research (from principles of Collaborating for Equity and Justice)
Shared governance	Model of Collaborative Governance[55]	*Starting conditions* • Power-resource-knowledge asymmetries • Incentives for and constraints on participation • Prehistory of cooperation or conflict *Facilitative leadership* • Inclusive public manager • New Public Service *Institutional design* • Selective recruitment of participants • Deliberation and negotiation decision-making • Co-governance forms of power and authority *Collaborative process* • Face-to-face dialogue • Trust-building • Commitment to process • Shared understanding • Intermediate outcomes

Shared financing	Trust-based philanthropy[166]	• Provide multi-year unrestricted funding • Proactively identify prospective • Simplify and streamline paperwork • Be honest and transparent in communications • Solicit and act on feedback • Provide non-monetary supports that bolster organizational leadership and capacity
Shared communications	Truth, Racial Health, and Transformation framework (narrative change pillar)[144]	• Actively working to disrupt dominant narratives that normalize inequity and uphold oppression • Advance new narratives from communities and individuals in historically marginalized groups • Support community to develop full understanding and articulation of its history

Data Collection

Sample and Data Collection Overview

Data collection consisted of focus groups, key informant interviews, and online surveys to gather information from three participant groups: OHA-PHD staff, LPHAs, and CBOs. More specifically, data collection with OHA-PHD staff focused on those who support Modernization implementation (N=60). Data collection for Oregon's 33 LPHAs focused on public health administrators and program coordinators receiving Modernization grants from the OHA-PHD (N=66). Data collection for CBOs focused on grant coordinators receiving Modernization funding through the OHA-PHD Public Health Equity Grant Program (N=94). **Table 3.3** provides an overview of data collection methods for each study aim by partner type, including the number of participants for focus groups, key informant interviews, and surveys. Overall, the study included 5 focus groups with a total of 29 participants, 3 key informant interviews, and 59 Delphi survey respondents. A more detailed description of data collection methods follows the table, including criteria for defining the populations of focus (e.g., rural/frontier, Communities of Color).

Table 3.3. Data collection methods by research aim and partner type

Research aim	Data collection method	Partner type	Population focus	Number of participants (N)
1. Characterize the degree to which factors of cross-sector alignment are currently fulfilled 2. Compare similarities and differences in how partners perceive factors of cross-sector alignment	Key informant interviews	OHA-PHD	Senior leadership	3
	Focus groups	OHA-PHD	Program staff	5
		Total OHA-PHD		**8**
		LPHA	Urban	5
			Rural/frontier	4
		Total LPHA		**9**
		CBO	Communities of Color	7
			General	8
		Total CBO		**15**
3. Explore perceived roles of each partner in advancing health equity	Delphi survey series	OHA-PHD		7
		LPHA		18
		CBO		34

Qualitative Data Collection (Aim 1 and Aim 2)

The study used semi-structured focus groups and key informant interviews to explore the degree to which factors of cross-sector alignment are currently fulfilled and compare perceptions of alignment across partners. Focus groups and key informant interviews were selected as the data collection method given the exploratory nature of the study and the need to gather an in-depth understanding of experiences from many potential participants across the three partner groups (OHA-PHD, LPHAs, and CBOs). Focus groups included up to 8 participants to allow for as many partners to participate while maintaining a manageable size for facilitation and participation in discussion (the actual number of participants in focus groups ranged from 4 to 8). Focus group participants were selected from those who responded to an open recruitment email (**Appendix A** includes the Portland State University Institutional Review Board overview and pre-screening form, **Appendix B** includes the focus group consent form, and **Appendix C** includes the focus group recruitment email). Focus group segmentation and priority perspectives

are described in more detail below. A one-page fact sheet describing the study purpose and focus group process accompanied the open recruitment email. The fact sheet was tailored to OHA-PHD, LPHA, and CBO partner groups with a focus on "why they should care" about the study (**Appendix D** includes the fact sheet used for CBO focus group recruitment).

The perspectives of OHA-PHD senior leadership (N=3) were captured in key informant interviews, while program staff (N=8) perspectives were collected in a focus group. LPHA staff perspectives were captured through two focus groups. Focus group segmentation based on geography has been requested by LPHAs in past OHA-PHD projects seeking their perspectives. Therefore, this study included one group for LPHAs serving urban communities and one group for LPHAs serving rural and frontier communities. Recruitment of LPHA staff prioritized a mix of public health department administrators and program coordinators implementing Modernization grants. CBO staff perspectives were captured through two focus groups, including one with targeted recruitment of CBOs serving Communities of Color, and another focus group with CBOs serving other priority populations (e.g., rural and frontier communities, people with disabilities, LGBTQ+ communities). The open recruitment email was sent to each CBO's primary contact for the Public Health Equity Grant with a stated preference that the grant program coordinator participate in the focus group. The segmentation of CBO focus groups ensured that the perspectives of culturally specific CBOs were adequately captured. While people living in rural and frontier areas, people with disabilities, and people who identify as LGBTQ+ (all in the first focus group) are distinct communities, convening separate focus groups for CBOs serving each of these communities was not feasible, so targeted recruitment of these perspectives for one group was a compromise. Similarly, considering all CBOs serving

Communities of Color for one focus group masks the diversity across these communities, but conducting separate focus groups for each community of color was not feasible for this study.

CBOs serving rural or frontier communities were be determined using information OHA-PHD collects from funded CBOs on the "county served." County-level service areas were flagged as rural or frontier for focus group recruitment using the Oregon Health and Science University's Oregon Office on Rural Health rural/urban designations.[187] The sample of CBOs serving Communities of Color and LBTQ+ or disability populations were determined using information collected from CBOs on "population(s) served." The categories "American Indian/Alaskan native/indigenous," "Black/African American/African," "Asian," "Pacific Islander," and "Latino/a/x" were combined into a "Communities of Color" designation for the CBO. Given the intersecting identities of populations served by funded CBOs, there was overlap between the four categories of CBOs (rural/frontier, Communities of Color, people with disabilities, and LGBTQ+ communities) used for targeted recruitment. The intersectionality of populations served was explicitly acknowledged in focus group recruitment materials, and CBOs had the option to self-select into one of the two focus groups.

Focus groups and key informant interviews included high-level questions intended to solicit participant perceptions of facilitators and barriers to collaboration on Modernization implementation. Focus group and key informant interview questions and prompts were based on the FAS core components (shared purpose, data, governance, financing, and communications) and adaptive factors (community voices, equity, power dynamic, and trust).[29] Participants of focus groups and key informant interviews received a PowerPoint slide deck that describes FAS core components and adaptive factors in advance of meeting (**Appendix E**). Focus groups and key informant interviews also began with a brief overview of the slides to ensure participants

were grounded in the meaning of FAS core components and adaptive factors before they were asked to describe their experiences with these dimensions of collaboration. **Appendix F** includes the focus group script used in the Communities of Color CBO focus group.

All focus groups were conducted online given most proposed participants reside outside of the Portland Metro area where the research lead resides. In addition, proposed participants residing in the Portland Metro area may have fully remote or hybrid work schedules that would make it difficult to schedule in-person focus groups. Focus groups were recorded and transcribed with participant consent using Sonix.ai.[188] The chat thread from each focus group was also downloaded and stored for later analysis. Focus groups were offered in both English and Spanish to reduce the barrier to participation for CBO and LPHA staff who primarily or exclusively speak in Spanish. Participants who preferred Spanish were engaged in focus groups through simultaneous interpretation services provided by the Immigrant and Refugee Community Organization's World Language Bank (at a cost of $222 for two interpreters for each 90-minute focus group). Spanish was the only non-English language offered through interpretation services, so the study missed the perspectives of staff who speak other languages. The Delphi survey series was conducted exclusively in English, so was not available to participants who exclusively read in other languages and was a study limitation.

Participants were invited to focus groups and key informant interviews via an email that specified the study purpose, the participant's role in the study, the high-level questions that would be asked, the estimated time the focus group would take, convening method (i.e., online), opportunity to review preliminary findings, and the option to suggest another staff member for the focus group. One reminder email was sent to participants two weeks after initial contact. While full-time government employees cannot be compensated for participation in the study,

CBO staff participating in focus groups were offered a $150 Visa e-gift card for their participation based on an OHA-PHD standard of $100/hour. Consequently, a stipend budget of $2,400 was required for a maximum of 16 CBO staff participating in 90-minute focus groups.

Prior to sending recruitment emails, the study design was presented to representatives from each participant group in existing meeting spaces for discussion and feedback, including standing monthly meetings of the OHA-PHD Collaborative Funding Workgroup (comprised of staff who administer the Public Health Equity Grant), Conference of Local Health Officials (CLHO),[21] and the OHA-PHD CBO Advisory Committee. Time in these meetings was requested via emails to respective point(s) of contact and committee chair(s). These meeting spaces routinely receive requests for presentations on public health strategic initiatives, including Modernization, so were likely to grant requests for time and appreciate the opportunity to inform the study approach. Focus group and key informant interview participants were also invited to optional listening sessions to review preliminary findings, clarify interpretations and ask questions, identify findings to highlight in reporting out the research, and provide updates on any themes since focus groups and key informant interviews were conducted in April–May 2024.

Quantitative Data Collection (Aim 3)

The study used the Delphi technique to examine the roles of each partner in fulfilling the HECR capability of the Modernization framework. While the Modernization framework has seven foundational capabilities, this study focused on the HECR capability given advancing health equity was the impetus for the Public Health 3.0 initiative and equity is an adaptive factor of the FAS, the study's primary framework.[29,1] In addition, recent findings from an unpublished evaluation of Modernization grants to LPHAs and CBOs in 2021-2023 found that grantees were

unsure how to operationalize the HECR capability, including each partner's unique and complementary role in fulfilling the capability. The Delphi process is a method for achieving convergence of opinion among topic area "experts," especially in situations with limited information.[189] The method was developed in the 1950s and has been used across a range of disciplines, including healthcare, education, business, engineering and technology, social sciences, and environmental studies.[189] Delphi studies use rank-order questions, rating scales, or open questions to examine levels of consensus among experts.[190] The aggregated group opinion is fed back to participants across multiple rounds of discussion or survey administration. After each round, participants review aggregated results and may reconsider their assessment from the previous round based on added quantitative or qualitative information.[189] The anonymity of participant responses is maintained throughout the process. There can be variation in aspects of the process, including the number of rounds, the format by which questions are delivered and responses are collected, and how "consensus" is determined (e.g., there is inconsistency across Delphi studies with the suggested level of consensus ranging from 51% to 100%).[189]

This study featured one Delphi process to determine consensus opinion on each partner type's roles in advancing the HECR capability. Participants were recruited to the Delphi process through emails to existing listservs of OHA-PHD staff who support Modernization implementation (N=60), LPHA public health department administrators and Modernization grant program coordinators (N=66), and CBO staff coordinating Modernization grants (N=73). The Delphi process was conducted in three phases: 1) idea generation; 2) rating role statements; and 3) prioritizing role statements. In the "idea generation" phase, participants received an online survey with statements based on the "roles" described for the HECR capability in the Modernization Manual.[26] **Table 3.4** indicates the number of role statements for state and local

governmental public health for the HECR capability, as well as a few example consensus statements based on role descriptions in the Modernization Manual.[26]

Overall, the Modernization Manual specifies 56 HECR roles for OHA-PHD staff and 46 roles for LPHA staff, with some degree of overlap between state and local roles.[26] The Modernization Manual does not include roles for CBOs (the Modernization Manual was developed in 2015 prior to OHA-PHD providing Modernization funding to CBOs). The survey asked all participants (regardless of partner type) to review the two groups of role statements for OHA-PHD and LPHA staff and suggest modifications to existing roles and/or offer up to five new roles for state and local governmental public health using an open-ended question at the end of each group of role statements. The survey also asked participants to offer up to 10 new roles for CBOs to include in the second and third surveys. Respondents also had the option to include their rationale for suggesting new roles in an open-text field. A larger number of additional roles was allowed for CBOs given roles were never described for this partner type in the 2015 Modernization Manual, so respondents may have more "write-in" roles for CBOs than for OHA-PHD and LPHA staff.

In the "rating role statements" phase, participants received an online survey with the role statements updated with suggested modifications and additions from the first survey. Participants were asked to review the role statements for each partner type and score the "importance" of each role to advancing HECR using a Likert-type response of 1-5, with 1 being not important at all and 5 being very important. One open text question at the end of each role statement group solicited respondents' rationale for their ratings. In the "role statement prioritization" phase, participants received an online survey with role statements updated with the average score that

each role received from respondents to the second survey. For each group of role statements, participants were asked to rank the top 5 most important roles to advancing HECR.

All online surveys were administered via Qualtrics, ensuring a unique invitation link was sent to each potential respondent and allowing for 1 response per link. All surveys included a consistent set of demographic questions asking respondents to indicate their partner type (OHA-PHD, LPHA, CBO), number of years working in their respective sector, and whether they have worked in the other sector in the past. Participation in the second and third surveys was not contingent on participation in previous survey rounds, so participation varied across survey rounds (described in Chapter 4). Participants had two weeks to complete each survey, and nonrespondents received two email reminders, one at 7 days and another at 11 days prior to the survey end date. Participants did not receive compensation for participation in the Delphi survey series; full-time government employees cannot be compensated and the limited funding for the study could not support incentives for CBO participants. Not providing an incentive ensured the anonymity of survey responses, because the collection of contact information was not needed.

Table 3.4. Number of Public Health Modernization Manual roles for health equity and cultural responsiveness foundational capability for Delphi process by partner type[26]

Partner type[1]	**# of role statements**	**Example role statements**
State governmental public health (OHA-PHD)	56	Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets, and protective factors) that influence health.
		Develop or support mass media educational efforts that uncover the fundamental social, economic, and environmental causes of health inequities.
		Increase flexible categorical and non-categorical funding to address health equity.
		Develop or use an existing antidiscrimination training to build a competent workforce.
		Establish greater flexibility in job classifications to tackle the root causes of health inequity.

Local governmental public health (LPHAs)	46	Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets, and protective factors) that influence health.
		Advocate for comprehensive policies that improve physical, environmental, social, and economic conditions in the community that affect the public's health.
		Monitor funding allocations to ensure sustainable impacts on health equity.
		Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities.
		Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities.

[1] CBOs will receive the same role statements as LPHAs in the first-round Delphi survey.

Data Analysis

Qualitative Data Analysis

Focus group and key informant interview data, both transcribed verbal responses and downloaded chat threads, were organized and analyzed using Dedoose software.[191] Each transcript was read in detail prior to analysis to check transcription accuracy and to reflect on the overall meaning of the focus group, including general ideas and tone. The memo feature of Dedoose was used to record thoughts on initial readthrough. The study employed a deductive approach to thematic analysis that used the FAS core components and adaptive factors as a preliminary codebook, but allowed for new themes to emerge (see **Appendix G** for the preliminary codebook).[29,186] Transcripts were double coded by another researcher with qualitative analysis experience. A colleague at OHA-PHD with experience in qualitative research and analysis received a $1,000 stipend to serve as the double coder for the study.

The Northwest Center for Public Health Practice supported this study with a $3,500 Faculty-Student Collaborative Project award. The award was used for stipends to CBO focus

group participants and the qualitative analysis double coder; use of Sonix.ai for focus group and key informant interview transcriptions; a 3-month subscription to Dedoose qualitative analysis software; and Spanish language simultaneous interpretation services from the Immigrant and Refugee Community Organization's World Language Bank.

This study employed multiple procedures to ensure validity of focus group and key informant interview findings, including: use of member checking with participants to determine accuracy of themes and major findings; clarifying how interpretation of findings was shaped by researcher's background; and presenting negative or discrepant information that conflicts with the general perspective of a particular theme if it emerges.[186] Qualitative reliability was also strengthened by checking focus group and key informant interview transcripts for obvious mistakes made during transcription; making sure there was not drift in the definition of codes during the coding process by writing memos about the codes and their definitions and continually comparing data with the codes; and resolving discrepancies with the double coder by meeting to discuss specific differences, clarify coding guidelines, and reach consensus on interpretations.[186]

Quantitative Data Analysis

For the "idea generation" survey, de-identified data was downloaded from Qualtrics as an Excel spreadsheet for analysis. New role statements were developed from thematic analysis of open-ended responses to the survey questions asking for other roles that should be included and are not currently present in the Modernization Manual. A new role statement was only included in the second survey if not redundant with an existing role statement in the Modernization Manual. New role statements from multiple respondents that were similar were combined to reduce

redundancy in the second survey. Thematic analysis was also conducted on open text responses from respondents describing the rationale for suggested modified and new role statements. Themes from respondent rationale are reported in results and recommendations (Chapters 4 and 5) .

For the "role statement rating" survey, de-identified data were downloaded from Qualtrics as an Excel spreadsheet and imported into Stata for analysis. Stata was used to calculate the average score for each role across all respondents, ensuring missing responses are excluded from the denominator. Excel was used to conduct thematic analysis of open text responses from respondents describing the rationale for their scores. Themes from respondent rationale are reported in results and recommendations (Chapters 4 and 5). For the "role statement prioritization" survey, de-identified data were downloaded from Qualtrics as an Excel spreadsheet and imported into Stata for analysis. The rank ordering of role statements was analyzed using a Borda count in which the lowest ranked role statement received 1 point, the next-lowest received 2 points, and the highest-ranked role statement received 5 points.[192] Points were summed for each role statement and ordered from highest to lowest according to total points received. Stata was used to assign points and sum total points for each role statement.

Preliminary findings from qualitative analyses were member checked with OHA-PHD, LPHA, and CBO focus group and key informant interview participants in optional virtual listening sessions conducted over Zoom from April 7–11, 2025. Separate listening sessions were held for each participation group (three total) to maintain a manageable size for discussion. Listening sessions allowed for participants to ask questions and clarify preliminary findings, discuss which findings feel most important to highlight in reporting out the research, and to offer any updates since focus groups and interviews were conducted last April–June 2024. Listening

sessions were also intended to capture partner preferences for how final results are disseminated to the field and the most appropriate products (e.g., fact sheets, slides) to aid dissemination to priority audiences. Listening sessions were also intended as a venue to review preliminary Delphi survey results. However, priority was given to the discussion of qualitative findings, so neither of these topics were discussed within the 60-minute sessions.

Anticipated Challenges

There were several anticipated challenges with data collection. The first challenge was data collection fatigue among LPHA and CBO staff receiving Modernization funding, which could negatively affect participation in focus groups, key informant interviews, and Delphi surveys. For example, grant recipients are required to submit biannual expenditure and activity reports and support program evaluation activities, including participation on an evaluation advisory group. Funded CBOs were also recently asked to complete surveys and participate in focus groups related to a process evaluation of the Public Health Equity Grant.

Data collection fatigue was mitigated by proactively discussing the study purpose and proposed methods at meetings of the OHA-PHD Collaborative Funding Workgroup, CLHO, and the CBO Advisory Committee to distinguish this study from other recent data collection activities. Data collection fatigue was also mitigated by providing participants with the opportunity to review and discuss preliminary findings and consider dissemination audiences and products to cultivate shared ownership of study findings. Partner interest in the study was also strengthened in optional listening sessions by describing how the study will inform both Modernization efforts in Oregon, as well as public health system transformation efforts in other

US states and local jurisdictions. For CBOs in particular, stipends were intended to mitigate data collection fatigue by honoring their time and expertise through adequate compensation.

Another potential data collection challenge stemmed from my positionality. First, my position within the OHA-PHD as a lead on the Public Health Equity Grant Program, former program evaluator for Modernization, and budget manager for large grant awards to LPHAs and CBOs could have led to participants feeling pressured to consent to study participation. This challenge was mitigated by ensuring that study communications and materials stressed the voluntary nature of the study and a participant's ability to not answer questions or completely opt-out of any data collection activity at any time. In addition, my position within OHA-PHD could have led to participants not feeling comfortable speaking truthfully about negative experiences with the grant program. For example, OHA-PHD staff may fear repercussions from senior leadership and LPHA and CBO staff may fear changes to their grant funding if negative comments are identifiable. This challenge was mitigated by assuring focus group participants that participation is voluntary and they can withdraw at any time; that all data will be kept confidential and only available to the lead researcher and one other researcher who is supporting data analysis; that they will be notified immediately if an unlikely breach of confidentiality occurs; that their names will not be included on any products associated with the research and any quotes used will be deidentified; and participation in the focus group will have no impact on employment or funding.

My position as a white, exclusively English-speaking researcher limited my capacity to engage both participants with a preference for non-English languages and participants representing Communities of Color in in a manner that fostered trust and mitigated inherent power dynamics. This challenge was, in part, mitigated by offering Spanish language

simultaneous interpretation in focus groups. As a white researcher proposing a study that seeks to apply an equity lens and center the voices of people from systematically oppressed communities, particular attention was paid to data collection processes that were extractive or appropriative. An extractive study design was mitigated by ensuring principles of co-creation were embedded throughout the data collection process, including engaging study participants in the interpretation of preliminary results and discussing preferences for how final results are disseminated. In addition, study communications (e.g., focus group recruitment email) included my positionality statement to be as transparent as possible with potential study participants and easily allow for participants to not engage with a white, exclusively English-speaking researcher.

Study Limitations

There are several study limitations. First, focus groups, key informant interviews, and surveys with LPHA and CBO staff did not capture all possible perspectives from these partner groups given these optional opportunities are more open to those who have time and capacity to participate. This limitation was addressed, in part, by targeted recruitment to ensure LPHA perspectives include those serving both rural/frontier and urban communities and a mix of public health administrators and program staff. Similarly, recruitment for CBO focus groups prioritized staff from organizations serving rural and frontier communities, Communities of Color, people with disabilities, and LGBTQ+ populations. In addition, stipends for CBO participation lowered the barrier to participation for those who may experience economic instability and also honor the importance of lived experience. Another limitation is that the Delphi survey process was only conducted in English. Delphi surveys in non-English languages were not available to interested

CBOs, which excluded the perspectives of CBOs with staff who primarily or exclusively read in non-English languages.

Another limitation is that while the study captured the perspectives of three partner types (state and local governmental public health and CBOs), the study did not reflect perspectives from other essential partners in the public health system, including tribes and those from other sectors, such as healthcare and education. The study was also limited in its exploration of outcomes from cross-sector alignment, typically an interest of decision-makers, and instead focused primarily on the degree to which Modernization collaborations between governmental public health and CBOs reflect FAS core components and adaptive factors. Lastly, the study's generalizability to other jurisdictions was limited by the unique context in which Modernization is being implemented in Oregon, including the FPHS framework being codified in law and the presence of a dedicated HECR capability in Oregon's Modernization framework.

Chapter 4. Results

Introduction

Chapter 4 begins with a restatement of the research question, study aims, and corresponding data collection methods. The chapter then describes results for the qualitative analysis of focus group and key informant interview data (Aims 1 and 2). Qualitative analysis results are organized by the elements of the study's primary conceptual framework, the Framework for Aligning Sectors. Lastly, the chapter describes results for the modified Delphi survey process (Aim 3).

Research Question and Aims

The research question for this study is "What factors of cross-sector alignment impede or facilitate collaboration among state and local governmental public health and communities to advance health equity?" This research question was addressed through three specific aims: 1) characterize the degree to which factors of cross-sector alignment are currently fulfilled; 2) compare similarities and differences in how partners perceive factors of cross-sector alignment; and 3) explore perceived roles of each partner in advancing health equity. Data for aims 1 and 2 were collected through five focus groups with local public health authorities (LPHAs), community-based organizations (CBOs), and Oregon Health Authority Public Health Division (OHA-PHD) program staff, as well as three key informant interviews (KIIs) with OHA-PHD senior leadership. Data for aim 3 were collected through a modified Delphi survey process with same group of LPHA, CBO, and OHA-PHD staff as the focus group and KIIs.

Aim 1 and 2 Focus Groups

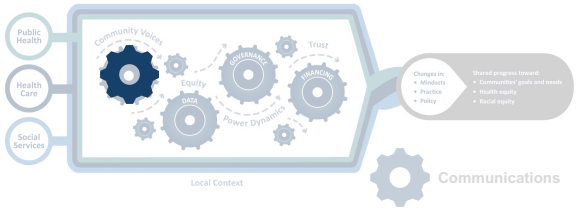
In total, results reflect the perspectives of 32 public health practitioners. The five focus groups were convened April 22 through June 6, 2024. The focus group with LPHA staff serving rural and frontier communities had four participants, including three administrators and one grant program manager. The focus group with LPHA staff serving urban communities had five participants, all of which were administrators. The focus group with CBOs serving Communities of Color had seven participants and the focus group with CBOs serving other priority populations had eight participants. The focus group with OHA-PHD program staff had five participants. The three KIIs with OHA-PHD senior leadership were conducted June 3–5, 2024. **Table 4.1** summarizes the sample for each focus group. Results reflect thematic analysis of both transcribed focus group discussions and the chat thread from each focus group. Results from the focus group and interviews with OHA-PHD staff will hereafter be attributed to "OHA program staff" and "OHA leadership" for brevity.

Table 4.1. Focus group and key informant interview samples, April 22–June 6, 2024

Data collection method	Partner type	Segment	Number of participants
Key informant interview	OHA-PHD	Senior leadership	3
Focus group	OHA-PHD	Program staff	5
	LPHA	Urban	5
		Rural/frontier	4
	CBO	Other priority populations	8
		Communities of Color	7
		Total	**32**

Results are organized by the elements of the Framework for Aligning Sectors,[29] which served as the preliminary codebook for thematic analysis. Each theme described is supported with representative de-identified quotes. The richness of description across themes was affected

by time constraints and the order in which questions were asked (i.e., focus groups and KIIs started with questions about framework core components and then adaptive factors). In several focus groups and KIIs, not every question was asked within the time allotted (90 minutes for focus groups and 60 minutes for interviews), which inherently prioritized core components over adaptive factors in most instances and breadth over depth in general. This limitation will be described further in Chapter 5 with implications for future research. While the role of context was not asked explicitly in focus groups and interviews, this area of the primary framework arose organically in conversation and was identified as an emergent theme in analysis. **Appendix H** summarizes parent and child themes with a brief explanation of the theme's meaning and a representative quote.



Shared Purpose

Shared purpose is defined in the Framework for Aligning Sectors as a "feature of aligned systems in which sectors share a mutual understanding and commitment to a vision and priority outcomes." Five themes relating to shared purpose were identified. Themes relate to: 1) experiences of shared purpose early in Modernization implementation; 2) structures that support the development and maintenance of shared purpose; 3) experiences with shared purpose changing over time; 4) barriers to maintaining a shared purpose; and 5) the impacts of an unclear shared vision.

Early Shared Purpose

Participants across nearly all focus groups and interviews described experiences of feeling or having a shared purpose while implementing Public Health Modernization (referred to as "Modernization" hereafter). One OHA leader described how the vision for Modernization initially arose from a set of recommendations for public health system transformation developed by Oregon's Public Health Task Force on the Future of Public Health Services (OHA Leadership KII 1). A LPHA participant reflected on early decisions that went into developing shared purpose for Modernization: "They [OHA] hired a whole consulting group for the roadmap and we were kind of part every step of the way…Like how are we going to communicate this? What are our talking points? What are we going to fund? What are we going to prioritize first? I felt that was very much shared decision-making. We're going to focus on communicable disease, core public health, right? It's sorely underfunded. I think that was a decision really made together" (Urban LPHA Focus Group). Another LPHA participant similarly reflected on aspects of early visioning for Modernization, many of which speak to other complementary core components of the Framework for Aligning Sectors: "We spent a lot of time thinking about even first what do we call it? Modernization…not everybody loved that term, so we kicked around a lot of other ideas too. There was a lot of time spent on…developing the roadmap, and there were videos done, and there was a lot of effort put into having a shared communication strategy. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. It felt like a good collaboration" (Urban LPHA Focus Group). Lastly, one CBO noted "a very strong relationship" with the OHA climate and health program, specifically, and feeling that "we're definitely working from a shared purpose" (OPP CBO Focus Group).

> "There was a lot of time spent on…developing the roadmap, and there were videos done, and there was a lot of effort put into having a shared communication strategy. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. It felt like a good collaboration"
> – Urban LPHA Focus Group

Shared Purpose Supports

One OHA leader noted several structures that support the development and maintenance of shared purpose across Modernization partners. The leader described the role of the Public Health Advisory Board (PHAB) as "working really well as that one table that brings everyone together" (OHA Leadership KII 1). The OHA leader further described the importance of PHAB in the "early days of Public Health Modernization" as a space that brought partners together to learn about Modernization and "do some visioning when we were really starting from zero and moving forward" (OHA Leadership KII 1). The OHA leader attributed the successful development of a shared vision within PHAB to the newness of Modernization and the initial focus on governmental public health: "It seemed very easy, honestly, to come together around a shared purpose for Public Health Modernization back in 2015, 2016, 2017…it was easy at that point to be aspirational in what we believed that we could achieve one unified public health system" (OHA Leadership KII 1). The OHA leader also emphasized that PHAB received a "very intentional redesign" to include an expert in health equity, CBO representatives, and an

individual representing the education system to ensure its relevance as "the place that brings everyone to one space to develop this purpose and direction."

OHA leadership and LPHA participants also described the Modernization framework and related Modernization Manual as outputs of early shared visioning. One OHA leader noted that the detailed definitions of Modernization foundational programs and capabilities in the manual "reflect a shared approach" because they were developed "completely collaboratively with Public Health Division…content experts and local public health administrators…and then vetted by an overarching working group" (OHA Leadership KII 2). One LPHA participant described early efforts to define shared purpose through the collaborative development of the Modernization Manual and other supportive processes and outputs: "I felt like it was a pretty clear roadmap. We created the Modernization Manual, we did a whole big assessment that took lots of time and commitment from local public health that all got rolled up. We had a very clear dollar amount of what we needed" (Urban LPHA Focus Group). While the Modernization Manual was described as an anchoring framework for the shared vision, one LPHA participant who was relatively new to their role had a "hard time knowing what the shared vision is generally" and did not find clarity in the manual, saying "I read the Modernization Manual back to front a lot and I still can't quite get a grasp on it" (Rural LPHA Focus Group).

> "…the actual creation of the Public Health Modernization Manual…the deeper definitions of each foundational capability and program. That work was all done completely collaboratively with Public Health Division at OHA, content experts and local public health administrators so that those definitions really reflected a shared approach and then similarly vetted by an overarching working group."
> – OHA Leadership Key Informant Interview 2

OHA leadership and LPHA participants also noted the Modernization accountability metrics as a facilitator of shared purpose. One OHA leader described how the accountability metrics reflect "some really urgent public health issues…that we as a system are committing to being able to improve through the investments that we get" (OHA Leadership KII 1). One LPHA participant affirmed that "part of the shared purpose in my mind is the public health accountability metrics" and described how OHA requires LPHAs to indicate how their Modernization-funded activities align with the accountability metrics in their biennial workplans (Rural LPHA Focus Group).

Shared Purpose Changed Over Time

OHA and LPHA participants described how the sense of shared purpose changed over time. The OHA leader first reflected on the success of early visioning, stating that "it seemed very easy, honestly, to come together around a shared purpose for Public Health Modernization back in 2015, 2016, 2017" and attributed this ease in part to Modernization being "so new…we really were creating something that we didn't have and it was easy at that point to be aspirational in

what we believed that we could achieve one unified public health system in Oregon" (OHA Leadership KII 1). An LPHA participant affirmed this sentiment, saying "early on it was really about how do we ensure that we have these core foundational programs and capabilities across Oregon…how do we get our state to invest more into, at the time, it was governmental public health. I felt like it was a pretty clear roadmap" (Urban LPHA Focus Group). However, the OHA leader acknowledged that the shared vision for Modernization "started to fragment a little bit" over time – a perspective echoed by several LPHA participants – and described several factors that contributed to this fragmentation (OHA Leadership KII 1).

This leader first attributed the fragmentation to learning over time saying, "as we got really into Public Health Modernization and we learned a lot more, it led to a lot of variation in how people think about the work…ask ten people what Public Health Modernization is and you will get ten different responses" (OHA Leadership KII 1). One LPHA participant affirmed this sentiment and described a need for local variation, especially for smaller counties, despite the negative impact of variation on shared vision: "…it's hard to feel that there's a shared vision because it feels so incredibly clunky to try and fit into this model that is meant to be for all LPHAs, but we all have very different needs and priority populations…it feels that sometimes the smaller counties are not as well equipped to fit into this model…it feels like I'm giving someone else's PowerPoint presentation that I wouldn't have built that way" (Rural LPHA Focus Group). Another OHA leader similarly described the change in vision as a natural progression of the Modernization initiative where "a modern public health practice requires constant changing…we should as a public health system be evaluating our efforts, identifying where we have gaps, and then responding to those in real time through continuous quality improvement effort" (OHA Leadership KII 2).

Second, the OHA leader highlighted the two-fold impact of the COVID-19 pandemic on maintaining a shared vision. First, governmental public health's central role in the pandemic response was, in and of itself, a "a major interruption in our ability to hold on to that visioning work and be aspirational" that required a singular focus on communicable disease control and access to clinical preventive services to the detriment of advancing all other areas of the Modernization framework during this time (OHA Leadership KII 1). Further, OHA's experience working with CBOs on culturally-specific outreach during the pandemic would ultimately lead to a more explicit role for CBOs in the public health system and then resourcing that part of the system (OHA Leadership KII 1). This leader acknowledged that while the "role of community partners has never been a question in Public Health Modernization work," resourcing CBOs directly was new and contributed to the fragmentation of a shared vision that historically centered governmental public health agencies (OHA Leadership KII 1). The OHA leader described "early work" to define how governmental public health needed to collaborate with community partners, including "partners that we needed to be funding, partners that we needed to be including in…decision-making roles both at the state and locally" (OHA Leadership KII 1). However, this work stopped short of articulating the roles of these community partners (including funded partners) in Modernization, especially relative to the funded work of governmental public health.

One OHA program participant described the implications of not articulating the roles of CBOs in the Modernization Manual (or otherwise) on establishing a shared vision, saying "…it [Modernization Manual] was written for government entities…we then introduced CBOs later on without a clear vision or guide on how they would fit into…the original proposition. I think that has led to a lot of confusion" (OHA Program Staff Focus Group). Another OHA participant

affirmed that how CBOs "fit" into Modernization is "not always clear to all parties" and expressed concerns that CBOs would be expected to fulfill similar roles as governmental public health saying, "…it's not a one-to-one relationship with LPHA or OHA Modernization roles in the manual…there are different needs and capacities for different organizations" (OHA Program Staff Focus Group). The participant further noted that clarifying the roles of CBOs in Modernization would support better understanding of where the work of CBOs and LPHAs intersects and foster improved partnerships across organizations.

LPHA participants affirmed the fragmentation of shared vision introduced by OHA directly funding CBOs for Modernization. One LPHA participant described how the Modernization Manual includes a "clear acknowledgement that the community work belonged in local public health [rather than with OHA]" (Urban LPHA Focus Group), while another LPHA participant reflected on Modernization being exclusively a governmental public health initiative early in implementation, saying "early on it was really about how do we ensure that we have these core foundational programs and capabilities across Oregon. And honestly, how do we get our state to invest more into, at the time, it was governmental public health" (Urban LPHA Focus Group). The LPHA participant described how OHA's decision to fund CBOs "completely undermined that shared purpose [focused on governmental public health]…just blew it up, blew up our system without any idea of what was going to replace it" (Urban LPHA Focus Group).

One LPHA participant reflected on the disconnect in shared purpose between the Public Health Equity grant for CBOs and the broader Modernization initiative, saying "…having spoken with our local CBOs, they are unaware of where the source of their funding has come from. It's like, 'yay, OHA's got these funding opportunities, I'm going to apply for them.' I would too if I was them. But they are not being made aware of this is Public Health

Modernization money… here's the framework and why it's being financed. It's just been presented as this is equity money" (Rural LPHA Focus Group). Another LPHA participant expanded on this sentiment, reflecting on the "great work" of LPHAs and CBOs on community health assessments and community health improvement plans that are funded through Modernization, but feeling CBOs "don't fully understand what public health does…what Modernization is, it's a fairly mysterious word" (Urban LPHA Focus Group). Another LPHA participant attributed the "divergence of shared purpose" to OHA's differential application of Modernization frameworks and guidance, saying, "we are held to this Modernization framework and the accountability metrics and that was not carried over on the CBO side" (Rural LPHA Focus Group).

Complementary to funding CBOs for Modernization, OHA and LPHA participants also noted a new or renewed focus on health equity following the COVID-19 pandemic response, with implications for shared purpose. One OHA leader asserted that Modernization was "designed around health equity from the very beginning" and noted how Oregon's model "stood out from everything happening nationally at that point in time" due to "uniquely defin[ing]" health equity and cultural responsiveness as a foundational capability in the modernized framework for governmental public health services (OHA Leadership KII 1). However, another OHA leader emphasized that a 2016 Modernization capacity assessment revealed OHA's greatest gap to be the health equity and cultural responsiveness capability and noted "…the COVID-19 pandemic allowed us to see more of what we didn't know…the scope and scale of what it takes to more meaningfully implement health equity and cultural responsiveness" (OHA Leadership KII 2). The OHA leader further highlighted how OHA has since been working "with greater intention" to eliminate health inequities by 2030 and "…identify where we still have

egregious and unjust health inequities…and to do things differently to improve and do better for communities" (OHA Leadership KII 2).

> "Modernization is a complex deal with these fundamental things…And then really kind of overnight it switched to a health equity focus, which is not wrong, but it's different from before. We never changed the Modernization Manual and said this is how we've changed. And so that purpose, that had changed, and I'm not saying it's good or bad, but that purpose that changed was never really discussed."
>
> – Rural LPHA Focus Group

OHA program staff who support CBO grant administration also affirmed the shared purpose for the relatively new Public Health Equity grant program being rooted in improving health equity, with one participant noting equity as "the lens that we function through…in terms of pushing out money to specific communities or [for] specific needs" (OHA Program Staff Focus Group). However, another OHA program participant shared that while health equity serves as an internal "focal point" for shared purpose, it does not "feel like we're all on the same page" about what health equity means across Modernization partners (OHA Program Staff Focus Group). The OHA participant further noted that the original vision for the Public Health Equity grant to CBOs, which focused on flexible funding to meet community priorities, "slowly shifted and changed" over time as pressure both internal and external increased to conform to the Modernization framework (OHA Program Staff Focus Group).

While OHA leadership described health equity as foundational to the shared vision since the inception of Modernization, LPHA participants considered the focus on health equity to be a significant change and one that happened quickly: "Modernization is a complex deal with these fundamental things…then really kind of overnight it switched to a health equity focus, which is not wrong, but it's different from before…that purpose that changed was never really discussed" (Rural LPHA Focus Group). Another LPHA participant affirmed "…we all agree that equity is important, and reaching the hardest to reach people is important, and that is a priority outcome" but also emphasized that "…it makes it tricky because if we all have a different definition that we're working from, it's hard to have a shared purpose" (Rural LPHA Focus Group).

The LPHA participant further asserted that the change was not reflected in the Modernization Manual and "was never really discussed" (Rural LPHA Focus Group). Another LPHA participant affirmed the rapid change in shared vision and reflected on the loss of early work on materials that supported a shared vision: "…somebody decided that the definition of Modernization now included CBOs. It had been governmental public health and that's when it was really clear…We had the manual, we actually had a road map, we had it all…We had put so much effort into that development and then for that definition of what Modernization is to change basically overnight" (Urban LPHA Focus Group). Another LPHA participant described the impact on shared vision of expanding funding not only to new partners in CBOs but also allowing funding to be used for work outside of the foundational programs prioritized by the PHAB: "…when we say Modernization, what are we talking about? Because there's governmental Public Health Modernization, and there's the foundational programs and the foundational capabilities of which equity is one. And then it kind of became this nebulous thing

of like, let's just infuse money all over the place into all kinds of public health related topics" (Rural LPHA Focus Group).

Another LPHA participant agreed that "we all had a clear end goal" to ensure basic governmental public health services are available in every community and now "that's just not what we're working towards anymore" (Urban LPHA Focus Group). The participant further questioned why the public health system would stop at CBOs if working to expand which partners are reflected in Modernization: "What is the end goal? Is it we're building a comprehensive public health infrastructure by adding CBOs, but then what about health systems?" (Urban LPHA Focus Group). The participant further reflected that while the Modernization Manual still has value and continues to guide their local Modernization work, "it's not at all the same as where we started" (Urban LPHA Focus Group). Another LPHA participant clarified that "I still have a good feeling of what I need to do locally for local governmental public health, but I don't feel like we have a shared vision across all the system" (Urban LPHA Focus Group).

Shared Purpose Barriers

In addition to funding CBOs and a renewed focus on health equity, participants described several other barriers to developing shared purpose across partners. One CBO participant described feeling aligned with OHA on shared vision but not with LPHAs. Importantly, this difference in alignment between state and local governmental public health was not due to differences in understanding of shared vision, but rather a lack of access to LPHAs working on Modernization: "I feel like we haven't had those kinds of conversations or opportunities to even find out if we're on the same page or working toward that same goal" (OPP CBO Focus Group). Another CBO

participant affirmed the lack of "shared understanding and shared priorities" and posited that their exclusion from deeper conversations of shared vision may be related to the program-specific funding they receive from the Public Health Equity grant (COC CBO Focus Group). Another CBO funded to work statewide described the structural barrier of Oregon's decentralized public health system, requiring a CBO with limited staff to engage each of the 36 LPHAs in a "conversation about whether or not we are connected and aligned" (OPP CBO Focus Group).

> "I have a reasonable, from my side of things, alignment with OHA around the vision, the understanding of Public Health Modernization and those things. I don't feel like I have that with our county entities, government entities. Not that they may not, but I feel like we haven't had those kinds of conversations or opportunities to even find out if we're on the same page or working toward that same goal."
> – Other Priority Populations CBO Focus Group

When asked if OHA had addressed this structural barrier, the participant acknowledged that OHA has begun to facilitate connections between funded CBOs and LPHAs but emphasized that "quite honestly a 30-minute conversation could have saved hours, days, weeks, months of time and productivity up front. This is how we're structured. This is who we are. This is how you reach us. This is what our initiatives are. This is what we are, do and don't do" (OPP CBO Focus Group). LPHA participants similarly expressed a lack of access to funded CBOs serving the same communities, saying "…we had CBOs that got money to do very specific work in our

community that we've never heard of and won't take meetings with us" (Rural LPHA Focus Group). Another LPHA participant was more concerned with CBOs funded to serve all counties, similarly noting that some of these CBOs would not take meetings with LPHAs and "had a different flavor than the local ones" (Rural LPHA Focus Group). One OHA leader explained that convening partners to update the shared vision to reflect CBOs was sacrificed for the timely distribution of funds administered by OHA-PHD: "…our first step was to prioritize the resource…We prioritized getting the money out the door into partners' hands, and what we're doing now is a lot of process improvement" (OHA Leadership KII 3). Relatedly, a CBO participant expressed appreciation for OHA's "great work" to recognize the need for and getting funds to LPHAs and CBOs but wondered, "Now, how do we work together for a common goal and who's going to drive that?" (COC CBO Focus Group).

Several participants noted how shared purpose between Modernization partners was attenuated by contextual factors. One OHA leader noted how community context, including politics and partners, contribute to variation in shared purpose: "…every local public health authority serves a very different jurisdiction…what their community wants to see from public health, what their commissioners expect from public health, how they're positioned with the other public health system partners…there's always going to be a high level of variation because Oregon is a very diverse state" (OHA Leadership KII 1). This leader further reflected on how the original vision of Modernization to promote "…a standard across the entire state…a system that's the same everywhere" is in tension with the inherent variation of local settings: "a decade into the work there's a recognition that there's always going to be this variation in local contexts. So how do you balance those two things?" (OHA Leadership KII 1). One CBO participant noted that alignment on shared purpose with frontline staff and management at the LPHA is

complicated by the power dynamics and politics of county elected government, particularly with equity as a central focus: “getting things through our board of county commissioners poses a serious challenge to equity initiatives even when we have alignment. So that's been a barrier for all of us” (OPP CBO Focus Group).

Negative Impacts of Unclear Vision

Participants described several implications of having an unclear or fragmented vision for Modernization. One LPHA participant described the difficulty of communicating about Modernization with other governmental public health practitioners: “I'm at a NACCHO [National Association of County and City Health Officials] meeting…I mentioned Public Health Modernization at this meeting, and I actually kind of struggled to say what it was. I have a hard time describing it because it has changed over time… even after doing it for, how many years since 2016, I still struggle on how to communicate it outside of Oregon public health to partners and people that are working in public health in other jurisdictions” (Urban LPHA Focus Group). Another LPHA participant described the implications of an unclear vision on sustained funding for Modernization, saying “I honestly don't think a lot of our legislature or our commissioners, when they hear Modernization, they think ‘we need to fund it’…there's a lot of legislators and commissioners that are also confused now of where the funding is going for Modernization” (Urban LPHA Focus Group).

> "I honestly don't think a lot of our legislature or our commissioners, when they hear Modernization, they think 'we need to fund it'…there's a lot of legislators and commissioners that are also confused now of where the funding is going for Modernization."
>
> – Urban LPHA Focus Group

Another LPHA participant similarly described the effects of a diverging purpose on advocacy efforts: "…when we're advocating for Modernization…we've talked about how the purpose is that between frontier, very rural Oregon all the way up to the urban areas, we all have this foundational set of programs and capabilities…that was the tune that we were marching to. But then the message when the CBOs came about switched only to equity…and it made it hard to continue to advocate for Modernization money when we're all talking about very different things" (Rural LPHA Focus Group). One LPHA participant summed up this tension saying, "It wasn't a shared vision any longer, it wasn't something that we could take to the legislature together" (Urban LPHA Focus Group). In addition to implications on funding advocacy, another LPHA participant described the impact of an unclear vision on prioritizing areas for investment in resource scarce situations (a common occurrence with boom-and-bust public health funding): "…what are we working towards? What are we going to prioritize? Because we're going to have to get to that point. When you have reduced resources, what's the priority and who makes that decision?" (Urban LPHA Focus Group).

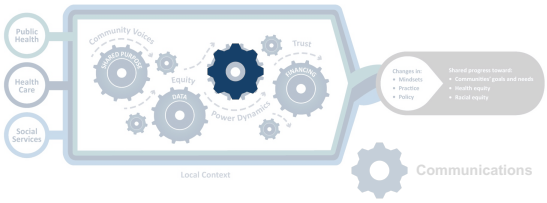
Another LPHA described the negative impact of rapid changes to the Modernization approach on their relationships with local partners, saying "as someone just boots on the ground

doing this work, it felt like this added a lot of confusion to some really strong existing partnerships that we already had. And just a real lack of clarity and aligned focus that felt like it made my job a bit harder" (Rural LPHA Focus Group). Another LPHA participant similarly described how lacking a clear vision makes it "hard being someone who's supposed to represent Modernization efforts for our county health department, that's been a big frustration in my work" (Rural LPHA Focus Group). While findings related to the *trust* core component of the primary framework will be described in further detail later in the chapter, it is worth noting that LPHA participants described a lack of trust in OHA related to the lack of shared purpose, with one LPHA participant stating, "I don't trust that OHA is steering this ship well…I fear that there's not really a roadmap" (Rural LPHA Focus Group).

Shared Purpose Similarities and Differences Across Partner Types

In summary, all participant groups described experiences of shared purpose while implementing Modernization. However, OHA and LPHA participants felt this shared purpose fragmented over time. While OHA leaders ascribed this fragmentation to a natural process of learning and adaptation over time, LPHA participants offered more specific causes for fragmentation, primarily OHA directly funding CBOs for Modernization without the new partner type reflected in shared purpose supports like the Modernization Manual and accountability metrics. OHA and LPHA participants also differed in their understanding of how health equity drives shared purpose. While OHA participants commented that health equity was a central component of shared purpose from the beginning, LPHA participants considered health equity as one of several foundational workforce capabilities in the Modernization framework. LPHA participant further considered the singular focus on health equity following the COVID-19 pandemic response and

funding of CBOs to be a significant change in shared purpose that happened quickly and without conversation or planning. CBO participants described feeling a sense of shared purpose with OHA related to their activities funded through the Public Health Equity Grant, but did not describe an understanding of or shared purpose in the broader Modernization initiative. CBO participants also affirmed a lack of shared understanding or priorities with LPHAs and attributed this to a lack of access to LPHAs, wondering whether their exclusion from assumed conversations of shared vision between OHA and LPHAs was due to the type of funding they received through the Public Health Equity Grant. LPHA participants similarly described a lack of access to CBOs funded for Modernization in their communities.



Shared Governance

Shared governance is defined in the Framework for Aligning Sectors as a "feature of aligned systems in which infrastructure has leadership, appropriate roles, and defined relationships." Twelve themes relating to shared governance were identified. Themes relate to: 1) shared governance experiences early in Modernization implementation; 2) the identification of formal governance spaces; 3) a lack of role clarity across funded partners; 4) a lack of transparency in decision-making; 5) partner representation in governance groups; 6) clear boundaries around shared decision-making processes; 7) acknowledging the history of conflict between partners; 8) the need for governance capacity building; 9) the accessibility of governance spaces; 10)

opportunities for shared learning across partners; 11) the absence of leadership in shared governance; and 12) the need for OHA internal coordination.

Early Shared Governance Experiences

Similar to shared vision, OHA leaders and LPHA participants described experiences of shared governance early in Modernization implementation with a diminished sense over time. One OHA leader described conversations between OHA, LPHAs, and the PHAB to take "high level guidance we get from the state legislature about how the funds can be used and then figuring out how we want to operationalize it" (OHA Leadership KII 1). Given the relatively small magnitude of early legislative investments (i.e., receiving $5 million of a requested $210 million in 2015-2017), these conversations included decisions on how funds would be used, which public health foundational program areas (e.g., communicable disease control) would be prioritized, and different payment models for staffing: "There was a lot of work up front to support counties coming together to share the types of positions that don't necessarily need to be embedded within one county, but could be providing specialized services across a number of counties" (OHA Leadership KII 1). One LPHA participant similarly recalled the range of early implementation questions that LPHAs and OHA collaboratively addressed: "What's the funding look like? What are we going to fund? What are we going to prioritize first? I felt that was very much shared decision-making" (Urban LPHA Focus Group).

> "…we were kind of part every step of the way…Like how are we going to how are we going to communicate this? What are our talking points? What's the funding look like? What are we going to fund? What are we going to prioritize first? I felt that was very much shared decision-making. We're going to focus on communicable disease, core public health, right? It's sorely underfunded. I think that was a decision really made together…"
>
> – Urban LPHA Focus Group

OHA leaders and LPHA participants further described outputs of early shared decision-making, including the creation of the Modernization Manual, which was developed "completely collaboratively with Public Health Division at OHA, content experts and local public health administrators so that those definitions [of foundational programs and capabilities] really reflected a shared approach" (OHA Leadership KII 2). Another OHA leader also described the PHAB's development of a strategic data plan and a "considerable amount of collaboration" between the PHAB, OHA, and LPHAs to identify, define, collect, and report on a set of shared accountability metrics (OHA Leadership KII 1). Although not within the scope of this research, an OHA leader further noted the "same work" to define what each foundational capability and programs means for federally-recognized tribes in Oregon was conducted with tribal public health authorities (OHA Leadership KII 2).

Formal Governance Spaces

One OHA leader highlighted the intricacies of governance for Modernization, referencing not only the different spaces for decision-making, but also the authority for decision-making within those spaces. The OHA leader highlighted the PHAB as part of the Modernization governance structure, as well as OHA's relationship with the Conference of Local Health Officials (CLHO) and intergovernmental agreements with Oregon's nine federally recognized tribes, all of which have defined statutory roles for decision-making. Similar to shared vision, the PHAB was noted by OHA and LPHA participants as one of the primary spaces for Modernization shared governance. One OHA leader described PHAB as "the table that brings everyone together" to "think functionally" about what the public health system needs to do to modernize, clarify roles across partners in the public health system, and ultimately decide how funding is used to achieve the shared purpose (OHA Leadership KII 1). Another OHA leader described the establishment of PHAB in 2016 as a "foundational shift" for governance in Oregon's public health system, noting "we didn't really have a space to bring other public health experts and individuals who have an interest in public health together to guide what the public health system should be…this approach brought in not only state and local public health, but also health care, CCOs, academia, eventually a tribal member" (OHA Leadership KII 2).

> "The Public Health Advisory Board was also established to be the governing body for Public Health Modernization in Oregon. And that was a foundational shift in 2016 because we didn't really have a space to bring other public health experts and individuals who have an interest in public health together to guide what the public health system should be."
>
> – OHA Leadership Key Informant Interview 2

The OHA leader further reflected on how establishing the PHAB reflected a shift in decision-making power away from governmental public health. The OHA leader described how a legislative champion of Modernization questioned how much control local public health had over its own funding and programs and wanted to "build a bigger table for support for public health, so that it's not just governmental public health talking to governmental public health, but we have broader interest in the fate of the public health system in Oregon" (OHA Leadership KII 2). The OHA leader further described how the statutes that govern the CLHO changed to accommodate what is now the PHAB and "started us on a trajectory…that placed more of the 30,000-foot level direction for the public health system into the Public Health Advisory Board and the operational relationship between state and local public health into the Conference of Local Health Officials" (OHA Leadership KII 2).

While LPHA participants agreed that PHAB served as a shared governance space early in Modernization implementation, the degree to which PHAB members were engaged in decision-making has decreased over time. One LPHA participant described how OHA's decision to fund CBOs never came to PHAB for consideration and contrasted this to early decision-making for the "first couple of allocations" when OHA and CLHO jointly determined funding allocations

(Rural LPHA Focus Group). The participant further reflected on how "there has been this deferral to PHAB [by OHA leadership], but the big decisions, the biggest decisions around public health never went to PHAB." The participant contended that PHAB is "not really a decision-making body," citing that OHA sets the agenda and the need for member education on the public health system before meaningful decision-making can take place (Rural LPHA Focus Group).

Similar to shared vision, one OHA leader identified the COVID-19 pandemic response as an inflection point in the use of PHAB as the shared decision-making space, referring to "a lot of questions and maybe some broken trust" arising from resource allocation and other decisions made unilaterally by OHA outside of PHAB during that time. The OHA leader further described ongoing confusion about the role of PHAB in shared decision-making coming out of the pandemic: "…I hear [PHAB] members continue to reflect back on decisions that were made three years ago outside of PHAB and it just broke a lot of trust for people that are in that space…it has led to a lot of questions like what comes to the public health advisory board and what happens outside of it?" (OHA Leadership KII 1).

The OHA leader also noted that natural turnover in both PHAB membership and governmental public health leadership generally following the pandemic has compounded this lack of clarity: "Public health advisory board members term out, people that were very involved in the work in 2016 and 2017 are no longer there…a lot of leaders in the current governmental public health system weren't part of any of those early conversations…they're stepping in and hear pieces of what the history was like but didn't experience it" (OHA Leadership KII 1). While the OHA leader primarily described PHAB member turnover as a natural process of attrition, one LPHA participant connected LPHA retention issues to the unclear role of PHAB and related lack

of trust in OHA (Urban LPHA Focus Group). The OHA leader also highlighted more recent efforts to expand PHAB membership to include "more seats" for CBOs and health equity experts (OHA Leadership KII 1). Another OHA leader cited the expansion of PHAB as an example of continuous improvement and credited PHAB members with recognizing the governance structure was not meeting the need for representation and inviting more participation (OHA Leadership KII 2). While the OHA leader lauded PHAB for "keeping up in their space" as Oregon reconceptualized who is considered part of the public health system, broadened representation nonetheless adds to the complexity of using PHAB as a space for shared decision-making (OHA Leadership KII 1).

Similar to shared vision, several LPHA participants noted the decision to allocate Modernization funding to CBOs following the COVID-19 pandemic response as an inflection point in shared governance. One LPHA participant described their experience serving on the PHAB saying, "we got together between OHA and CLHO and decided how the funding would be allocated together…this hasn't happened since CBOs were engaged" (Urban LPHA Focus Group). Another LPHA affirmed confusion around on this decision, saying "you would think this [PHAB] would be the group that would be making sort of those big, tough decisions. How are we going to integrate community-based organizations in our future of public health? And, you know, that's a tough decision" (Rural LPHA Focus Group). The LPHA participant further described a disconnect between OHA leadership's promotion of PHAB as the decision-making body for Modernization and experiences serving on the PHAB: "I would expect to hear from OHA leadership 'that's a PHAB decision,' but it's not really. Those kinds of decisions are not made in PHAB" (Urban LPHA Focus Group). The participant further recalled how the Interim Public Health Division Director attributed the decision to fund CBOs at the same level as LPHAs

as a decision made by the PHAB, which was refuted by the participant who served on the PHAB, saying "I was there and I don't know, maybe I missed a meeting" (Urban LPHA Focus Group).

One LPHA participant noted they are "still trying to understand the goals of PHAB, honestly" due to the lack of PHAB involvement in CBO funding decisions. The participant affirmed that while Modernization funding goes to both LPHAs and CBOs, "we're only talking about funding for local public health and what that looks like. We're not talking about the CBO portion." The participant further explained "those decisions aren't being made at PHAB…I don't know how those are going to be made and by whom" (Urban LPHA Focus Group). Overall, while the vision for Modernization has expanded to include CBOs, both in the definition of the public health system in Oregon and as funded partners, the purview of the primary governance body for Modernization has not been similarly expanded to include CBOs. The change in PHAB's authority, specifically related to CBO funding, has damaged the integrity of PHAB as a governance space in the eyes of LPHA participants. One LPHA participant described PHAB as a "dog and pony show" with very little decision-making authority (Rural LPHA Focus Group). Another LPHA participant affirmed that PHAB now feels "just for show" and noted that several LPHA directors left PHAB, reflecting how "disingenuous the whole thing became" (Rural LPHA Focus Group).

In contrast, one OHA participant who supports the Public Health Equity funding opportunity for CBOs described an increase in shared governance over time, particularly the role of PHAB in influencing OHA decision-making: "…the power that they [PHAB] have has really shifted our decision-making, because when they make a decision, then we implement it, right? Whether or not we agree with it" (OHA Program Staff Focus Group). While OHA leadership were deeply familiar with PHAB, most having been integral to PHAB's convening since the start

of Modernization, one OHA program participant noted a disconnect between PHAB and their daily work with CBOs funded through Modernization, saying "…there's the PHAB…I have nothing to do with any of that, I just kind of hear about it and whatever has happened has happened…it's in the mix, it's in the stew" (OHA Program Staff Focus Group).

While LPHA participants consistently described a breakdown of shared governance over time, one participant highlighted a recent experience in which a "funding workgroup" comprised of LPHAs and CBOs provided recommendations for changes to the next CBO funding opportunity. However, the participant caveated this example, saying these shared governance opportunities come in "bits and pieces, it's not comprehensive" (Urban LPHA Focus Group). Another LPHA participant described a recent "pilot project" in which LPHAs could opt in to pass through Modernization funding to CBOs in their jurisdictions as "the closest we've come to shared decision-making" (Rural LPHA Focus Group) However, the participant noted that their pre-existing relationship with the CBO proved essential for shared decision-making: "…because the CBO who said, 'yes, we're going to do this' we've been friends for a decade, there is shared decision-making and we talked back and forth about what the work plan would look like" (Rural LPHA Focus Group). One OHA leader also described how OHA convened a workgroup of the PHAB comprised of local public health administrators and CBOs to develop recommendations to ensure broader reach of CBO Modernization dollars after the first round of funding lacked statewide reach (OHA Leadership KII 2).

In addition to the PHAB, OHA and LPHA participants noted CLHO as a governance body for Modernization. One OHA leader described CLHO as a space to "set a direction" for Modernization with "clearly defined the topics that can be covered there" and existing relationships and processes for working between OHA and LPHAs (OHA Leadership KII 1).

One participant described the role of CLHO in decision-making for Modernization during early implementation, including developing strategic messages with a communications team from Portland State University and hiring a consulting group to support the creation of an implementation roadmap for Modernization (Urban LPHA Focus Group). Generally, LPHA participants described CLHO being included in decision-making pre-pandemic, especially related to shared talking points and funding allocations and priorities (Urban LPHA Focus Group).

The OHA leader further highlighted CLHO's "defined statutory roles" for Modernization governance. While CLHO has a defined role in statute, the power for decision-making shifted early in Modernization implementation when the statutes that govern CLHO changed to "make the space" for what would become the PHAB. As one OHA leader described it, this shift "placed more of the 30,000-foot level direction for the public health system into the Public Health Advisory Board and the operational relationship between state and local public health into the Conference of Local Health Officials" (OHA Leadership KII 1). LPHA participants affirmed CLHO as a clear and effective "infrastructure for decision-making" and provided examples of how the group was leveraged to inform Modernization funding formulas and general funding priorities (Urban LPHA Focus Group). The participant described decision-making within CLHO between OHA and LPHAs as "very beneficial" and acknowledged that the system works for the most part" (Urban LPHA Focus Group).

Similar to the PHAB, LPHA participants described a change in the types of decisions brought to CLHO. One participant recalled how "in the first couple of allocations, we got together between OHA and CLHO and decided how the funding would be allocated together and what the percentages would be to each partner" and that this level of decision-making ceased

after the inclusion of CBOs in funding allocations (Urban LPHA Focus Group). Another participant further expressed that early implementation decisions "were made together" but now "I don't know where that [decision-making] sits as far as what the priorities are and who and how that's going to be decided moving forward" (Urban LPHA Focus Group).

One LPHA participant described the detrimental effect of CLHO's exclusion from certain Modernization decisions and the related "shift in power" on the typical coordinated, shared approach to legislative session: "…we [LPHAs] used to depend utterly on OHA to advocate for us to the legislature for funding, and we [LPHAs and OHA] were very much in lock step when it came to discussing requests with legislators…part of that was because we had we had developed it together, so it was also something that we could support very wholeheartedly. And that's changed" (Urban LPHA Focus Group). The participant further described that CLHO now leverages its own lobbyists to conduct advocacy outreach to legislators and is no longer "sticking to whatever OHA is requesting for public health" (Urban LPHA Focus Group). The LPHA participant acknowledged that while CLHO has its own avenues for local public health to advocate to legislators, the lack of cohesion between state and local governmental public health "makes me really worried…I don't know what the plan is as we head into legislative season for how we're talking about Modernization" (Urban LPHA Focus Group).

While the PHAB and CLHO were identified as the primary governance spaces for Modernization, OHA leadership and program staff also highlighted the monthly CBO Advisory Committee, which is convened by OHA, as "a group of community-based organizations and community leaders who are constantly working with OHA and informing OHA on how to set up funding and processes for working with community-based organizations" (OHA Leadership KII 1). The OHA leader further noted that while the Committee has no decision-making authority,

“we [OHA] wouldn't go in a different direction unless there was a reason that we couldn't do what was being recommended” (OHA Leadership KII 1). Another OHA leader affirmed “they [CBO Advisory Committee members] are advising, but I take the feedback they give seriously and use it as part of decision-making processes” (OHA Leadership KII 3). This OHA leader further described the Committee space as “super informal and chill” which they attributed to the reason “we [OHA] get really candid feedback” (OHA Leadership KII 3). In slight contrast, the OHA program participant noted that power for decision-making in this Committee has increased over time, saying “I think they're now being given more power to kind of make decisions and influence decision-making points, where and how to put money, advice on moves that we need to make” (OHA Program Staff Focus Group). The potential reasons for these discrepant perspectives on the Committee’s decision-making power were not explored in focus groups and interviews.

One OHA leader highlighted several other governance groups that OHA convened for non-Modernization public health priorities. The examples situate shared governance as part of modern public health practice more broadly than Modernization, and include an advisory group of culturally-specific CBOs convened by OHA to design a process for allocating new tobacco tax revenues to community partners; a cross-sector advisory group with “over 90 people involved, 60-plus organizations” to develop Oregon’s state health improvement plan, Healthier Together Oregon; a vaccine advisory committee that engaged a “large swath of community partners” to determine COVID-19 vaccine sequencing in the state; and a similar advisory model to inform how OHA should be communicating and staging access to the Mpox vaccine in 2022” (OHA Leadership KII 2).

Another OHA leader reflected on the complexity of Modernization governance, describing how the "chain of command up through OHA and then through the legislature and the governor's office" as well as local boards and county commissioners inform state and local governance (OHA Leadership KII 1). The OHA leader noted the importance of "knowing this context, there's never just one governance model…All of those are in play all of the time" and emphasized the need to understand within the various complementary governance spaces "what is their authority, what do they make decisions on, what is the process for making those decisions," which is likely not consistently understood across all Modernization partners (OHA Leadership KII 1).

Unclear Funded Partners and Roles

While participants identified the formal governance spaces for shared decision-making, all participants expressed both a lack of clarity on who is funded for Modernization and the roles of funded partners. Similar to the discussion of shared vision, LPHA participants expressed greater role clarity pre-pandemic and attributed the lack of clarity to the inclusion of CBOs in Modernization without reflecting the new partner type in Modernization frameworks and guidance. One LPHA participant referenced the "clear acknowledgement that community work belonged in local public health" in the Modernization Manual. The participant further described LPHAs as "OHA's community" and affirmed that LPHAs "are the ones they [OHA] are supporting so that we can do the work in the community" (Urban LPHA Focus Group). Another LPHA participant expressed confusion about how the work of funded CBOs could contribute to Modernization without a clearly articulated role for CBOs in the Modernization Manual, similar to OHA and LPHAs. The participant contended that while "there's a lot of great work that

happens," the Modernization-funded work of CBOs is not inherently "foundational public health work" (Urban LPHA Focus Group). The participant further challenged OHA to "have an honest discussion with CBOs about what is the work that they are doing that is contributing to Modernization" to achieve greater role clarity and cohesion of Modernization work across funded partners (Urban LPHA Focus Group). In contrast, OHA leaders and program staff described funding to CBOs as contributing to governmental public health's capacity for the health equity and cultural responsiveness and community partnership development foundational capabilities, as well as culturally-specific approaches to the communicable disease control and environmental health foundational programs.

Another LPHA participant similarly perceived Modernization funding supporting "these really vague CBO projects" and questioned why funding with a stated focus on health equity is not being allocated to known health inequities, such as viral hepatitis and lead poisoning (Rural LPHA Focus Group). (These health outcomes fall outside of the Modernization accountability metrics framework, which focuses on population health outcomes related to vaccinations, syphilis prevention and management, and community resilience to extreme weather events). While an LPHA participant expressed having a "good relationship" with CBOs in their county, the participant similarly perceived that CBOs "don't fully understand what public health does" and felt that Modernization was "a fairly mysterious word" for CBOs (Urban LPHA Focus Group). In addition to a lack of overall role clarity, LPHA participants also indicated not being aware of the specific activities that CBOs were funded to implement. One LPHA participant asked, "What were they supposed to be doing?" and described the lack of available information on CBO funded work as "this secretive thing…It wasn't really shared" (Rural LPHA Focus Group). Multiple LPHA participants also expressed frustration with a lack of access to funded

CBOs in their communities, with one participant recalling how "CBOs were getting funded through OHA, but then not showing up to do the work" (Rural LPHA Focus Group). This sentiment is perhaps attributable to the disconnect between the Public Health Equity Grant through which CBOs are funded for Modernization work and the broader Modernization initiative. In addition, some CBO participants described reaching out to LPHAs and being met with non-response in some cases and outright resistance to partnering in others.

OHA program staff asserted that the "system that we had in place before 2020" in which only OHA and LPHAs received funding was insufficient to eliminate health inequities and emphasized the need to engage and fund communities following experiences with the COVID-19 response (OHA Program Staff Focus Group). Most LPHA participants similarly understood that OHA began funding CBOs as formal partners in Modernization based on experiences during the COVID-19 pandemic response. However, not all LPHA participants agreed that CBOs served a critical role during the response that would justify their formal inclusion in Modernization: "It's something that we said came up because of our experiences during COVID, but it certainly wasn't our experience during COVID" (Rural LPHA Focus Group). This participant further noted that CBOs' "prominent" role in Modernization as "not something that other states do" that are leading on public health transformation (Rural LPHA Focus Group).

Regardless, one OHA staff participant emphasized a "mutual understand[ing] [that] we're not going to go back to the time where we just fund LPHAs" and acknowledged the need to clearly define "what's the lane for LPHAs, what's the lane for CBOs, the lane for OHA" (OHA Program Staff Focus Group). Another OHA staff participant noted that OHA and LPHA roles in Modernization are clearly articulated in the Modernization Manual, while "how CBOs fit into Modernization… is not always as clear to all parties" (OHA Program Staff Focus Group). The

OHA staff participant highlighted that the role for CBOs is likely not going to have a "1 to 1 relationship" with the roles that LPHAs and OHA serve as described in the Modernization Manual (OHA Program Staff Focus Group). An OHA leader affirmed this perspective saying, "I think where we've had conflict initially was the expectation that the work CBOs were going to be doing is the same as the work LPHAs are doing" (OHA leadership KII 3). However, the OHA staff participant acknowledged that LPHAs have asked for role clarity, "defin[ing] how CBOs fit into Modernization, where the work [between CBOs and LPHAs] intersects and how it can foster better partnerships across different organizations" (OHA Program Staff Focus Group).

> "How CBOs fit into Modernization is not always as clear to all parties…it's not a 1 to 1 relationship with LPHA or OHA Modernization roles in the manual…So, I think that's where we need to have more clarity and I know LPHAs have asked for this and others have asked for this…can we further define how CBOs fit into Modernization, where the work intersects and how it can foster better partnerships across different organizations. I think that's where we need to get more clarity."
> – OHA Program Staff Focus Group

Some OHA program staff who support OHA's Public Health Equity Grant program (the mechanism by which the Modernization dollars are allocated to CBOs) expressed initial "tension and confusion" with the role of LPHAs, particularly why local governments would contribute to or inform the process by which OHA administers grants to CBOs: "I don't think anybody understood how LPHAs fell into our work and why we were making a decision based on their feedback when we didn't really have a connection or they didn't seem to be a part of the work"

(OHA Program Staff Focus Group). However, the OHA staff person acknowledged a shift in their understanding of how LPHAs "fall into this work" and expressed a realization that LPHAs, along with CBOs, are "part of the whole [public health] system" and as such should be represented in OHA's administration of CBO Modernization dollars (OHA Program Staff Focus Group).

LPHA participants were aware of this lack of OHA staff understanding of the LPHA role in Modernization. One participant described an experience with an OHA staff person who supports CBO grant administration: "Recently reached out to one of the [OHA staff] and quote, 'I don't know much about LPHAs or what they do'" (Rural LPHA Focus Group). The LPHA participant contrasted this experience against their expectation that these new OHA staff positions would "help bring LPHAs and CBOs together…facilitate the conversation, facilitate the connection" (Rural LPHA Focus Group). The LPHA participant acknowledged that the lack of understanding was "not this person's fault" but highlighted the lack of capacity at OHA and understanding of their role in "helping this Modernization journey and bringing us together" (Rural LPHA Focus Group).

One OHA staff person described how the lack of role clarity among staff supporting CBO grant administration has contributed to misperceptions that "LPHAs are against CBOs" and acknowledged that this stems from staff not understanding "all the players accurately and fully" (OHA Program Staff Focus Group). The OHA staff participant further advocated for more dedicated resources for relationship building with CBOs, including a dedicated position in OHA that would "focus their energies on bridging and trust" between partners (OHA Program Staff Focus Group). OHA program staff supporting the Public Health Equity grant program not only described role confusion with the "dynamics between OHA and CBOs and LPHA and the

various advisory boards" for Modernization, but also internally between the OHA programs who support CBO grant administration. The OHA staff participant further explained that conversations of role clarity for Modernization are "not really in a vacuum" because the CBO grant includes funding from other public health programs and funding sources, so the lack of role clarity for Modernization contributes to confusion for grant administration overall (OHA Program Staff Focus Group). In addition to a lack of role clarity between partner types, a lack of internal role clarity was expressed by OHA staff in Public Health Division programs who support several aspects of Modernization implementation, including CBO grant administration and Modernization accountability metrics. One OHA staff participant described being tasked by the Director's Office with Modernization without adequate power/autonomy for decision-making, saying "there's so much that's out of my purview and out of my control and it's a very stressful, it's a very stressful feeling to have" (OHA Program Staff Focus Group).

One CBO lauded OHA for "spearheading or pioneering" CBO engagement in Modernization decision-making and emphasized that Oregon's approach aligns with recent calls in federal funding opportunities to engage community members and organizations (OPP CBO Focus Group). The participant further advocated for standardizing how CBOs are engaged in shared decision-making across OHA outside of Modernization (OPP CBO Focus Group). Another CBO participant expressed that while engaging in OHA's various opportunities for shared decision-making have "proved fruitful," participation comes at a cost to organizations: "every work committee that a CBO participates in takes time away from our focus on our mission" (OPP CBO Focus Group).

While CBO participants expressed general appreciation to OHA for funding and engagement, the separation of the Public Health Equity Grant program from the overall

Modernization initiative may contribute to role clarity issues for CBOs as well. One CBO participant inaccurately described funding their organization was receiving for adolescent and school health as "Modernization" (OPP CBO Focus Group) and another CBO participant did not know whether the local partners with which they collaborate are receiving funding for Modernization or another public health program area (COC CBO Focus Group). One CBO participant was not aware of the full list of Modernization grantees ("not to say that it wasn't shared") and described collaboration between funded CBOs as being driven by "are you passionate about this work let's collaborate and not so much like do you have this funding too" (COC Focus Group). One LPHA participant affirmed that CBOs may be "unaware of where the source of their funding has come from" after meeting with CBOs in their jurisdiction. The LPHA participant described how OHA is presenting Modernization funding to CBOs as "this equity money" and does not fault CBOs for applying without fully understanding the funding source, saying "I would too if I was them" (Rural LPHA Focus Group).

While CBOs were not involved in early Modernization implementation or changes to Modernization funding allocations post-pandemic, CBO participants expressed a vague understanding of these changes and the resulting tension between OHA and LPHAs: "…at some point LPHAs were funded to do some of this work that now…is being redirected to CBOs to take on this work for a variety of different reasons, all valid…I think there is a rub there…because you're talking about moving money away from a public health department…In certain meetings we have felt that." (COC Focus Group). Further, CBO participants were aware of the "rub between local public health departments and OHA" when OHA began funding CBOs during the pandemic response in the same communities as LPHAs, acknowledging that LPHAs "knew who the players were in their counties" and the difficulty of OHA funding CBOs where

"maybe there wasn't a relationship there" between the funded CBO and LPHA (COC CBO Focus Group).

Some CBO participants also reflected on their understanding of LPHA and OHA roles in Modernization more specifically. While one CBO participant indicated a "good, friendly" relationship with LPHAs, they further described local public health as a "black box…in terms of what they do…I wouldn't even know how do you crack that black box open? Honestly, it really is a bit of a mystery" (OPP CBO Focus Group). Another CBO participant questioned who was driving the strategic direction for Modernization as a collaborative systems change initiative, particularly the role of OHA: "…who's going to drive that [collective action of funded partners]? Is it the funder? Is it OHA? Can they do that because of the power dynamics, because of who they are, because of the funding, because of their stake in this work? (COC CBO Focus Group). One CBO participant also expressed confusion about how to navigate OHA as a Modernization grantee, including "who and where and why to talk to the right person within OHA for the right reasons" (OPP CBO Focus Group). The participant described "simple things" like clarity on organization structure, roles and responsibilities, and "who to call, for what, and when" that OHA could improve or make existing resources easier to navigate (OPP CBO Focus Group).

While most participants described barriers to role clarity across partner types, one OHA participant highlighted the role of public health emergencies as a facilitator of role clarity. The participant reflected on experiences responding to the COVID-19 pandemic and more recently to well water quality issues in northern Morrow and northwestern Umatilla counties, saying "…you have to deal with this, you have to deal with this now…you have to talk to each other, you have to work together…it certainly forces some of these things out in the open and forces them to be clarified" (OHA Program Staff Focus Group).

Lack of Transparent Decision-Making

LPHA participants in particular described a lack of transparency in decision-making processes for Modernization and noted a change in transparency post-pandemic, similar to shared purpose and other aspects of shared governance. Several key decisions were noted by LPHA participants for their lack of transparency. LPHA participants were unanimous that OHA's decision to directly fund CBOs for Modernization was made without LPHA involvement. One LPHA participant summarized how "all of these decisions came out of left field. They were given to us, not with us. And even when asked who made the decision, we still don't know" (Rural LPHA Focus Group). More than just a strained communication during the chaos of a pandemic response, one LPHA participant described OHA's decision to fund CBOs as intentionally "done really secretly" (Rural LPHA Focus Group). The perception of "secrecy" surrounding the decision to fund CBOs for Modernization was compounded by the additional lack of insight into the scope of work that CBOs were funded by OHA to implement; one LPHA participant described that CBO funding felt like "this secretive thing, what were they supposed to be doing? It wasn't really shared" (Rural LPHA Focus Group). Another LPHA participant described the shared confusion among local public health leadership at the time: "talking with other administrators, everyone was in the same boat…we all thought we missed some type of important messaging or conversations or meetings" (Urban LPHA Focus Group).

Some LPHA participants emphasized that funding CBOs was not the problem per se, but rather "the decision-making that OHA or whoever – we don't actually know who made the decision because we were never told but somebody decided that the definition of Modernization now included CBOs" (Urban LPHA Focus Group). Indeed, one LPHA participant affirmed "we've always done good work with our community partners and value them so much as doing

public health work and reaching into a community in the way we can't" (Rural LPHA Focus Group). The LPHA participant further noted that many LPHAs passed through funding to CBOs in their jurisdiction prior to the direct funding from OHA and asserted "if local public health was asked [about Modernization funding to CBOs], we would have said yes" (Rural LPHA Focus Group). However, the LPHA participant caveated "…if we can have the funding that we need and the opportunity to pass through funding to our CBOs who can do work that we can't do, we want to do that" (Rural LPHA Focus Group).

> "…it's not funding CBOs that's the problem. It was the decision-making that OHA or whoever, we don't actually know who made the decision because we were never told, but somebody decided that the definition of Modernization now included CBOs…there was no discussion about it, except later when it was like, well, that decision has been made you need to just get over it now and go forward. I think we still all have questions about go forward with what, it's not clear."
> – Urban LPHA Focus Group

LPHA participants also described being unaware of which CBOs would be funded by OHA, including those based in or proposing public health activities in the LPHA's jurisdiction, and that for OHA "[t]o make decisions on who is funded in what county without engaging local public health…it just did not feel good" (Urban LPHA Focus Group). The LPHA participant further emphasized the implications of this exclusion on their local partnerships, saying "We had organizations that had never set foot in our county that were funded to do work in our county… the power to be able to say 'this CBO is funded and these aren't' when you may not have a full

understanding of what it looks like on the ground in any one community" (Urban LPHA Focus Group). Another LPHA participant affirmed "we could have all moved forward with the money and made sure it's going to the populations that need it most" and similarly reflected that "it felt really kind of backwards for us to be trying to track down these groups that got money to do work in our community" (Rural LPHA Focus Group).

LPHA participants emphasized understanding the need for more unilateral decision-making by OHA during the pandemic response, with one LPHA participant recalling "when CBOs were funded without any LPHA input during COVID, we all kind of chalked it up to it was an emergency…decisions had to be made. Fine, totally fine. Water under the bridge" (Rural LPHA Focus Group). However, the participant asserted that when "all of the sudden it was sprung on us" that CBOs would be allocated a portion of Modernization funding and LPHAs were "completely cut out of" the CBO grant-making process, trust in OHA was "obliterated" (Rural LPHA Focus Group). One LPHA participant recalled the lack of transparency in the CBO grant-making in particular saying, "We were not allowed to know who had even applied, what they were applying for, we couldn't see the applications. Zip. And then it was super-secret when they were going to tell us who was funded" (Rural LPHA Focus Group).

In addition to exclusion from decision-making, LPHA participants also noted experiences of having partial or siloed participation in OHA-led processes to develop Modernization funding recommendations for the legislature. One LPHA participant reflected "…it was pretty much asked how much do we need for LPHAs…and then it was, how much do CBOs need over here, and then they [OHA] just put it together and sent it forward. There was no interaction between the two [LPHAs and CBOs]" (Urban LPHA Focus Group). The LPHA participant expanded on the implications of this siloed process, recalling how it led to a "massive policy option package

or ask for our legislature" which the LPHA participant felt lacked credibility given "there's a lot of legislators and commissioners that are also confused now of where the funding is going for Modernization." (Urban LPHA Focus Group).

One LPHA participant described the lack of transparency stemming from not using established governance spaces for Modernization decision-making, saying "…I sit on PHAB, so you should have heard it at PHAB. I sat on CLHO, you should have heard it there. I'm otherwise pretty well-connected and had no inkling" (Rural LPHA Focus Group). This lack of transparency led another LPHA participant to remark "I'm still trying to understand the goals of PHAB, honestly" and reflect on their role on the PHAB Incentives and Funding Subcommittee, which historically developed recommendations on the distribution of Modernization funding: "…we're only talking about funding for local public health. We're not talking about the CBO portion…those decisions aren't being made at PHAB…I don't know how those are going to be made and by whom" (Urban LPHA Focus Group). Another LPHA participant affirmed the disconnect between hearing from OHA leadership that Modernization decisions are made in PHAB and their experience participating in PHAB: "I do keep hearing often, 'well that's a PHAB decision, that's a PHAB decision,' and I'm not seeing that happening in PHAB" (Urban LPHA Focus Group).

In addition to existing governance spaces, one LPHA participant noted how transparency was hindered by OHA not employing decision-making tools developed and used by PHAB historically. This LPHA participant contrasted the "incredibly clear funding formula for the counties" with the siloed, closed process to develop CBO funding allocations (Rural LPHA Focus Group). Another LPHA participant expressed particular concern with the lack of transparent decision-making given reductions in public health funding post-pandemic and the

need for prioritization. The participant questioned, “When you have reduced resources, what's the priority and who makes that decision? Who decides what POP [policy option package] goes through? Who decides what's in it? I just feel I don't really have a good sense of anymore” (Urban LPHA Focus Group).

Further, one LPHA participant described how OHA was not willing to acknowledge or discuss the lack of transparency, recalling “…it was like, well, that decision has been made you need to just get over it now and go forward. I think we still all have questions about go forward with what, it's not clear” (Urban LPHA Focus Group). Another LPHA participant affirmed this experience and described feeling “gaslit” by OHA when asking about how the decision was made and who made it: “…if you even bring that up, we're just seen as not willing to work with CBOs or not willing to see OHA's vision in this…it's really disheartening, you almost can't have those honest conversations” (Urban LPHA Focus Group). Another LPHA participant similarly described feeling dismissed by OHA, saying “…decisions were made and we were told ‘that's it, it doesn't matter how you feel about it, this is a decision and that's the end of the story’” (Rural LPHA Focus Group). The LPHA participant further reflected that LPHAs are now trying to “simply make the best of a situation that is tricky, while also preserving, quite frankly, our integrity and our reputation” (Rural LPHA Focus Group).

Fewer OHA participants commented on transparent decision-making. One OHA leader acknowledged that decisions made outside of PHAB during the pandemic contribute to questions about PHAB’s contemporary role in decision-making: “I hear members continue to sort of reflect back on decisions that were made three years ago outside of PHAB…it has led to a lot of questions like what comes to the public health advisory board and what happens outside of it?” (OHA Leadership KII 1). Internally at OHA, a program staff participant who serves as a liaison

to funded CBOs described "just kind of hear[ing] about" Modernization decisions that occur in PHAB and other venues and how a general lack of awareness of decision-making contributes to them being "in this awkward middle a lot of time" as they participate in conversations between their assigned CBOs and LPHAs (OHA Program Staff Focus Group). Another OHA leader affirmed this experience and acknowledged that "I don't always think that those decisions [in PHAB] were clearly communicated back to the larger collaborative that's supporting the [Public Health Equity] grant" (OHA Leadership KII 3). More generally, the OHA leader noted the inherent difficulty of making Modernization decision-making transparent for all partners in a large, statewide public health system: "…even when we are creating places of shared decision-making, it often doesn't feel that way because…it doesn't mean that the 5,000 governmental public health employees and all community partners are part of the decision-making" (OHA Leadership KII 1). However, the OHA leader acknowledged there are opportunities for OHA to facilitate transparency through improved communications about "where and how and who is making decisions" (OHA Leadership KII 1).

Expanded Partner Representation

All partner groups described aspects of representation in decision-making spaces. Participant comments on decision-making representation primarily referenced which groups are and are not represented in the formal membership of the PHAB as the primary decision-making space for Modernization. One OHA leader described the original vision for cross-sector membership in the PHAB saying the space was "always intended to bring together governmental public health and all of those other partner types that we work with in the system…really thinking broadly" (OHA Leadership KII 1). Another OHA leader described the foundation of the PHAB in 2016 as a

"fundamental shift" for representation in public health decision-making because "we didn't really have a space to bring other public health experts and individuals who have an interest in public health together" and noted cross-sector membership including state and local governmental public health, healthcare and coordinated care organizations, academia, and "eventually a tribal member" (OHA Leadership KII 2). The OHA Leader summarized the vision for the PHAB as "build[ing] a bigger table…so that it's not just governmental public health talking to governmental public health" but rather bringing together partners "who have a broader interest in the fate of the public health system in Oregon" (OHA Leadership KII 2).

Another OHA leader further highlighted how PHAB membership has expanded over time to include "more seats" for CBOs and health equity experts, which required changes to the Oregon Revised Statutes specifying PHAB's composition (OHA Leadership KII 1). The OHA leader attributed the expansion to these perspectives being identified as gaps following the COVID-19 pandemic response in which existing health inequities were exacerbated and CBOs were funded to support culturally-specific outreach. The OHA leader emphasized PHAB's membership expansion demonstrated how the governance body was "really keeping up in their space" as the public health system is being "reconceptualized" to acknowledge and formally include certain types of partners and expertise not historically represented in decision-making spaces (OHA Leadership KII 1). Another OHA leader lauded PHAB members at the time for knowing "that our governance structure was not meeting where we needed to be as a public health system and invited more participation" (OHA Leadership KII 2).

> "The Public Health Advisory Board always intended to bring together governmental public health and all of those other partner types that we work with within the system, so healthcare, academia…Another thing that PHAB has done over the past few years is really expand their membership, very specifically to include more seats for community-based organizations, bringing in expertise in health equity. Tribes are also involved in the public health advisory board…this is really positive as we're reconceptualizing how we think about the public health system. PHAB is really keeping up in their space."
>
> – OHA Leadership Key Informant Interview 1

One LPHA participant emphasized that expanding PHAB's membership to include CBOs was not only important for general representation, but also essential to CBO funding being include in PHAB's scope. The LPHA participant recalled the OHA leadership position that if "there's nobody from the CBOs on PHAB, you have no business talking about them" and follow-up efforts to amend PHAB bylaws to include formal CBO representation (Rural LPHA Focus Group). Awareness of which sectors are represented on the PHAB may not be consistent across partner types. Despite formal representation from the healthcare sector on the PHAB, some CBO participants emphasized that healthcare should be represented in decision-making spaces for Modernization. One participant highlighted that Oregon Health Plan providers in particular would be "really important to bring into this conversation and find out if we have a shared vision and what our alignment is really like" while another CBO participant asserted "I don't know how we do this without the CCOs [Coordinated Care Organizations] at the table. I feel like they have just been missing, missing, missing" (OPP CBO Focus Group).

Related to this sentiment of missing perspectives, one OHA leader cautioned that while PHAB was created and has evolved to include representative perspectives from across the public health system, “it often doesn’t feel that way” for individual partners because “it doesn't mean that the 5,000 governmental public health employees and all community partners are part of the decision-making” (OHA Leadership KII 1). The leader further emphasized that while PHAB and its related steering committees “bring together different types of representatives from community and different organization types to make recommendations,” OHA will implement the recommendations that come through those conversations “to the extent that we can, and sometimes something's being asked for that we just can't do, but that that's our intention” (OHA Leadership KII 1). The extent to which this boundary for shared decision-making is explicitly communicated to participants of Modernization governance spaces was not described or asked in follow-up questions.

While most comments about representation focused on engagement of external partners, one OHA program staff participant reflected on the degree to which programs felt represented in internal OHA decision-making for Modernization. The participant described the decision-making role of OHA program staff as “very limited” and acknowledged that while individual program staff “can’t really be tracking and understanding and engaged in all the various levels of decision-making that is happening” the lack of representation contributes to staff feeling “disempowered” given they are responsible for implementing decisions made in spaces to which they do not have access (OHA Program Staff Focus Group). The program staff participant further described feeling overwhelmed by expectations from OHA leadership to lead on aspects of Modernization that were decided without program staff representation: “I might get, ‘well, what do you guys think? It's up to you, you're the program.’ Oh my gosh, I feel like all the

decisions have actually been made in a different level of the organization. You tell me because I actually don't know, I don't know the answer to that" (OHA Program Staff Focus Group). The participant also emphasized that the lack of program-level representation extended to their leadership, reflecting on the "tendency of our organization…to be paying more attention and almost prioritizing external partners" (OHA Program Staff Focus Group). The OHA staff participant further asserted that OHA programs supporting Modernization sit at "the lowest level in terms of power and hierarchy" and consequently their managers lack a formal structure through which to engage in Modernization decision-making (OHA Program Staff Focus Group).

While most comments about governance representation focused on the PHAB, one LPHA participant commented on changes in OHA staff representation in CLHO spaces. The participant recalled "pre-COVID" participation from not only Director's Office staff but also Public Health Division Center Administrators in CLHO meetings and retreats (Urban LPHA Focus Group). The participant emphasized that "it feels like our only connection right now is with the Director's Office" and lamented the loss of more diverse participation (Urban LPHA Focus Group). The participant recalled "having that linkage…the Centers wanting our thoughts and feedback. I would just love to see the center directors and more of that representation beyond the Director's Office at big CLHO" (Urban LPHA Focus Group).

Not Acknowledging History of Conflict

LPHA participants commented on acknowledging a history of conflict as a pre-condition for engaging in shared decision-making. Reflections from LPHA participants centered on OHA not explicitly conceding that LPHAs were not engaged in decision-making for Modernization during and immediately following the COVID-19 pandemic response, especially in the decision to

directly fund CBOs. LPHA participants emphasized the difference in power between LPHAs and OHA implied by the unilateral decision-making on funding allocations, as well as the broken trust resulting from being excluded from decision-making. (Power dynamics and trust will be discussed in more detail later.) When asked if OHA has acknowledged these missteps, one LHPA participant reflected "there's been discussion kind of around the edges of it, but I haven't heard anything like, 'we acknowledge that we've really broken trust by our actions and things weren't transparent'" (Urban LPHA Focus Group). One LPHA participant wondered whether OHA's hesitation to acknowledge past conflict stems from the "fear" that publicly acknowledging problems could "unravel" the new approach to funding CBOs. The participant concluded that while OHA appears defensive of past decisions, that local public health likely needs to "acknowledge and check our assumptions as well" (Urban LPHA Focus Group).

Another LPHA participant explained that OHA has acknowledged the conflict in "bits and pieces" including during a workgroup of LPHAs and CBOs that OHA convened to identify opportunities for better alignment between their Modernization funded work. While some of the tension was acknowledged through the workgroup process, the participant emphasized that OHA has never provided a "whole-hearted apology or real effort to rebuilt trust" (Urban LPHA Participant). One LPHA participant sympathized with OHA staff, saying "we've all been through it personally…you mess up, you feel terrible, you desperately want forgiveness and for them to instantly trust you again" but acknowledged that the obvious distress of individual staff members does not compensate for a formal acknowledgment from OHA leadership and observable changes to inclusion and transparency, concluding "they're [OHA] troubled by it and it hurts their personal feelings, but then at the end of the day, it's, quite frankly, an empty apology" (Rural LPHA Focus Group). Another LPHA participant was optimistic that LPHAs and OHA

could find common ground in their "heart and passion" for public health to move forward and rebuild trust. The participant emphasized that moving forward required "a willingness and an openness" to acknowledge the history of conflict and "a little bit of admission of…you [OHA] held all the power and how can we rebuild that differently" (Urban LPHA Focus Group).

> "It's like bits and pieces, but not like a whole-hearted apology or real effort to rebuild trust. There's been some improvements, like there was that funding group between LPHAs and CBOs to determine the next cohort of CBOs that were funded. And through that process, there was some acknowledgement and changes to future funding, but it's just bits and pieces, it's not comprehensive, a whole situation."
>
> – Urban LPHA Focus Group

Governance Capacity Building Needed

OHA and LPHA participants described the need for capacity building to ensure partners can fully engage in shared governance spaces. Participant comments primarily related to capacity building for PHAB members, especially CBO representatives who were more recently added to the governance group. One OHA leader acknowledged that capacity building and member onboarding to the PHAB is "a big area we could do more, and I think where members want us to do more" (OHA Leadership KII 1). The OHA leader further described a growing need to support individual members to "fully step into their role" as membership has changed over time to include CBOs, health equity experts, and the education sector. The OHA leader considered capacity building especially important for mitigating potential power dynamics amongst its

diverse membership, acknowledging a "natural tendency to look to the people who clearly work…in governmental public health as having a level of expertise or insight that should be weighted more highly than people that are outside of that governmental system" (OHA Leadership KII 1). The OHA leader emphasized that this potential deference to governmental public health does not acknowledge the value of lived expertise and is "not how PHAB is supposed to be set up…because everyone's perspective is important and valuable at an equal level" (OHA Leadership KII 1). One LPHA participant affirmed that some members appear to not understand the public health system and suggested that "a lot more education" is needed before shared decision-making is possible in the space (Urban LPHA Focus Group).

> "The way the agenda is set is set by OHA and there's not great decision-making happening there because folks don't really understand the public health system either. There's a lot of more education that needs to happen there before that's possible."
>
> – Urban LPHA Focus Group

Outside of capacity building for PHAB members, one OHA program staff person who supports CBO Public Health Equity grant administration recommended onboarding OHA staff to "all of the intricacies" of Modernization. The OHA staff person reflected on being in their role for two and a half years and "just now some of these things are becoming clear" related to partner relationships and decision-making processes. The OHA staff person acknowledged that while not every OHA staff person needs to understand these dynamics and structures, a general onboarding for new staff would be beneficial: "if we're onboarding new fiscal staff that are

trying to understand how these relationships work, or if we're onboarding new engagement coordinators or if we get a new manager…to try and understand these intricacies coming in – it's so hard" (OHA Program Staff Focus Group).

Accessibility of Governance Spaces

Only two participants commented on the accessibility of governance spaces as an incentive or constraint on participation in collaborative decision-making. One OHA leader reflected on PHAB's transition to virtual meetings during and following the COVID-19 pandemic response saying, "It's hard for me to fathom that it was standard practice a few years ago…every month a number of people were making a very massive commute and stepping away from their entire lives for 2 or 3 days. So virtual is good, people can participate equally" (OHA Leadership KII 1). While the OHA leader acknowledged the accessibility benefits of virtual meetings, they also recognized that four years into virtual meetings "what you can't do is form those relationships that you form when you're actually in a physical space with someone and the side conversations that are never going to happen on a Zoom platform." The OHA leader further emphasized the opportunity for "really thoughtful" in-person meetings with the goal of "bringing together [partners] within actual local communities, making sure that partners have a chance to be together" (OHA Leadership KII 1).

The same OHA leader also acknowledged that while PHAB has increased the breadth of partner representation over time, accessibility may be limited by OHA "still holding those [meetings] in sort of our governmental way, like come to our meeting, at this time, here's what we will talk about, right?" (OHA Leadership KII 1). The OHA leader highlighted the likely accessibility benefits of OHA and partners "looking at that model and breaking it down…letting

communities tell us what they expect out of governmental public health and then building the system for how to do that around what we're trying to achieve" (OHA Leadership KII 1).

One CBO participant noted financial compensation beyond the Modernization grant funding as an incentive for ongoing CBO engagement in decision-making spaces. The participant further noted that while they have enjoyed participating in various engagement opportunities, including those related to program evaluation and resource allocation, these engagement opportunities currently lack a "standard procedure across the board," including compensating CBOs for their participation. The participant was wary of overly-standardizing grantee engagement as "it takes away from the human connection," but offered that some standards could support continued engagement from CBOs for the decision-making opportunities (OPP CBO Focus Group).

> "I've definitely enjoyed the opportunities that have been presented to engage CBOs in work groups…there has not necessarily been a standard sort of procedure across the board… [to] offer sort of compensation for CBOs, additional compensation beyond the grant…A lot of standard standardization is not great, it takes away from the human connection, but I think there are some processes that could support continued engagement from CBOs through these various decision-making opportunities."
>
> – Other Priority Populations CBO Focus Group

Shared Learning Spaces Needed

Both CBO and LPHA participants described a lack of shared learning opportunities between partners, especially those that facilitate sharing between LPHAs and CBOs receiving Modernization funding. Both LPHA and CBO participants expressed appreciation for existing opportunities to learn from like-organizations and with OHA, but as one CBO participant noted, "We [CBOs and LPHAs] haven't had those kinds of conversations or opportunities to find out if we're on the same page or working toward the same goal" (OPP CBO Focus Group). This comment emphasizes not only the lack of shared spaces for partners to align Modernization-funded activities, but also how the partners' lack of access to one another limits development of shared purpose (as described earlier). One OHA leader highlighted that OHA convenes a "space for community to just hang out and chat and network" (OHA Leadership KII 3), as well as a space for CBOs to regularly receive programmatic information from OHA staff. One CBO participant affirmed that funded CBOs "get to meet on a regular basis…and learn about the great work that's being done throughout the region" (COC CBO Focus Group). The CBO participant further noted how the opportunity to learn and connect with other CBOs was missing from past OHA funding opportunities and emphasized the benefits of the shared learning space: "…it really allowed us to be creative with what we're doing, but also not have to recreate the wheel…that really helped out knowing that other community partners are doing similar work and what they've learned and kind of feed off of that and share with each other" (COC Focus Group). While CBO participants appreciated the existing OHA-convened spaces for CBO-to-CBO networking and learning, one participant recommended additional gatherings that are smaller in size "to talk about what are the barriers we are experiencing and what we can do to remove them" (COC CBO Focus Group). Similarly, another CBO participant recommended following

up the large meetings focused on networking and information sharing with smaller, county-specific meetings to explore partnerships (COC CBO Focus Group).

LPHA participants were aware of the CBO-only learning spaces where "they all get to share these really cool stories of the cool work" (Rural LPHA Focus Group) and lamented how "LPHAs were not even invited to that… I think maybe I saw some emails come out that we could read about them after the fact" (Rural LPHA Focus Group). Another LPHA participant reflected on the implications of not having formal shared learning opportunities given the time-bound nature of CBO grant funding – in which organizations apply for funding from OHA every two years: "There's no learning from this and really an incredible worry in this is that when these projects go away, they're just going to go away and we will have learned nothing" (Rural LPHA Focus Group).

> "I would say it's a get together of the CBOs and they all get to share these really cool stories of the cool work that they're doing, and it was totally separate. LPHAs were not even invited to that. I think maybe I saw some emails come out that we could read about them after the fact."
> – Rural LPHA Focus Group

In addition to the lack of shared learning opportunities, one LPHA participant described how an existing meeting space dedicated to broad information sharing across Modernization partners did not supporting their learning. In reflecting on the monthly Modernization Chats convened by OHA, the LPHA participant expected a "great space to ask questions" but instead experienced didactic presentations "about someone's experience that's completely separate from

mine" (Rural LPHA Focus Group). The participant further explained that not having a space to learn and ask questions has contributed to feeling like "I don't have a great roadmap for how this is supposed to work…that's a scary spot to be in, because I can't ask questions" (Rural LPHA Focus Group).

Leadership Absent from Decision-Making

Both OHA leaders and program staff and LPHA participants commented on the lack of OHA leadership in decision-making spaces, primarily the absence of the OHA Public Health Division (PHD) Director. Internally, one OHA leader reflected on the difficulty of implementing the CBO Public Health Equity grant program in the absence of a permanent PHD Director, describing how "a lot of the meetings we're having with leadership where we're trying to get buy in and move forward…they're like, 'sure, and I don't really know what my next new boss is gonna want'" (OHA Leadership KII 3). The OHA leader further explained that this hedging conflicts with the pressure on OHA program staff to allocate CBO funding as quickly as possible: "I don't have time to wait for y'all to decide what you want to do, I'm just gonna do what I need to do" (OHA Leadership KII 3). In addition to the absence of a permanent PHD Director, one OHA program participant described the absence of center- and program-level leadership in internal decision-making, given "there's not been a structure for them to be engaged" (OHA Program Staff Focus Group).

> "…it's a weird time right now because we don't have a director. And so, I feel like a lot of the work we're doing and a lot of the meetings we're having with leadership where we're trying to get buy in and move forward, I'm understanding that they're like, 'sure, and I don't really know what my next new boss is gonna want.'"
>
> – OHA Leadership Key Informant Interview 3

LPHA participants also acknowledged the absence of the PHD Director in various Modernization governance spaces, including one LPHA participant who stated the PHD Director "is almost never there [at PHAB]…she doesn't come to the LPHA meetings, she doesn't come to the CLHO meetings" (Rural LPHA Focus Group). While the LPHA participant expressed appreciation for other OHA staff being present in these spaces, they conceded "you don't ever get to talk to the person you really want to talk to which is the director, but that's now been almost open for six months or so" (Rural LPHA Focus Group). Another LPHA participant acknowledged that the interim PHD Director "has done a nice job" but emphasized the value of a new permanent director who demonstrated a "clear commitment to support local public health and understanding the value and the distinction in roles [between LPHAs and CBOs]" (Urban LPHA Focus Group).

OHA Internal Coordination Needed

Several OHA participants highlighted the need for more internal OHA coordination in support of shared governance. One OHA leader described successfully engaging OHA "program experts" in

early Modernization efforts to develop the Modernization Manual, collect data for the 2016 capacity and cost assessment, and design the program elements and contracts for grant administration; however, the leader acknowledged the "opportunity for growth…in terms of how we do that more seamlessly across our siloes" (OHA Leadership KII 2). In contrast to these engagement examples from early Modernization implementation, OHA program participants emphasized that staff were not engaged by OHA senior leadership in the development of the CBO Public Health Equity grant or the ongoing updates to the scope of work for LPHA Modernization funding (OHA Program Staff Focus Group). In addition to the lack of program staff engagement in program design and decision-making, OHA program staff further highlighted the disconnect between program staff supporting CBO grant administration and those focused on Modernization funding to LPHAs. One OHA staff person who supported CBO grant administration expressed that "it was really frustrating because I don't think anybody understood how LPHAs fell into our work and why we were making a decision based on their feedback when we didn't really have a connection, or they didn't seem to be a part of the work" (OHA Program Staff Focus Group).

> "I think we have had success when we've been able to really meaningfully engage our program experts…in the public health model, in the Public Health Modernization Manual, in the collection of our cost and capacity assessment, and in design of program elements and contracts, scope of work etc. for the public health system. I think structurally we still have some opportunity for growth and advancement in terms of how we do that more seamlessly across our silos."
> – OHA Leadership Key Informant Interview 2

Another OHA program participant highlighted that newer internal coordination spaces have been established to begin to address this disconnect. The participant described a monthly meeting with the CBO and LPHA teams in the Office of the State Public Health Division Director and PHD programs supporting Modernization implementation, where "the goal is to really ensure that there is this shared understanding and coordination" (OHA Program Staff Focus Group). The OHA staff person who expressed frustration with LPHAs influencing decision-making for the CBO Public Health Equity grant acknowledged these new coordination spaces as supporting them to "take those perspectives into account and try to meet kind of everybody's needs" (OHA Program Staff Focus Group).

In addition to more formal spaces for internal coordination, one OHA program participant identified a need for a dedicated staff person to liaise between the various OHA teams who support Modernization implementation. The OHA program participant reflected on once having a liaison who left OHA and how a "dedicated staff for coordination between teams is really critical… Coworkers on my team have been doing the best that we can, but lacking a dedicated person to focus on bridging around LPHAs and CBOs has been a gap" (OHA Program Staff Focus Group).

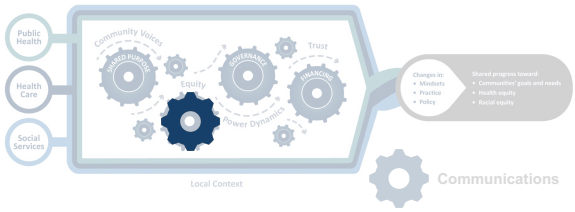
Shared Governance Similarities and Differences Across Partner Types

Similar to shared purpose, OHA and LPHA participants described experiences with shared governance early in Modernization implementation and highlighted the PHAB as the primary decision-making space. OHA and LPHA participants also described outputs of early shared decision-making, including the creation of the Modernization Manual and jointly-determined funding allocations, as evidence of effective shared governance practices. Both OHA and LPHA

participants also lauded the expansion of PHAB's membership to include CBO representation. Relatedly, OHA leadership and one LPHA participant emphasized that the new CBO PHAB member would benefit from a more concerted, intentional onboarding effort by OHA. However, LPHA participants commented that shared governance decreased over time, noting the COVID-19 pandemic response and OHA's decision to directly fund CBOs as inflection points, after which fewer decisions were made jointly in formal governance spaces and using agreed-upon processes and tools (e.g., inconsistent use of the Modernization funding formula). LPHA participants also described how this change to shared governance practice has sowed confusion about the role of PHAB as a joint decision-making space, with one LPHA participant asserting that OHA alone sets the agenda. While OHA leaders acknowledged ongoing confusion about the role of PHAB in shared decision-making post pandemic, they did not describe the inconsistent use of PHAB for certain decisions – like funding to CBOs – as problematic. Also, in contrast to LPHAs, OHA program staff who support the Public Health Equity Grant program felt that PHAB's influence on how OHA administers grant funds to CBOs has increased over time.

While participants differed in their perception of shared governance spaces, all participant groups agreed that role clarity across partner types is lacking. Both OHA and LPHA participants emphasized that while they benefit from a clear articulation of state and local roles in the Modernization Manual, the distinct but complementary roles of CBOs were not included in the manual or any other supporting documents. Some OHA program staff who administer the Public Health Equity Grant also expressed confusion about the role of LPHAs broadly as local governmental public health agencies and more specifically as recipients of Modernization funding. CBO participants generally described LPHAs as a "black box" and, while expressing more familiarity with OHA, recommended that OHA develop resources that clearly describe the

agency's organizational structure and clarify roles across the various staff that liaise with funded CBOs. In addition, both LPHA and CBO participants expressed a lack of clarity from OHA on who is funded for Modernization and their planned activities. Relatedly, LPHA and CBO participants recommended that OHA facilitate shared learning opportunities for LPHAs and CBOs receiving Modernization funding.



Shared Data and Measurement

Shared data and measurement are defined in the Framework for Aligning Sectors as a "feature of aligned systems that enables sectors to collectively and systematically gather, organize, and share data between entities, and the process of using this information to track progress." Five themes relating to shared data and measurement were identified. Themes relate to 1) the Public Health Modernization accountability metrics as the primary framework for shared data and measurement; 2) the accountability metrics not being aligned across partner types; 3) a general lack of shared data across all three partner groups; 4) the data that are collected not capturing the impact of Modernization funding investments; and 5) experiences related data justice and equity.

Accountability Metrics as Shared Measurement Framework

OHA and LPHA participants referenced the Modernization accountability metrics as the primary framework for shared data and measurement, with one LPHA participant affirming "in the local public health realm, we have very specific measurements and metrics that we're looking at

regarding syphilis, immunizations, climate and health" (Urban LPHA Focus Group). One OHA leader detailed the "fairly unique" impetus for developing the accountability metrics in 2017, noting "we in statute are required to have public health accountability measures" (OHA Leadership KII 2). The OHA leader further described how the metrics include both outcome measures or the "changes in health status that we look to pursue" as well as process measures "which are the things that OHA and local public health authorities do day-to-day as a part of our work to contribute to those improved health outcomes" (OHA Leadership KII 2). The OHA leader also highlighted that one percent of the funding allocated to LPHAs will be reserved for incentive payments to local governments that achieve certain process measure benchmarks (OHA Leadership KII 2). While one OHA program participant expressed skepticism that incentive payments are appropriate for the public sector, the OHA leader considered paying on performance as an "exciting milestone in terms of being able to identify how this is going" (OHA Leadership KII 2).

The OHA leader noted that accountability metrics development and oversight is "work that the Public Health Advisory Board has always led" and highlighted the process to develop the metrics as an early collaboration between the PHAB, OHA, and LPHA in "identifying, defining, collecting [data] and reporting on those metrics" (OHA Leadership KII 2). The OHA leader also emphasized that the metrics were meant to not only guide governmental public health, but also other cross-sector partners in Oregon's public health system: "These are accountability metrics on some really urgent crisis public health issues in the state of Oregon right now that we as a system are committing to being able to improve through the investments that we get and the changes that we're making through public health Modernization (OHA Leadership KII 2).

> "These are accountability metrics on some urgent public health issues in the state of Oregon right now that we as a system are committing to being able to improve through the investments that we get and the changes that we're making through public health Modernization…we have statewide goals around health outcomes that we're trying to change over the coming years."
>
> – OHA Leadership Key Informant Interview 1

Metrics Not Aligned Across Partners

While all partner groups referenced the accountability metrics as a shared measurement framework, participants also emphasized that the metrics are not applied consistently across all funded partners. An LPHA participant described the accountability metrics as "a huge data piece that shows what we're doing and how" and criticized that the metrics "just have not been a component of any of their [CBOs] work" (Rural LPHA Focus Group). A CBO participant expressed vague familiarity with the accountability metrics as the "large, state-level sort of measurements that we are accountable to" and affirmed "it'd be good to learn more about the methodology behind the measurements, like what the intention behind it is" (OPP CBO Focus Group). An OHA program participant described the absence of CBOs from a shared measurement framework as expected given their lack of inclusion in guiding frameworks, such as the Modernization Manual: "…there isn't shared data or measurement at this point…LPHAs have it very clear, there's a guide. From the very beginning of Modernization, it was clear how they would fit…we then introduce CBOs later on without a clear vision or guide on how they fit into the original proposition" (OHA Program Staff Focus Group).

> "…the accountability metrics and how that is a huge data piece that shows what we're doing and how, because there's the process measures, there's the outcome measures, and we have to either report on them or the state reports on it for us…And that does not happen with CBOs. That just has not been a component of any of their work."
>
> – Rural LPHA Focus Group

One OHA leader noted that the statutes requiring OHA to establish the accountability metrics for governmental public health do not include CBOs or tribes – given these partner groups began to receive Modernization funding after the initial metrics were developed in 2017. Regardless, the OHA leader noted the crucial role of CBOs and tribal health authorities to achieve the health outcome metrics – "particularly in eliminating health inequities" – and described recent efforts by OHA to increase awareness of the accountability metrics among funded CBOs, including requiring CBOs to tie workplan strategies to a particular health outcome metric (OHA Leadership KII 2).

Another OHA leader recalled OHA's recent outcome metrics presentations to funded CBOs and the palpable engagement on the priority health topics: "they [CBOs] are getting riled up and they don't like the syphilis rates in their county, and they're going to do something about it. I think this is a very interesting way for us to inspire community with facts and science, like here's what's actually happening in your community" (OHA Leadership KII 3). Based on the positive reception from CBOs to the accountability metrics, the OHA leader lamented that "we are teaching them about the accountability metrics and public health Modernization after we

already gave them the money, straight up…we're kind of doing it backwards" (OHA Leadership KII 3). The OHA leader further reflected on the missed opportunity for collaboration had CBOs been engaged in metrics discussions from the outset of their funding: "we could have seen more work plans that were better aligned with the accountability metrics, and maybe CBOs reaching out to local public health initially to better align" (OHA Leadership KII 3).

In addition to missed opportunities for partner collaboration, participants noted several other impacts from not having a shared measurement framework. One OHA program participant recalled the formation of an internal workgroup to align LPHA and CBO data collected through regular grant activity reporting. While the participant acknowledged "there are different things we want to measure for CBOs and LPHAs," gathering a set of common measures was thought to support "tell[ing] a collective story about the work LPHAs, CBOs and OHA is doing" (OHA Program Staff Focus Group). The OHA participant concluded that "we can ask questions and gather data and measure in ways that spans all of our grantees, but I don't think that we've gotten to that point yet…once we figure it out, we'll be able to say, 'here's the value of CBOs, here's why they should continue to be in this financing model and part of how the funds should be divided up'" (OHA Program Staff Focus Group).

Similarly, an LPHA participant commented that without CBOs sharing the same measurement framework, "how do we roll that [grant data] up to show the overall success and tell that story to the legislature as far as here's what Modernization has bought you or here's what you bought with Modernization" (Urban LPHA Focus Group). Given the novelty of including CBOs in Modernization as funded partners, one OHA leader similarly considered how better connecting the work of OHA, LPHAs, and CBOs through common metrics would "raise the profile of what CBOs are doing" (OHA Leadership KII 3).

One OHA leader alluded to future efforts to determine "what are those metrics that CBOs can contribute to at a process level, that both respect the community context where they serve and culturally-specific needs and priorities and community wisdom and values." (OHA Leadership KII 2). The OHA leader also reflected on a future with "everyone in" on achieving the accountability metrics by collectively defining incentive payment benchmarks for non-LPHA partners to "share in the benefits of improved health outcomes for a community" (OHA Leadership KII 2). While OHA leadership participants described current efforts and future plans to more explicitly incorporate CBOs into the accountability metrics framework, some OHA participants expressed concern with measuring CBO progress in the same manner as LPHAs and defined expectations for future processes to identify CBO-specific accountability metrics. One OHA leader responded to the lack of CBO engagement in developing the original accountability metrics, declaring "for one they need to be at the table as we're developing them" (OHA Leadership KII 3).

The OHA leader further suggested that developing accountability metrics for CBOs will require flexibility to prioritize community-specific metrics that reflect "things that might be happening at a more micro level" in addition to issues impacting communities statewide (OHA Leadership KII 3). However, the OHA leader worried this flexibility would lead CBOs to propose metrics on housing, transportation and other social determinants of health that are "outside of our box" and put OHA in the difficult position to "either we say 'no, community, we can't do this' or we go to our state partners that are in transportation, that are in housing, and we say this is what we're hearing from our community partners…how can we break down our silos and come together in the way that communities are asking us for support" (OHA Leadership KII 3). Another OHA program participant described this as feeling a "push and pull" between

aligning CBO funding to LPHA metrics and feeling "that's maybe not necessarily what we should be doing" given CBOs should not be held to the same expectations as local governments (OHA Program Staff Focus Group).

The OHA leader similarly described "conflict initially" between OHA and LPHAs with measurement expectations for CBOs receiving Modernization funding, saying "I think the expectation that the work CBOs were going to be doing is the same as the work LPHAs are doing, and thus the accountability was going to be the same, and it is not" (OHA Leadership KII 3). Another OHA leader alluded to potential flexibility within the accountability metrics framework, saying "we can really demonstrate that the system is working together" through shared health outcomes, but "it doesn't mean these are the only things that we're working toward" (OHA Leadership KII 2). Regardless of whether CBOs are afforded flexibility within a shared metrics framework, the OHA leader was also concerned with expectations to immediately demonstrate outcomes within a shared measurement framework and the need for time to thoughtfully integrate the shared measurement into formal grant deliverables: "I'm not completely confident that we're going to see the results in data this biennium. I think we figured out a strategy on how to do the trainings and engagement with community…then I think by next biennium, we could be in a better place to invite community to really craft work plans that are aligning with those things" (OHA Leadership KII 3).

While all LPHA participants described the accountability metrics as foundational to a shared measurement framework, they also expressed several issues with the current framework. One LPHA participant emphasized that local efforts to address the priority health outcomes are not exclusively supported by state general fund dollars earmarked for Modernization by the legislature, but rather a combination of state, federal, and other sector funding sources: "…some

of the metrics aren't necessarily the work that's done with Modernization money. Syphilis, we use EISO funds. We don't really use our Modernization funds for immunizations. Climate work, we're using HealthShare dollars" (Urban LPHA Focus Group). The LPHA participant concluded that reporting on the accountability metrics may both overestimate the impact of Modernization funding and underestimate the resources still needed to engage in the work to address priority health outcomes: "…it's not a direct, 'oh, because of this investment we're moving the needle on these accountability metrics' because it's a variety of funding sources" (Urban LPHA Focus Group).

Another LPHA participant reflected on how reduced public health funding from all sources may limit achievement of specific accountability metrics, saying "as my county general fund goes down, which funds a lot of our core public health services…we might have to put more Modernization [funding] to basic core public health" (Urban LPHA Focus Group). Lastly, another LPHA participant reflected on the tension between accountability metrics that focus on overall population health outcomes and local investments in diversity, equity and inclusion, especially in a rural, conversative context: "…if our metrics are around syphilis and climate, it gets difficult to justify having these staff that are really focused on health equity… I live in a county that is fairly conservative and rural and I'm getting a lot of questions about how much money we dedicate to DEI efforts now with our budget committees" (Urban LPHA Focus Group).

> "I'm really trying not to cut the community partnerships program…But if our metrics are around syphilis and climate, it gets difficult to justify having these staff that are really focused on health equity. Especially, as I live in a county that is fairly conservative and rural and I'm getting a lot of questions about how much money we dedicate to DEI efforts now with our budget committees. Because they're looking at other states and other places where they're cutting DEI programs and funding and wanting also to go down that path. So that's part of the struggle here locally when it comes to Modernization as well and maintaining the gains that we've made."
>
> – Urban LPHA Focus Group

No Shared Data Between Partners

All participant groups described a general lack of shared data between Modernization partners. One LPHA participant recalled OHA sharing the number of jobs in local health departments supported with Modernization funding and believed these workforce data were also reported to the legislature: "That's really the only piece of shared data or metric that comes to my mind…I don't know, because I don't know what we're tracking" (Urban LPHA Focus Group). Another LPHA participant similarly concluded "if we're talking about OHA, CBOs, and local public health having a shared purpose with shared outcomes with shared data, I don't think that exists" (Urban LPHA Focus Group). Another LPHA participant emphasized shared data as "a big gap"; however, while most LPHA participants wanted to receive data from OHA and CBOs, the participant desired an opportunity to provide OHA with their local data as "it could really assist

my work…OHA knowing more about my community and the health needs" (Rural LPHA Focus Group).

CBO participants similarly described "limited" data sharing between partner groups with one CBO participant noting an insular process by which "we set our own objectives and outcomes and the way that we evaluate our progress" (COC CBO Focus Group). Another CBO participant described sharing data with OHA through regular grant activity reporting but acknowledged "[I'm] not sure how that's going to be used, what that's feeding, or how that's going to be taken into account" (COC CBO Focus Group). The CBO participant was also concerned with the lack of data coordination between CBOs and LPHAs, saying "It seems like it's an issue that we don't know what information would be helpful to them or what information we should be sharing or trying to capture to help the local community" (COC CBO Focus Group). Similarly, another CBO participant recounted completing data collection for a community-specific needs assessment and being unaware of opportunities for data sharing with local partners, saying "we're trying to figure out what partners [exist] and what data we can ask of those partners, including the public health departments and other community-based organizations that have done similar work" (OPP CBO Focus Group). Another CBO participant affirmed the lack of shared data with LPHAs also funded for Modernization and attributed this to the lack of a shared vision: "…it would be helpful to have that shared understanding or shared priorities and how we do the data collection and how we measure it and for what purpose. I don't think we've dived deeper into that, especially…in a community centered way" (COC CBO Focus Group).

> "We kind of set what we were going to report on and we have. Not sure how that's going to be used, what that's feeding, or how that's going to be taken into account…It seems like it's an issue that we don't know what information would be helpful to them [LPHAs] or what information we should be sharing or trying to capture to kind of help the local community, so there's not a connection there, unfortunately."
>
> – Communities of Color CBO Focus Group

No participant described data sharing between all three partner groups. Most participant examples of shared data highlighted unidirectional data sharing from one partner group to another or a collaborative measurement effort between two of the three partner groups, some of which occurred prior to receiving Modernization funding. One OHA leader emphasized "a really large expansion of governmental public health improving the ways that we make data available to partners" and cited efforts to develop "user friendly" interactive dashboards for online data sharing (OHA Leadership KII 1). A LPHA participant affirmed this comment describing how Modernization funding enabled their health department to "have a contract with a company to start putting all of our community health improvement plan goals and objectives and measurements online and public facing" (Urban LPHA Focus Group).

However, the OHA leader conceded that this expanded data availability was "very one directional" and communicates "we have the data, we'll make it available to you" to partners rather than collaboratively collecting and sharing data. The OHA leader emphasized a future focus on "how we're working with partners to collect and use their own data," while also acknowledging this approach as "a big paradigm shift" for governmental public health data

practices (OHA Leadership KII 2). The OHA leader also noted local data collection as a topic of conversation in the PHAB with "a few members [who] work in this area and feel like this is the critical area to be focusing on with new investments as they come into the system" (OHA Leadership KII 1). While the OHA leader reflected on how "empowering and resourcing communities to collect their own data and fully own all aspects of it is really critical to equity work," they acknowledged "there's very little funding for it right now" (OHA Leadership KII 1).

Another OHA leader described the agency's engagement of community researchers and leaders to review specific OHA public health data sets to "learn about the challenges in the data that we collect and how it's presented and how it doesn't represent those communities" (OHA Leadership KII 1). The engagement process culminated in recommendations "for what the governmental public health system needs to be changing to have a truly community-centered approach to data" (OHA Leadership KII 1). (The OHA leader did not describe whether or not the recommendations were implemented, and this was not asked in follow-up questions.) However, the OHA-led community data initiative may not be widely understood by Modernization partners, with one LPHA participant remarking, "I know the state's putting a lot of money into this data initiative, and I've heard the presentation four times, and either I'm incredibly dense or the presentation makes no sense…I have no clue what this is" (Rural LPHA Focus Group). At the local level, one LPHA participant described how staff in their Community Partnership Program – established with Modernization funding – engaged community members in reviewing and discussing the relevance of local public health data: "They call them data parties, so they'll create reports on health disparities and then share it back with communities to see how that resonates or doesn't resonate with them" (Urban LPHA Focus Group).

CBO participants described data sharing experiences with LPHAs and OHA *prior* to receiving Modernization funding. One CBO participant recalled sharing data with LPHAs in the Tri-County area that were collected through a joint heat mapping campaign focused on "the most vulnerable communities and hotter areas that we serve within our agency" (COC CBO Focus Group). Another CBO participant described providing survey data to OHA, DEQ [Department of Environmental Quality], and the Lane County Regional Protection Agency: "…we would go knock on doors and ask folks, what type of health impacts are you experiencing? We shared that data with these entities, and they were able to use some of the data that we collected in an OHA report regarding [industrial pollution in the community]" (COC CBO Focus Group).

OHA, LPHA, and CBO participants all described grant activity reporting to OHA as an example of data sharing. One OHA leader commented on CBO activity reporting, describing the difficulty of balancing the promise to CBO grantees for low burden reporting requirements with expectations from external partners requesting detailed data demonstrating outcomes (OHA Leadership KII 3). An OHA program participant described the impact of balancing these competing demands on the data collection process, noting how the "very short-term vision" of responding to every request and concern has led to inconsistent information being collected over time rather than basing data collection around a shared, long-term strategy (OHA Program Staff Focus Group).

A CBO participant described feeling this tension in data collection, recounting how "reporting and gathering that information constantly changes. The cadence changes, the requirements change, the timeframe becomes extended or you're trying to remember what happened when" (OPP CBO Focus Group). Another CBO participant affirmed these "frequent revisions" to the activity reporting process and highlighted that "it is not at all transparent why

these changes are being made or who is making them" (OPP CBO Focus Group). Another CBO participant who similarly experienced changing expectations for their activity reporting, commented on the need for more upfront coordination on data collection: "It would be helpful at the start having that one-on-one meeting, this is what we're trying to achieve our outcomes, this is how it's going to be reported, and does that fit with what OHA is looking for rather than waiting six months and then saying, 'hey, wait a minute, I still need a little bit more information'" (COC CBO Focus Group).

In addition to the data collection process itself, an OHA leader acknowledged that "we [OHA] could be doing more around sharing data back with community" and noted this as a future process improvement (OHA Leadership KII 3). Relatedly, one CBO participant indicated "a lack of transparency in seeing how activity reporting information or feedback is used by OHA" (OPP CBO Focus Group). Similarly, another CBO participant emphasized that follow up from OHA on "'I heard this, this looks great, this is how we can connect partners'…it can be really lacking" (OPP CBO Focus Group). One LPHA participant expressed interest in seeing CBO activity reporting data collected by OHA, saying "they [CBOs] were submitting quarterly reports, and yet we never saw any of them…the only way for us to get information was for us to ask our local CBOs ourselves" (Rural LPHA Focus Group).

While OHA receives activity reporting from CBOs, one OHA program participant emphasized that OHA does not have capacity to receive and engage with other data provided by funded CBOs. The OHA participant recalled several CBOs that completed population-specific data collection projects and attempted to share findings with OHA, but "we have absolutely no mechanism to receive that, or if there is, none of us have been able to figure it out" (OHA Program Staff Focus Group). The OHA program participant further lauded LPHAs for engaging

with these same CBOs, describing how the spurned CBOs "go to the LPHA and the LPHA publishes it, and they actually make actionable things with it. Or at least there's a conversation. And even if this is the first time they've ever worked with a CBO before, a lot of times that's a way to open the door to have that conversation" (OHA Program Staff Focus Group).

Data Not Capturing Impact of Funding

OHA, LPHA, and CBO participants also described various concerns with how the data collected from Modernization grantees are not adequately describing outcomes or impacts on the public health system and community health. One OHA leader described the difficulty of capturing information in a manner that communicates the "impact" of CBO funding across the diverse partners to which OHA is accountable. The OHA leader emphasized that while "we are getting a lot of qualitative data and we're good at the storytelling" – the preferred approach of CBO grantees and OHA staff supporting Public Health Equity grant administration – other partners like the Governor's Office "want numbers" (OHA Leadership KII 3). In response to the perceived needs and preferences of the Governor's Office, OHA changed CBO activity reporting requirements to collect data more frequently (from biannual to quarterly reporting) and to capture more quantitative data intended to characterize the reach and outcomes of the funding.

Despite these changes, one LPHA participant questioned whether these quantitative data were truly capturing public health impact, saying "The data on that is, you know, 14 seminars held, 62 fans delivered that kind of stuff. That's not really the kind of data that we usually think of as public health data" (Rural LPHA Focus Group). CBO participants also questioned the value of collecting certain quantitative measures like the number of partners engaged for funded activities, saying "I think there are other ways that we can be able to communicate the success of

our work outside of offering the very arbitrary number of partners" (OPP CBO Focus Group). Another CBO participant characterized activity reporting as "a bit of a game" and a "false sense of counting" rather than a genuine attempt to understand how CBOs are supporting population-specific communities (OPP CBO Focus Group). In particular, the CBO participant described reporting on the number of partnerships as "an absurd representation of whether or not we've achieved our goals" and questioned OHA's lack of CBO engagement before changing activity reporting questions, asserting "I'm not sure we ever had an agreement up front that that's what we were going to do" (OPP CBO Focus Group).

> "I'm not entirely sure that the questions they're [OHA] asking is going to communicate whether or not we're achieving what we said we were going to achieve. I feel like it's a bit of a game instead of genuine, 'are you doing what you want to do with the money that you asked for and that we gave you?' I'm speaking directly to counting or sharing the partnerships that you've created or that have existed amongst other CBOs. I find that to be an absurd representation of whether or not we've achieved our goals."
> – Other Priority Populations CBO Focus Group

In addition to the type of information collected through activity reporting, one CBO participant questioned whether OHA should rely solely on activity reporting data to tell the story of how CBOs advance Modernization: "…activity reports are generally a single Smartsheet that I have found did not allow opportunity to accurately reflect work or impact of the work we were doing. I am not sure how informed decisions or discussions move forward within that format"

(OPP CBO Focus Group). Another CBO participant affirmed "I don't always feel I can accurately represent the impact of the work we're doing" through the "one-size-fits-all" activity reporting form. The CBO participant wondered "how are we all being heard?" with these concerns and conceded "it doesn't feel to me like it's truly representing the work that we're doing, but we're answering the questions presented" (OPP CBO Focus Group).

Only one LPHA participant described the OHA-led evaluation of Modernization as an opportunity for shared data but seemed unaware of past evaluation findings and vaguely described these previous efforts as "sometimes miss[ing] the mark" due to a perceived focus on "workforce versus moderate modernizing our system" (Urban LPHA Focus Group).

Modernization Driving Data Justice and Equity Practice

Several OHA and CBO participants commented on data justice and equity practices in the context of shared data. One OHA leader described a general "180-degree shift" whereby governmental public health practitioners are positioned as "stewards of the data" and acknowledge the communities represented in the data as experts who "should really be in control of all aspects of how data is collected and reported and used" (OHA Leadership KII 1). The OHA leader contrasted this perspective with their early career experiences grounded in the sentiment that "I, as a public health professional, own the data. I know the data. I'm an expert in the data. People need to ask me for their data" (OHA Leadership KII 1). The OHA leader further acknowledged that "we have not made that full pivot, but you can sort of see the direction that things are going" (OHA Leadership KII 1). While an OHA staff participant similarly acknowledged that "ideally, community should be engaged in this process" of developing a shared measurement framework, they conceded that the skill set required for OHA staff to

engage community in this manner are “not very robust in terms of data justice or being more community driven…I know we've made some strides in that way, but we're still just not very well equipped” (OHA Program Staff Focus Group).

> “…work around public health data is one of the areas that has changed most drastically in the past few years…My earlier career in public health was grounded in this concept of like, ‘I as a public health professional own the data. I know the data. I'm an expert in the data. People need to ask me for their data’…over the past few years, you've seen a massive change to positioning us as the stewards of the data, but actually the people who are represented in those data, whose communities are represented in those data, are the experts. They own and should really be in control of all aspects of how data is collected and reported and used.” – OHA Leadership Key Informant Interview 1

In addition to the general paradigm shift toward data justice, the OHA leader noted that the PHAB spent two years developing a strategic data plan with recommendations for data governance and other considerations “framed around data equity, data justice and community engagement around public health data” (OHA Leadership KII 1). No other participant mentioned the PHAB’s strategic data plan. The OHA leader also highlighted that PHAB has discussed “empowering and resourcing communities to collect their own data” as a critical area in which to invest any new Modernization resources (OHA Leadership KII 1).

The OHA leader also highlighted OHA’s engagement of community researchers and leaders to learn about the limitations of population health data collected by OHA, including how

the data do and do not reflect the experiences of local communities. This engagement culminated in recommendations for how governmental public health can employ a more community-centered approach to data collection and sharing (OHA Leadership KII 1). Another OHA leader also described this effort and emphasized that the resulting recommendations will help OHA to "ask better questions about health, engage in better community-specific methods to collect better public health data, and ultimately to determine ways of ownership and use of community specific data" (OHA Leadership KII 2). More specifically, the OHA leader emphasized that the recommendations would inform OHA's approach to the next state health assessment, as well as determine investments in the public health surveillance system to ensure the data that OHA collects are more timely, useful to communities, provide appropriate context when describing health inequities, and "work from a strengths-based perspective and not only a deficits model" (OHA Leadership KII 2).

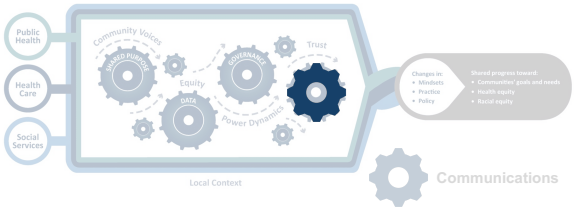
One CBO participant asserted "there's still a lot of work that needs to be done around decolonizing data and making data available," emphasizing that public health data should be understandable to the disenfranchised community members who are affected by the health inequities reflected in the data (OPP CBO Focus Group). The CBO participant further described how much of the public health data reporting "is very academic jargon that not everybody, not everyday folks are able to digest. And I'm counting myself in there" (OPP CBO Focus Group). The CBO participant concluded "what good does it do if most folks in the community don't understand what that means" and highlighted the limitations on using the data "as a tool to build more engagement and hopefully ultimately encourage more participation [in the legislative process]" (OPP CBO Focus Group).

Shared Data and Measurement Similarities and Differences Across Partner Types

OHA and LPHA participants referenced the Modernization accountability metrics as the primary framework for shared data and measurement. Both OHA and LPHA participants also emphasized that the metrics are not applied consistently across all funded partners. However, LPHA participants felt that CBOs should be reflected in the shared measurement framework to ensure their funded work is informed by the same process and outcome metrics as LPHAs. In contrast, one OHA program participant pragmatically expected that CBOs would not be included in the shared measurement framework given their absence from the Modernization Manual. Another OHA leader participant acknowledged that OHA's more recent attempts to educate funded CBOs on the accountability metrics feels "backwards," but also expressed concern with measuring CBO progress in the same manner as LPHAs. The OHA leader expressed concern that CBOs would be expected to immediately demonstrate progress on any shared outcomes and suggested that CBO accountability metrics would need to be community-specific rather than part of a shared measure set with LPHAs. These differences aside, both OHA and LPHA participants commented that it will be difficult to communicate a cohesive story about Modernization successes to decision-makers without embedding CBOs into a shared measurement framework with OHA and LPHAs.

LPHA participants emphasized several issues with local implementation of the shared measurement framework. First, LPHA participants described how reporting on the accountability metrics may overestimate the impact of Modernization funding and underestimate the resources still needed given progress on the health outcome metrics is not exclusively supported by Modernization funding but rather a combination of other funding sources. LPHA participants also explained how the population-level health outcome metrics in the framework – without

consideration of disparities in these outcomes – hamper local investments in diversity, equity and inclusion staffing and programming. While OHA participants did not express opposing viewpoints, they did not speak to these local concerns with the accountability metrics framework, perhaps indicating a lack of awareness of how the framework influences local Modernization work. All participant groups described a general lack of data sharing between Modernization partners, with most sharing occurring unidirectionally from OHA to CBOs or LPHAs. All participant groups also agreed that current data collection efforts are not adequately capturing the impact of Modernization funding, with all groups citing an overreliance on quantitative data collection, like number of events held or number of partnerships formed.



Shared Financing

Shared financing is defined in the Framework for Aligning Sectors as a "feature of aligned systems characterized by sustainable methods with appropriate incentives and shared accountability." Five themes relating to shared financing were identified. Themes relate to 1) mixed impressions of the degree to which Modernization financing is shared; 2) financing decision-making becoming more siloed over time; 3) the lack of shared accountability to the funding; 4) mixed perceptions among partners on the degree to which Modernization funding has been equitably allocated; and 5) the uncertainty of Modernization sustainability.

Mixed Impressions of Shared Financing

OHA leadership and staff offered examples of shared financing for Modernization. One OHA leader described the 2014 recommendations from Oregon's Public Health Task Force on the Future of Public Health Services as the foundation for shared financing. The leader emphasized that shared financing was "very intentionally built into everything from the get-go" given the Task Force recommendation for "significant and sustainable funding for the public health system in Oregon" and related statutory requirements for how funds would be used, how funding decisions would be made, and anticipated outcomes for the funding (OHA Leadership KII 1). The OHA leader emphasized that the hallmarks of shared financing are all considered in the statutes prescribing Modernization implementation: "In your definition you talk about sustainability and incentives and accountability and all of those are very intentionally in statute, words that are used right along with all of the funding mechanisms" (OHA Leadership KII 1). The OHA leader also described shared decision-making between OHA and LPHAs on funding allocations early in Modernization implementation when the initiative focused exclusively on the governmental public health system. The OHA leader recalled conversations between OHA, LPHAs, and the PHAB to "take the high-level guidance we get from the state legislature about how the funds can be used and then figuring out how we want to operationalize it" (OHA Leadership KII 1). The leader further described how these conversations resulted in shared decisions to "focus on certain public health topical areas like communicable disease…thinking about different models for how we pay for staffing and really identifying where all of our obstacles were in doing what we wanted to do [with the funding]" (OHA Leadership KII 1). One LPHA participant affirmed that "We had a very clear dollar amount of what we needed, and we

were one of the first to do the regional approach, which is still very successful" (Urban LPHA Focus Group).

Another OHA leader commented on the "appropriate incentives" aspect of shared financing, noting how "For the first time ever this biennium [2023-2025], we [OHA] will be paying on performance for achievement of measure benchmarks" (OHA Leadership KII 2). The leader described how one percent of overall funds allocated to LPHAs will be reserved for incentive payments tied to achievement of process-level accountability metrics defined by the PHAB (note that CBOs are not formally included in Modernization accountability metrics framework, including incentive payments). The leader further envisioned a future in which the public health system "collectively define[s] and share[s] in the benefits of improved health outcomes for a community that could include more partners than just local public health authorities" (OHA Leadership KII 2). The leader offered that this "everybody in" approach may benefit from more creative financing models like social impact bonds that were more prevalent in the early days of health system transformation and highlighted the PHAB Incentives and Funding Subcommittee as the space to explore shared financing concepts (OHA Leadership KII 2).

An OHA leader also described how the number of partner types to consider in shared financing expanded over time to include not only LPHAs, but also federally recognized tribes and the urban Indian program in 2021 and then CBOs in 2023 (OHA Leadership KII 1). The leader further reflected on the implications of this expansion on PHAB's role to set the strategy for funding allocations, saying "we've [OHA] tried to support PHAB to really think about how all of that funding is really to one purpose. It's funding different parts of the system, but we're all

working toward the same goals, and we all have a different piece of it…we are a bunch of individual organizations, but we work together as a system" (OHA Leadership KII 1).

> "…from OHA's perspective, what we've tried to support PHAB to do is really think about how all of that funding is really to one purpose. It's funding different parts of the system, but we're all working toward the same goals, and we all have a different piece of it…we are a system, we are a bunch of individual organizations, but we work together as a system."
> – OHA Leadership Key Informant Interview 1

One OHA program staff highlighted the Public Health Equity Grant for CBOs as an example of shared financing for both Modernization and other programs in the Public Health Division contributing to the funding opportunity. (The first Public Health Funding Equity Grant in 2021 included Modernization funding for environmental public health, communicable disease control, and emergency preparedness and response, as well as program-specific funding for commercial tobacco prevention, overdose prevention, adolescent and school health, and breast and cervical cancer screening.) The OHA staff person emphasized that while OHA was not able to "braid" the categorical funding streams comprising the grant opportunity as initially hoped, "we were able to accomplish one entry point for community-based organizations to apply for this funding and that was a win for what we were trying to do" (OHA Program Staff Focus Group).

The multi-program approach to the Public Health Equity Grant was noted as an opportunity to eschew the sole focus on foundational programs prioritized by the PHAB (i.e., communicable disease control and environmental public health) and elevate the Modernization

framework more broadly across the Public Health Division. However, this approach may have resulted in a lack of clarity among certain partners, specifically where Modernization funding originates and what purpose it is meant to serve. When asked about experiences with Modernization funding, one CBO participant misidentified one of their funding sources as Modernization (COC CBO Focus Group) and an LPHA participant described discussions with funded CBOs in their community about Modernization and finding "they are unaware of where the source of their funding has come from…they are not being made aware this is Public Health Modernization money…here's the framework and why it's being financed…It's just been presented as this is equity money'" (Rural LPHA Focus Group).

Shared Financing Decreased Over Time

Similar to other themes, OHA and LPHA participants noted that shared decision-making on funding allocations has decreased over time, particularly during and immediately following the COVID-19 pandemic response. One OHA Leader acknowledged the agency's unilateral decision to directly fund CBOs for Modernization following the pandemic response, saying "we had an opportunity to add funding for community-based organizations…to continue their work and then folded that investment into Public Health Modernization as the pandemic continued and we continued to have plenty of financial resources to respond…this was something that we did not consult with or talk to local public health about" (OHA Leadership KII 2). The leader conceded the decision "was very last minute" and asserted "It wasn't a great time to engage in thoughtful discussion among partners." However, the leader reflected on the downstream implications of this decision, noting that OHA is now "continuing to work backwards from that to bring partners together, recognizing it was a pandemic and a challenge, but also that we can do better" (OHA Leadership KII 2).

LPHA participants in both focus groups reflected on OHA's unilateral decision to directly fund CBOs for Modernization, with one participant reflecting on the lost opportunity to move forward together: "I wish there had been more shared financing…we had CBOs that got money to do very specific work in our community that we've never heard of… had it been a joint effort, we could have all moved forward with the money and made sure it's going to the populations that need it most" (Rural LPHA Focus Group). The LPHA participant further emphasized how OHA's siloed decision-making required LPHAs to expend limited resources attempting to align local Modernization efforts with funded CBOs: "It felt really backwards for us to be trying to track down these groups that got money to do work in our community…that feels like wasted money when we're having to spend money to make up for that work (Rural LPHA Focus Group).

> "I wish there had been more shared financing and this [funding to CBOs] could be more of a transparent process…we had CBOs that got money to do very specific work in our community that we've never heard of…and feels like had it been a joint effort, we could have all moved forward with the money and made sure it's going to the populations that need it most are."
> – Rural LPHA Focus Group

Another LPHA participant summarized the impact of siloed funding decisions, saying "We had organizations that had never set foot in our county that were funded to do work in our county. To make decisions on who is funded in what county without engaging local public health…just did not feel good" (Urban LPHA Focus Group). In addition to the unilateral

decision to directly fund CBOs, LPHAs also highlighted OHA's siloed approach to developing the 2023 Modernization policy option package (the vehicle by which OHA communicates the Modernization funding request to the Governor's Office and Legislature), saying "they [OHA] just put it together and sent it forward…there was no interaction between the two [LPHAs and CBOs]" (Rural LPHA Focus Group).

LPHA and OHA program staff participants highlighted that some LPHAs also directly fund CBOs, although state and local funding are not informed by a shared financing approach to reduce potential redundancy and ensure common outcomes. One LPHA participant described how "we had a CBO that is lovely and they had applied for funding [from OHA], and they didn't get it so we at Public Health ended up funding them anyway" (Rural LPHA Focus Group). One OHA program staff participant noted that multiple sources of governmental funding can be confusing to CBO recipients, saying "it gets odd very fast, especially if it's similar work…I've had questions from CBOs like, 'is this double dipping if I apply for X county's project about something related [to the Public Health Equity Grant]'…that question comes up pretty frequently" (OHA Program Staff Focus Group). Another OHA program staff participant acknowledged "these are the areas where we don't have a clear roadmap or clear guide for how we navigate these issues" (OHA Program Staff Focus Group).

In addition, LPHA participants recalled "we've passed through funding a lot to our CBOs" prior to OHA's Public Health Equity Grant and emphasized that locally "we've always done good work with our community partners and value them so much for doing public health work and reaching into a community in the way we can't" (Urban LPHA Focus Group). LPHA participants advocated for the flexibility to fund CBOs directly if an LPHA has the capacity to serve as grant administrator. One LPHA participant suggested that OHA "fund local public

health in a way that you can maintain the staff to be able to support CBOs…or say actually 'no, we don't have the capacity to do this…so OHA, if you could please route the funding through you instead of through local public health.' I think that if you at least had that choice, then it would be a little bit more successful" (Urban LPHA Focus Group). Another LPHA participant highlighted how the option to fund CBOs directly, especially if mandated by OHA, could have supported local public health departments in more conservative communities to advance equity goals through partnerships with culturally-specific CBOs: "…if OHA would have said, 'okay, here's how much for Modernization and you have to give this percentage to grants within your local community to CBOs to work with you on public health priorities' that would have been a game changer, because then we could have gone to our elected [officials] and say, 'hey, we have to provide this,' right?" (Urban LPHA Focus Group).

In response to LPHA concerns with OHA directly funding CBOs, a "pilot project" was initiated that allowed for LPHAs to serve as the passthrough organization for Public Health Equity Grant funding to CBOs in their counties. However, one LPHA participant noted sustainability concerns with OHA's pilot approach because "we were told [by OHA] very explicitly that 100% of the dollars go to the CBO, zero can be kept for indirect, which was really tricky because everybody who's ever done any kind of financing and budget work knows that it takes money" (Rural LPHA Focus Group). The LPHA participant further expressed being in the "lucky" position to absorb the indirect costs of participating but called this approach "completely unprecedented" and recalled, "even when our CBO was like, 'aren't you taking indirects, that's weird' we were told [by OHA] 'it's a pilot, we'll fix it later'" (Rural LPHA Focus Group).

Outside of the state funding environment, one OHA leader noted the state's reliance on federal grants as the "biggest barrier that we face" to shared financing given the federal grants

may not be directly supportive of Modernization. However, the OHA leader was optimistic that "there are ways to thread a needle" to both meet the requirements of federal grants and more meaningfully align federal funding goals with those of Modernization, including "align[ing] our CDC funded work plans or other federally-funded work plans with what we're doing in Public Health Modernization" (OHA Leadership KII 2).

Shared Accountability to Funding Lacking

LPHA and OHA participants commented on a lack of shared accountability to Modernization funding. As described in the shared data and measurement theme, LPHAs were concerned that the Modernization accountability metrics were not fairly applied to LPHAs and CBOs in the same manner, characterizing the accountability metrics as "a huge data piece that shows what we're doing and how… that does not happen with CBOs. That just has not been a component of any of their work." (Rural LPHA Focus Group). One OHA leader was aware that "LPHAs were very interested in the accountability metrics and how we were going to hold CBOs accountable" (OHA Leadership KII 3). An OHA program staff participant was concerned that LPHAs had a "misconception of OHA…we're seen as free with our money" and lamented the lack of understanding from LPHAs that OHA "holds folks accountable with the funding" through mechanisms other than the accountability metrics, including regular grant activity and expenditure reporting (OHA Program Staff Focus Group).

> "There's this misconception of OHA because we're seen as free with our money…There seems to be a lack of understanding of how we hold folks accountable with the funding and how we incorporate that accountability piece…there's this misconception that we don't [hold CBOs accountability to the funding] because accountability looks different between LPHAs and CBOs, and instead of trying to understand, there's this overarching 'if it's not held accountable like ours, then it's not accountability' and that's not necessarily true." – OHA Program Staff Focus Group

An OHA leader added to this sentiment by acknowledging "we have a lot of risk in the work we're doing because of how we're funding community" and described managing this risk by "asking them [CBOs] to document and track in ways that are pretty tedious" (OHA Leadership KII 3). However, the OHA leader further reflected that "we could be doing a lot better and it has everything to do with the sheer volume of work and the lack of staff that we have to support that work," highlighting that even after "introducing 200-plus new contracts, new payees…we haven't changed our internal infrastructure to accommodate" (OHA Leadership KII 3). The OHA program staff participant also emphasized that "accountability looks different between LPHAs and CBOs" and was concerned that instead of trying to understand potential differences in accountability across funded partners, LPHAs seemed to believe that "if it's not held accountable like ours, then it's not accountability" (OHA Program Staff Focus Group). Similar to other Framework components, the OHA program staff participant highlighted that thoughtfully embedding CBOs into a shared financing framework with clear accountability was

limited by the need to "incorporate them [CBOs] into this Modernization vision" whereas LPHAs benefit from a "clear guide or manual, things they can do and things they cannot do [with funding]" (OHA Program Staff Focus Group).

OHA program participants also commented on the lack of accountability to the funding amongst staff internally in the Public Health Division. Specifically, one OHA program participant noted a difference between staff in the Director's Office who support general administration of the legislative funding allocation and staff in programs who serve as technical experts in the areas prioritized for funding by the PHAB (i.e., communicable disease control and environmental health). The OHA staff participant summarized the issue, saying "because the funding sits in the director's office, there's not the sense of ownership from the programs, because they're not feeling like, 'hey, this is our funding and this funding is supporting us and our infrastructure'" (OHA Program Staff Focus Group). The OHA program participant further expanded that some programs supporting Modernization implementation are not receiving a portion of Modernization funding to ensure their capacity for the work. In addition to constraints related to where the funding sits in OHA and the limited investment in program staff support, another OHA program participant highlighted the "lack of real solid governance internally" as a barrier to shared accountability to the funding. The OHA program participant emphasized that program staff "accountability does not correspond with the level of authority or decision-making…there's a mismatch" and suggested this mismatch "needed to be worked out and decided by leadership so we could have a shared understanding of what we're accountable for" (OHA Program Staff Focus Group).

Mixed Perceptions of Equitable Financing

OHA and LPHA participants commented on both the intention and current barriers to equitably financing Modernization. One OHA leader emphasized that the "past couple rounds" of Modernization funding that included grants to CBOs "demonstrate a more equitable approach to funding" compared to the historic focus on the governmental public health system alone (OHA Leadership KII 1). In addition to Modernization funding specifically, one OHA leader provided other examples of Public Health Division programs that equitably allocate funding, suggesting a more diffuse commitment to equitable financing in the agency. The OHA leader described how the Oregon Tobacco Prevention and Education Program convened a committee of culturally-specific CBOs to design a process by which new tobacco tax revenues would be allocated in local communities (OHA Leadership KII 2). In contrast, LPHA participants described OHA's funding approach as inequitable, with one participant reflecting on changes to LPHA funding allocations over time: "When we're only getting 30-something percent of new Modernization funding, when we had first started we got 70%, there's a real problem there" (Rural LPHA Focus Group). LPHA participants were particularly concerned with the proportion of funding they receive given the current need to leverage other funding sources to advance Modernization priorities. One LPHA participant emphasized that a "variety of funding sources" are being used to advance work in prioritized program areas, including federal funding from Early Intervention Services and Outreach (EISO) for syphilis prevention and treatment and funding from HealthShare Coordinated Care Organization for climate and health (Urban LPHA Focus Group).

OHA participants described a resource scarcity mindset as a barrier to shared and equitable financing for Modernization. One OHA leader emphasized that approaching funding decisions from a deficit perspective can inadvertently narrow the focus of conversations to

individual organizations rather than the entire public health system. While the OHA leader acknowledged that the public health system is insufficiently funded, "how that plays out is a little bit of like, 'I'm going to take care of myself,' so there's a lot of thinking about what an individual organization needs, how they can get the most out of the funding that's available, the largest pot possible, and not as much thinking about the system and what does the system need" (OHA Leadership KII 1). One OHA program staff participant expressed feeling "disturbed" by a vocal minority of LPHAs that believe "CBOs are taking their money" and emphasized that this narrative "couldn't be further from the truth because the whole pie is expanding…the slice for LPHAs has increased and there's also now a slice for CBOs" (OHA Program Staff Focus Group). Another OHA program participant described the potential impact of this deficits-based narrative on partner relationships: "I have had an LPHA say that explicitly, 'I know this is not logical, I know this is not what's happening, but I can't help but feel this way and I'm trying really hard to not let this spill over into my relationships with CBOs'" (OHA Program Staff Focus Group). A CBO participant described feeling this tension in "certain meetings" and was aware of the deficits narrative, explaining "LPHAs were funded to do some of this work and now this money is being redirected to CBOs to take on this work for a variety of different reasons…I think there is a rub there if you will, because you're talking about moving money away from a public health department when maybe they were expecting some of that funding to do some of that work" (COC CBO Focus Group).

In addition to funding allocations across partner types, another LPHA participant highlighted geographic gaps in CBO funding allocations made by OHA, saying "a lot of the funded CBOs were in the metro area, and there were a few counties that literally had zero CBO funding coming to their community directly" (Rural LPHA Focus Group). The LHPA participant

attributed this inequitable distribution of CBO funding to OHA's grant-making approach, asserting that "The way the state did it is large, competitive grants, so you'd be guaranteed to get big organizations. You're not shocked at all that you'd get big Portland organizations that have directors who have their MBA or MPH" (Rural LPHA Focus Group). Given CBO funding concentrated in urban areas of the state, the LPHA participant questioned whether "those organizations that get funded really represent the populations who are most affected by health inequity" (Rural LPHA Focus Group).

> "…at the beginning, a lot of the funded CBOs were in the metro area and there was a few counties that literally had zero CBO funding coming to their community directly…So that further exemplified the power differential simply between the rural and the urban areas."
> – Rural LPHA Focus Group

Relatedly, one OHA leader reflected on initial CBO funding allocations that concentrated investments in urban communities and acknowledged "we could have done an even better job distributing these funds" (OHA Leadership KII 3). The OHA leader then described OHA's consequent attempt to "genuinely mak[e] sure we're distributing funds equitably across the state" by prioritizing grant applications from CBOs serving rural communities and people with disabilities in the second round of funding (OHA Leadership KII 3). While OHA attempted to address perceived inequities in CBO funding allocations, LPHAs generally promoted a shared decision-making process in which "we could have all moved forward with the money and made sure it's going to the populations that need it most are" (Rural LPHA Focus Group).

Lastly, as described in the "shared accountability to funding lacking" theme, one OHA program participant highlighted the inequitable distribution of funding within OHA. The participant asserted that not all Public Health Division programs expected to support Modernization implementation are receiving dedicated funding to support their capacity, saying "…there were some issues and tensions that needed to be worked out and decided by leadership so we could have it a shared understanding of what we're accountable for… HSPR [Health Security, Preparedness and Response] and ACDP [Acute and Communicable Disease Prevention] don't get funding from Modernization to be staffing the work, where EPH [Environmental Public Health] does. I know that's one piece around financing that's been challenging" (OHA Program Staff Focus Group).

Uncertain Funding Sustainability

OHA and LPHA participants highlighted concerns with the long-term sustainability of Modernization funding. LPHA participants commented on funding sustainability in the context of investments not keeping up with the costs of doing business. One LPHA participant emphasized that "because of cost, I'm not able to keep up with Modernization" and was "really fearful" of the funding outlook in light of decreases to their county general fund and OHA's guidance that LPHAs should not count on a meaningful increase in Modernization funding in the next biennium (Urban LPHA Focus Group). The LPHA participant further explained that even stable funding over time equates to a decreased investment due to inflation and requires LPHAs to focus resources on core mandated services at the expense of newer programming. The LPHA participant described making cuts to certain programs supported by Modernization that have not been able "to keep up with expenses," including communications and emergency preparedness,

and was concerned that future cuts would include a relatively new community partnership program (Urban LPHA Focus Group).

> "Unfortunately, we had a very robust community engagement team during COVID and a lot of that team is ending at the end of June, because the COVID funding runs out…because of cost, I'm not able to keep up with Modernization and I'm really fearful this next round when we hear that OHA can only ask for a 1% increase and don't count on increase in Modernization, which means more of a decrease…when we go back to what are our core mandated services that we have to provide, which are also not keeping up, then unfortunately that's where things are going to get cut. So, I agree, we need to figure out how to continue to support CBOs in that work."
>
> – Urban LPHA Focus Group

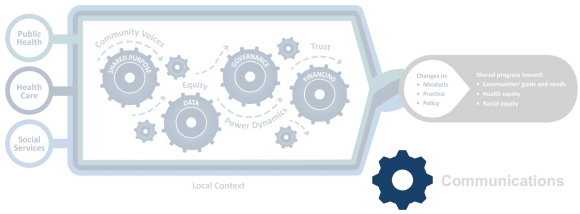
For CBOs, one OHA program participant who supports administration of the Public Health Equity Grant contrasted OHA and LPHA funding that is "more or less sustainable" with CBOs that must apply for competitive funding every biennium (OHA Program Staff Focus Group). The OHA program participant further emphasized that the funding cycle for CBOs limits their longer-term planning for Modernization work because "our current CBOs are up in the air as to whether or not they'll receive next biennium funding…it's not sustainable for them because it can end… I think we often forget that piece" (OHA Program Staff Focus Group).

Shared Financing Similarities and Differences Across Partner Types

OHA and LPHA participants described a shared financing approach early in Modernization implementation, with funding allocations to OHA and LPHAs jointly decided in PHAB. OHA participants further emphasized that shared financing has increased over time with the expansion of funding to include federally-recognized tribes and CBOs and the 2025 implementation of LPHA incentive payments for progress on accountability metrics. In contrast, LPHA participants commented that shared financing has decreased over time, particularly during and immediately following the COVID-19 pandemic response when OHA unilaterally decided to fund CBOs for Modernization. Similarly, OHA and LPHA participants differed in their perceptions of the equitable allocation of Modernization funding across partners. While OHA participants viewed the funding of CBOs as increasing equity in financing decisions, LPHAs saw this change as inequitable given the decision was made unilaterally by OHA rather than reflecting an agreed-upon shared financing strategy and contributing to inequitable decreases in the proportion of Modernization funding allocated to LPHAs.

The perceived decrease in Modernization funding was particularly concerning to LPHAs given parallel decreases in other sources of local public health funding and funding generally "not keeping up with the costs of doing business." While OHA leadership acknowledged the difficulty of boom-and-bust public health funding, they also described a "resource scarcity mindset" as a barrier to shared and equitable financing for Modernization. Both OHA and LPHA participants recognized geographic gaps in CBO funding as an equity issue, and one OHA leader described changes to the Public Health Equity Grant selection process that gave preference to applications from CBOs serving rural and frontier communities to address said gap. Lastly, OHA and LPHA participants differed in their perception of how CBOs are held accountable to the

funding they receive. While one LPHA participant commented that CBOs are not held accountable to the funding given their exclusion from the accountability metrics framework, another OHA program staff participant who supports administration of the Public Health Equity Grant referenced quarterly expenditure and activity reporting that OHA receives from CBOs as evidence of grant monitoring.



Shared Communications

Shared communications is not a feature of the Framework for Aligning Sectors but was identified as another core component for effective collaboration in the Chapter 2 literature and added to the study framework. Shared communications is defined as a "feature of aligned systems in which sectors have a shared communications strategy that centers community storytelling." Four themes relating to shared communications were identified. Themes relate to 1) experiences with shared communications during early Modernization implement; 2) varied capacity for accessible communications within OHA programs supporting Modernization; 3) a decrease in shared communications over time and the current lack of a shared communication strategy; and 4) a lack of materials that have shared language describing the purpose of Modernization and the funded partners.

Early Shared Communications

LPHA participants described work between LPHAs and OHA – both inside and outside of the Conference of Local Health Officials (CLHO) structure – to develop a shared communications

strategy and supportive materials early in Modernization implementation. One LPHA participant reflected on several facets of early communications planning, beginning with conversations on what the public health system transformation initiative would be called and work with an external communications contractor to develop shared, multi-format communications materials: "We had in fact spent a lot of time thinking about even first what do we call it? Modernization – not everybody loved that term – so we kicked around a lot of other ideas too. And we worked with a communications team at PSU [Portland State University] to come up with our primary messages to decide how do we use communication theory and what we know about the public health brand in the public to sell Modernization. There was a lot of time spent on that and developing the roadmap, and there were videos done, and there was a lot of effort put into having a shared communication strategy" (Urban LPHA Focus Group). The LPHA participant further reflected on being able to adapt communications materials to their local context and using context-specific – but still shared – talking points to meet with legislators about Modernization funding in a coordinated effort, saying, "We all had the same messages and the same access to that type of resource. We could adapt the communications for our local context too, we had a couple graphics that we would make specific too. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. We did do that earlier. It felt like a good collaboration too" (Urban LPHA Focus Group).

> "We all had the same messages and the same access to that type of resource. We could adapt the communications for our local context too, we had a couple graphics that we would make specific too. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. We did do that earlier. It felt like a good collaboration too."
>
> – Urban LPHA Focus Group

OHA leadership offered more recent examples of shared communications. One OHA leader acknowledged that "we have opportunity here to do a better job [with shared communications], if I'm being honest," but highlighted case studies of local Modernization implementation created through OHA's ongoing evaluation of Modernization, as well as "some nice videos that were done with interviews from local public health and community-based organizations about their work in the community" developed through an OHA contract with a communications firm (OHA Leadership KII 2). The OHA leader further highlighted a "really beautiful moment" in which several CBO grantees testified in support of the Public Health Division's budget and requested investment in Modernization and "really were able to tell stories about the work and the breadth and reach of these resources going into communities" (OHA Leadership KII 2).

In the context of shared communications, one CBO participant described the benefit of OHA "being a champion" and sharing out information about their organization's programming, which "is more compelling because they're more well known to certain entities compared to if we were to reach out" (COC CBO Focus Group). The CBO participant further detailed how

OHA is “obviously well-known and well regarded, so it helped with growth and spreading the message out of what we're trying to do” when OHA shared information about the CBO’s “EnviroNatal Equity Week” event, which supported connections with other organizations in the region with which they had not previously partnered (COC CBO Focus Group). While the CBO participant also emphasized effective communication between their organization and OHA generally, they did not describe co-developing shared communications strategies or materials with OHA or any communications work with the LPHA in their service area (COC CBO Focus Group).

Capacity for Accessible Communications is Varied

OHA leadership also described systematic efforts within OHA to ensure communications coming from the state public health division are culturally- and linguistically-responsive. These examples were described in the context of shared communications, despite focusing on unidirectional communications coming from OHA to culturally-specific communities. Reflecting on the governmental public health’s capacity for communications during the COVID-19 pandemic response, one OHA leader acknowledged that “the public health system was not prepared to communicate broadly with people across the state simultaneously and the right methods and in the right languages” (OHA Leadership KII 1). However, another OHA leader emphasized gains in culturally-responsive communications during the pandemic response, describing how CBOs served as “extenders to the public health system to communicate about health risks of COVID-19 in culturally- and linguistically-responsive ways that really met the needs of their communities and ways in which community members would best receive the information” (OHA Leadership KII 2). Relatedly, another OHA leader noted a key

recommendation from an evaluation of OHA's pandemic response was that the public health system should maintain "our expanded ways of communicating to make sure that everyone has access to important public health information" (OHA Leadership KII 1). The OHA leader acknowledged that "we've lost some of those gains" as timebound COVID-19 funding has left the public health system, but the commitment that "if it's not ready to be shared in all languages and modes of communication, then it's not ready to be shared" has remained in the OHA communications ethos (OHA Leadership KII 1).

Another OHA leader reflected on how certain programs and teams within OHA continue to center culturally-responsive and accessible communications, including in regular communications with Modernization-funded CBOs, highlighting, "things like our newsletters and those types of communications, which we automatically translate into Spanish…That and we also always have either closed captioning and/or interpretation depending on the meeting and which of our partners will be there, because we do have some CBOs that are only Spanish speaking" (OHA Leadership KII 3). However, the OHA leader noted this commitment to accessible communications is not universally supported across OHA, recalling "that's made us push back on all the people that want us to send stuff out to our [CBO] grantees. When I ask, 'Do you also have it in Spanish?' I would say that's a real weakness when it comes to Modernization outside of our team, quite frankly, is language access and it's very much an afterthought" (OHA Leadership KII 3).

> "…we do have grantees that are Spanish speaking and that's made us push back on all the people that want us to send stuff out to our grantees when I ask, 'Do you also have it in Spanish?' I would say that's a real weakness when it comes to Modernization outside of our team [the OHA-PHD Community Engagement Team], quite frankly, is language access and it's very much an afterthought."
> – OHA Leadership Key Informant Interview 3

The leader further emphasized that this communications capacity largely comes from the intentional hiring of bilingual and bicultural staff to the Community Engagement Team that serves as OHA liaisons to CBOs receiving Modernization funding. The OHA leader noted that this concentration of bilingual and bicultural staff may be limited to the team supporting the Public Health Equity Grant with implications for consistent culturally-responsive communications at OHA: "I have a lot of staff that are bilingual and bicultural, and not everyone else does, so there's then either this want for my team to translate and or a need to send it to Pubs [OHA Publications Department], which can take two weeks. I've just seen us push back to make sure things are accessible" (OHA Leadership KII 3). Despite OHA's enhanced capacity for accessible communications to CBO grantees, the OHA leader emphasized "I do not think OHA is good at communications… especially when it comes to communicating to community" and highlighted the distinct roles for OHA and CBOs in communicating to community members: "give them [CBOs] money and…give them access to technical assistance…to develop their own public health materials. We, as the state, should be providing facts and science. Let them make a TikTok. Let them make a cool poster with the QR code. They're better at it than we are" (OHA Leadership KII 3).

Current Shared Communications Strategy Lacking

Similar to other themes, shared communications activities described in early Modernization implementation were not continued after the COVID-19 pandemic response and OHA's funding of CBOs for Modernization. All partner groups acknowledged a current lack of shared communications. One OHA leader acknowledged that "the communications that we have been doing up to this point have been a little bit disjointed" and asserted there are "a lot of opportunities for thinking about how we talk about public health and a modern system more collaboratively across all parts of the system" (OHA Leadership KII 1). The OHA leader further noted siloed communications efforts across partner groups, including CBOs that "tap into" OHA contracts with communications firms to "support their communications efforts with their communities on different topics" and how LPHAs – through the Conference of Local Health Officials – "invests a lot in collecting information and telling the story of local public health" (OHA Leadership KII 1). Lastly, the OHA leader acknowledged that OHA's communications on Modernization "have been pretty small given the overall picture of Public Health Modernization and not a whole lot of connection" (OHA Leadership KII 1). One LPHA participant affirmed that "If we're talking about shared communication in our work with OHA and CBOs, that to me doesn't appear to be happening" (Urban LPHA Focus Group).

Similar to previous themes, one LPHA participant attributed the lack of shared communications to fragmentation of shared purpose after the COVID-19 pandemic and including CBOs as a formal partner in a historically government-focused initiative, saying "We had communication messages we had developed over a few years. We had put so much effort into that development and then for that definition of what Modernization is to change basically overnight. I think it goes back to we don't even know what Modernization is now. It's very

difficult to communicate about something that you don't understand any longer, or that it doesn't mean the same thing that it meant before" (Urban LPHA Focus Group). The LPHA participant emphasized that LPHAs in their region continued to advance "a lot of work around really sharing with our local representatives and our local leaders on how Modernization has impacted us at a local level regarding shared epi, communicable disease, infection control…and really worked hard in [our region] to kind of co-create that" (Urban LPHA Focus Group). However, the participant noted that while LPHAs continued to develop local communications together, "from my perspective, there seems to be a disconnect with – especially if we're talking about funded CBOs – the communication from OHA and with our CBOs" (Urban LPHA Focus Group).

Another LPHA participant thought this disconnect was exemplified in recent videos produced by OHA that broadly showcase partnerships between LPHAs and CBOs at the expense of clearly describing the purpose and outcomes of Modernization for a lay audience: "I think the communications has changed as the vision has changed. The communications that I see now…an example of a great partnership between an LPHA and a community-based organization…I think that's what OHA is thinking as Modernization communications, but it was just about how we work well together and what we did together during the pandemic and stuff" (Urban LPHA Focus Group). The LPHA participant hoped that this disconnect might "look different moving forward with this new funding opportunity" (Urban LPHA Focus Group), referencing the next round of funding to CBOs and commitments from OHA to better incentivize and facilitate alignment of CBO and LPHA funded activities.

One CBO participant described "definitely providing information that's feeding it [communications materials produced by OHA]," but acknowledged not being engaged in a process to co-create the materials with OHA, saying "I just don't know if we're necessarily

involved in what's actually produced at the end" (COC CBO Focus Group). The CBO participant further described their absence in the process of communicating on Modernization, saying "I don't recall being asked to kind of review, 'hey, this is what we're gonna let your legislator know or this is what's we're going to put on our website.' So, I know we are involved, but not necessarily throughout the whole from beginning to end" (COC CBO Focus Group). CBO participants also described the need for OHA and LPHAs to "increase their communication amongst each other, so that when they are reaching out to organizations for any collaboration or partnerships or proposals, they align with each other" (COC CBO Focus Group). The CBO participant described how the lack of coordinated communications between state and local governmental public health leads to "different messages in how we do the work itself…which put our organization in a difficult situation as to, okay, so how do we move forward, right?" The CBO participant affirmed "We all have the same priority, we want to serve the community, we know that they're asking for this, and there's mixed messages at times" (COC CBO Focus Group).

> "I just don't know if we're necessarily involved in what's actually produced at the end. I think we are definitely providing information that's feeding that, but I don't recall being asked to kind of review, hey, this is what we're gonna let your legislator know or this is what's we're going to put on our website. So, I know we are involved, but not necessarily throughout the whole from beginning to end."
> – Communities of Color CBO Focus Group

Similar to other themes, several LPHA participants were concerned that the lack of a shared communications strategy and materials negatively affected the public health system's ability to advocate for sustained investment in Modernization. One LPHA participant reflected on the 2023 legislative session, saying "it made it hard to continue to advocate for Modernization money when we're all talking about very different things" (Rural LPHA Focus Group), while another LPHA participant acknowledged "I don't know what the plan is as we head into legislative season for how we're talking about Modernization…It helps to have a unified message. To be on the same page would be optimal. I think we would be more effective. If we're divided, the legislature is going to ask questions like why are we funding this? It's not ideal" (Urban LPHA Focus Group).

Supportive Materials Lacking

In addition to a lack of shared communications strategy, LPHA and CBO participants also described a general lack of information on Modernization as a barrier to shared communications, including information on who is being funded locally and guidance on how to implement Modernization. One CBO participant recalled "Every single conversation that we've had of late…The question somebody always asks from a CBO is 'Do you have a list of LPHAs who are doing this work or who have best practices or who aren't doing this work, or who need help or who don't need help?' And more often than not, the answer is no. And that makes it challenging" (OPP CBO Focus Group). Similarly, one LPHA participant emphasized that it is "pretty dang hard to have shared communication" when LPHAs are not invited to spaces where CBOs share "really cool stories of the cool work that they're doing" and the information on who is funded for

Modernization and the work they are funded to do in local communities is not "put in a central database that we could see" (Rural LPHA Focus Group).

> "Every single conversation that we've had of late…The question somebody always asks from a CBO is 'Do you have a list of LPHAs who are doing this work or who have best practices or who aren't doing this work, or who need help or who don't need help?' And more often than not, the answer is no. And that makes it challenging."
>
> – Other Priority Populations CBO Focus Group

One LPHA participant who was relatively new to Modernization hoped for a "more organized and cleaner system for communications between OHA and LPHAs" and described doing "a lot of Googling and searching through odd links and all that to try and find just very basic information about Modernization and how we're supposed to do it…making sure we're keeping to what we're required to do and what CBOs are funded or not funded" (Rural CBO Focus Group). In the absence of clear and centralized communications resources, the participant described creating a page on their organization's website for Modernization and lamented "that was really me writing it and putting up what I feel is my interpretation of what we're doing. If it's truly this structure where we're trying to be aligned in messaging, then I think we should have an aligned message to share" (Rural LPHA Focus Group). The LPHA participant concluded that a shared communications infrastructure and materials would "assist me in better communicating to my community…the wishy-washy guidance doesn't help me in how I'm facing our

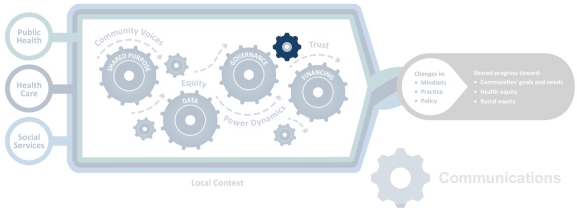
community…the squeeze of LPHAs is we answer to the community, as we should. But Modernization has made that work harder for me" (Rural LPHA Focus Group).

Shared Communications Similarities and Differences Across Partner Types

OHA and LPHA participants described the development of a shared communications strategy and supportive materials early in Modernization implementation. LPHAs commented that these shared communications activities with OHA did not continue after the COVID-19 pandemic response and OHA's funding of CBOs. One LPHA participant attributed the lack of ongoing shared communications activities to the fragmentation of shared purpose; the participant reasoned that OHA and LPHAs no longer knew how to communicate about a historically government-focused initiative after the inclusion of CBOs. All participant groups emphasized a current lack of shared communications, including the absence of both an overarching strategy and related materials to support funded partners in telling the story of Modernization.

One OHA leader highlighted recently-developed videos showcasing LPHA-CBO partnerships as examples of progress on shared communications; however, an LPHA participant did not consider these OHA-led communications activities as shared given the lack of connection to an agreed-upon communications strategy. Also, the LPHA participant did not agree with the strategy behind these new materials, asserting the videos broadly showcase local partnerships at the expense of clearly describing the purpose and outcomes of Modernization for a lay audience. This example demonstrates the downstream implications of an unclear shared purpose. While CBO participants described effective communication between their organizations and OHA program staff and providing information to OHA through activity reporting thought to contribute to communications materials, they also acknowledged not being engaged in a process to co-

create communications strategy or materials with OHA and LPHAs. LPHA and CBO participants also commented on a general lack of information on Modernization as a barrier to shared communication, including details on who is being funded and for what activities and guidance on how to implement Modernization.



Trust

The Framework for Aligning Sectors describes trust as "necessary in collaborative efforts" and defines trust as both relational trust "earned through shared experiences and backgrounds" and transactional trust "earned through interactions and give-and-take." The Framework for Aligning Sectors further emphasizes that trust "may need to be rebuilt or regularly renewed." Four themes relating to trust were identified. Themes relate to 1) a current lack of trust between OHA and LPHAs and barriers to rebuilding trust; 2) the negative impacts of broken trust on collaborative processes and spaces; 3) an increase in trust between CBOs and governmental public health over time; and 4) opportunities for rebuilding trust between Modernization partners.

Lack of Trust Between Oregon Health Authority and Local Public Health Authorities

Most comments on trust were from LPHA participants who described a lack of trust in OHA stemming primarily from the unilateral decision to fund CBOs for Modernization following the COVID-19 pandemic response. One LPHA participant asserted that OHA's decision to fund CBOs directly without the involvement of local public health "completely undermined that shared purpose" and questioned OHA centering equity to defend the decision: "They did it in the

name of equity, which was also very frustrating because as if we were not partners in equity and they needed different partners and the power dynamics were never acknowledged and it broke trust" (Urban LPHA Focus Group). Another LPHA participant affirmed that OHA deciding to fund CBOs "was done really secretly" and reflected on the impact on trust, saying "I just have to say that trust, which I know was a small little cog there [in the Framework for Aligning Sectors], but for me trust is a big cog. And OHA really blew a lot of political and personal capital by the way they did this" (Rural LPHA Focus Group).

One LPHA participant emphasized that LPHAs were not concerned with OHA unilaterally deciding to fund CBOs to support culturally-specific outreach during the COVID-19 pandemic response, but rather that the exclusion of LPHAs from decision-making continued well after the most acute phase of the pandemic response, including decisions about Modernization funding: "When all of a sudden it was sprung on us that it was now Modernization money [going to CBOs]…I think trust was obliterated multiple times" (Rural LPHA Focus Group). In addition to OHA's initial decision to directly fund CBOs for Modernization, one LPHA participant also attributed the lack of trust to the process by which OHA developed the Modernization policy option package during the 2023 legislative session in which funding conversations with LPHAs and CBOs were kept siloed, saying "that kind of stuff tremendously detracts from the trust that you need to have to move forward. So, I know the LPHAs have had this big problem with the state. This is where it comes. You know, you can't go ahead with the funding like that and do it as 'this has already been submitted' without any discussion of what the funding is, so who knows what the financing is about" (Rural LPHA Focus Group).

> "I would just say that when CBOs were funded without any LPHA input during COVID, we all kind of chalked it up to it was an emergency, you know, decisions had to be made. Fine, totally fine. Water under the bridge. But when all of a sudden it was sprung on us that it was now Modernization money, and I think trust was obliterated multiple times. One, we weren't told half of our funding is going away to CBOs. Then the second time it was crushed was when we were completely cut out of the RFA process. We were not allowed to know who had even applied, what they were applying for, we couldn't see the applications. Zip. And then it was like super secret when they were going to tell us who was funded. So, it was just over and over and over again. The trust was just, once again, broken."
>
> – Rural LPHA Focus Group

LPHA participants described several OHA staffing issues as barriers to trust. One LPHA participant attributed the lack of trust to the absence of OHA leadership in Modernization governance spaces, saying "the people who should be there [in PHAB], like the public health director, she's almost never there…she doesn't come to the LPHA meetings, she doesn't come to the CLHO meetings" (Rural LPHA Focus Group). Another LPHA participant asserted that OHA staff turnover also "kind of erodes the trust… people aren't committed to the work, they're here, and then they get as frustrated as everybody else and they want to just move on… it takes us all kind of being committed to the work and working together to rebuild the trust" (Rural LPHA Focus Group). Lastly, another LPHA participant recalled an interaction with an OHA staff person who did not understand the role of LPHAs in Modernization: "Recently reached out to

one of the CECs [community engagement coordinators] and quote, 'I don't know much about LPHAs or what they do'… That's not this person's fault, but that further eroded trust that I had in OHA and their genuine effort to make amends and make this work for everyone" (Rural LPHA Focus Group).

Several LPHA participants clarified that the mistrust with OHA is concentrated in certain programs rather than individual staff who have maintained a high level of trust with LPHA staff. One LPHA participant emphasized "I want to be careful when we say 'OHA,' that we're not lumping it all together, because I find that there's still quite a bit of trust and shared decision-making when it comes to working with the public health programs at the state level for most part" (Urban LPHA Focus Group). The participant further questioned "how much even the internal folks at OHA at the programmatic level had input into what decisions were made" and affirmed that "It's really at the director level that I think a lot of trust was broken" given perceptions that the Public Health Division Director's Office unilaterally made decisions to directly fund CBOs (Urban LPHA Focus Group). Another LPHA participant similarly highlighted trust in individual OHA staff and perceived these staff to lack control over agency decision-making: "I think all of them are great, but they're being told what to do in these areas and they privately apologize for the way this has been done. So, I think the trust in the individuals at the OHA is high. The trust in the way this came out is at an historic low" (Rural LPHA Focus Group).

LPHA participants expressed a desire to discuss past decisions and ways to move forward together and attributed OHA's lack of willingness to dialogue about past harms as a barrier to rebuilding trust. One LPHA participant felt "a lot of gaslighting happened" when asking OHA about the decision-making process to fund CBOs for Modernization "because I hear lots of

different things." The participant recalled "if you even bring that up, we're just seen as not willing to work with CBOs or not willing to see OHA's vision in this. So, it's really disheartening, you almost can't have those honest conversations" (Urban LPHA Focus Group). Another LPHA participant contrasted the apparent desire of some OHA staff to make amends with the lack of a formal apology of past harms, saying "we've all been through it personally. Like, you mess up, you feel terrible, you desperately want forgiveness and for them to instantly trust you again…they're troubled by it, and it hurts their personal feelings, but then at the end of the day, it's, quite frankly, an empty apology" (Rural LPHA Focus Group).

One LPHA participant perceived OHA's trust in LPHAs to decrease over time, saying "over the years that there's this norm where almost all levels, programs and director's office, that there is less trust in LPHAs" (Urban LPHA Focus Group). Another LPHA participant affirmed this sentiment, saying "we are not trusted to know our community, to know our work, to do our work well, to know what's best or how we how we go about it…This real lack of trust in my expertise to do my work and to continue these partnerships that I've worked on for many, many years" (Rural LPHA Focus Group).

> "I feel like there's another trust issue here of that I'm not trusted, or that we are not trusted to know our community, to know our work, to do our work well, to know what's best or how we how we go about it. So, my lesson learned is I'm kind of on my own to repair these relationships…This real lack of trust in my expertise to do my work and to continue these partnerships that I've worked on for many, many years."
>
> – Rural LPHA Focus Group

One LPHA participant attributed OHA's lack of trust in LPHAs to assumptions of low capacity to implement Modernization and was concerned these assumptions fed a harmful narrative to centralize public health services: "We are overburdened and that's part of the rationale for funding CBOs. Then there's also been this rhetoric around if LPHAs can't do this and OHA doesn't trust them, I've heard comments about centralizing local public health and counties give up their local public health authority and those things are really, really concerning. When those things are circulating it really breaks down trust in our system" (Urban LPHA Focus Group). Another LPHA participant affirmed "there were a lot of assumptions being said about LPHAs [during the COVID-19 response] that just weren't true, and that OHA just had to go in and do it and help" (Urban LPHA Focus Group).

Two OHA participants who primarily support the Public Health Equity Grant program for CBOs commented on their trust of LPHAs. One OHA leader admitted "LPHAs lost trust for me early on in this process" after being treated poorly by local public health administrators in a public meeting related to CBO funding. The OHA leader recalled "I kind of was hurt by that right from the get-go" but also described meeting with these same LPHA administrators for an in-person dinner and resolving much of this interpersonal conflict (OHA Leadership KII 3). One OHA program participant described initially feeling like LPHA staff "were trying to top-down tell OHA and CBOs what to do and were very much interfering when we were still trying to figure out how things were going to work" (OHA Program Staff Focus Group). Similar to the OHA leader, the OHA program participant emphasized increasing trust over time as they received "more exposure and more experience [with LPHAs], I see more from that perspective…this was probably very much a shock to LPHAs, this is a huge shift in the way things have been working'" (OHA Program Staff Focus Group).

Negative Impacts of Broken Trust on Collaborative Capacity

LPHA and OHA participants described several implications for the lack of trust in the post-COVID-19 implementation period, including negative impacts on formal collaborative processes and spaces. One LPHA participant asserted that the lack of trust in OHA has contributed to the siloing of Modernization advocacy efforts given "we cannot depend on OHA to advocate for local public health. They've made that really clear. So, we have to do the advocacy for ourselves if we're going to get the funding" (Urban LPHA Focus Group). Another LPHA participant described how the lack of trust in OHA extended to PHAB and influenced local public health participation in the governance space: "several of the LPHA directors dropped out and they said, 'I can't do it anymore'…that I think is indicative of how disingenuous the whole thing became" (Rural LPHA Focus Group). One OHA leader was aware of the lack of trust in PHAB, acknowledging "there were a lot of questions and maybe some broken trust that happened during the pandemic about decisions and conversations that were happening outside of PHAB and then those happening in PHAB…I hear members continue to sort of reflect back on decisions that were made three years ago outside of PHAB and it just broke a lot of trust for people that are in that space" (OHA Leadership KII 1). The OHA leader did not describe any actions OHA has taken to address to repair trust despite their awareness of the problem.

> "There were a lot of questions and maybe some broken trust that happened during the pandemic about decisions and conversations that were happening outside of PHAB…I hear members continue to sort of reflect back on decisions that were made three years ago outside of PHAB and it just broke a lot of trust for people that are in that space."
>
> – OHA Leadership Key Informant Interview 1

In addition to the impacts on collaborative processes and spaces, LPHA participants also described how the lack of trust between OHA and LPHAs affects the relationships with CBOs and community member in their jurisdictions. One LPHA participant asserted that barriers to trust with OHA "trickles down to the trust that us as local public health jurisdictions have with our community members and the clients" and described the additional labor required to "rebuild, restructure, reinforce relationships that I have built with our CBO partners, who may or may not have gotten funded for great work they're doing" (Rural LPHA Focus Group). Another LPHA participant affirmed "my lesson learned is I'm kind of on my own to repair these relationships" (Rural LPHA Focus Group).

Relatedly, several LPHA participants described needing to counteract a false narrative that emerged in the post-COVID-19 period that LPHAs do not want to collaborate with CBOs on Modernization. One LPHA participant emphasized that local governmental public health was not concerned with sharing power and resources with CBOs since "we've done that for years and we continue to work on that" but rather OHA's unilateral decision to directly fund CBOs which revealed "that the power was held at the top at the state level" (Urban LPHA Focus Group). The

participant further reflected that “I feel like we often get told we just don't want to work with CBOs, or we had to do this because LPHAs were refusing to work with CBOs and that's just a narrative that is just not true” (Urban LPHA Focus Group). Another LPHA participant affirmed “LPHAs have been painted as people, entities that don't want to collaborate with CBOs. And it's kind of been this whole false narrative, so I would say the point of the frustration is not that we don't want to work with our local partners. It was the way that it was done and the lack of inclusivity with the whole thing” (Rural LPHA Focus Group).

> “Through all of this LPHAs have been painted as people, entities that don't want to collaborate with CBOs. And it's kind of been this whole false narrative, so I would say the point of the frustration is not that we don't want to work with our local partners. It was the way that it was done and the lack of inclusivity with the whole thing…So we are navigating and we're trying to simply make the best of a situation that is tricky, while also preserving, quite frankly, our integrity and our reputation.”
>
> – Rural LPHA Focus Group

One LPHA participant described the coordinated response to the “false narrative” through the Conference of Local Health Officials (CLHO), saying “CLHO has been tasked, maybe by ourselves, to put forth these statements around like, ‘well, we like working with our CBOs and why do you keep treating us like we hate CBOs and we don't want to collaborate?’ So, we've put forth this effort to make purpose statements” (Rural LPHA Focus Group). The participant emphasized the shared work on the purpose statements has strengthened relationships and trust between LPHAs, which has been “one bright spot that’s come out of all of this” (Rural

LPHA Focus Group). The participant further clarified, however, that the purpose statements from LPHAs feel "aspirational" given OHA's lack of support in countering the harmful narrative (Rural LPHA Focus Group). One OHA program participant acknowledged that this false narrative is reinforced by some OHA staff who support the CBO Public Health Equity Grant program and attributed this perspective to a lack of clarity on the role of LPHAs in Modernization: "I've heard that some CECs [community engagement coordinators] may have misperceptions and misunderstanding about LPHAs are against CBOs, which I don't think that's really true for the most part, I think it's a lot more complex than that. And it could be the same thing in our team just not understanding all the players accurately and fully" (OHA Program Staff Focus Group).

CBO Trust in Partners Increased Over Time

CBO participants described having mutual trust with OHA, specifically with OHA staff that support administration of the Public Health Equity Grant program. One CBO participant emphasized "my relationship with our CEC [community engagement coordinator] has been a critical component of the trust I feel with OHA" (OPP CBO Focus Group). Similar to LPHA participants, one CBO participant distinguished positive relationships with individual OHA staff and perceived barriers to transparency coming from higher levels of the organization that contribute to a lack of trust in OHA. The participant reflected that "when it comes to OHA, that has been the trickiest for me in my experience, because which OHA? I work with probably at least 38 different OHAs right? Sometimes frontline staff is supportive, but they have a barrier higher up in the public health division or it's blocked at above the division level or the governor's office could block it. There's not a lot of transparency about how far feedback goes sometimes"

(OPP CBO Focus Group). The participant linked transparency and trust, saying "the amount of transparency shown is often the difference between retaining and building trust versus undermining trust" but – similar to LPHA participants – acknowledged "there are a lot of things that impact trust that we understand are outside of the control of the LPHA or OHA staff members we work with directly" (OPP CBO Focus Group).

Another CBO participant acknowledged that while OHA has "the very first and last say" of what their funded work can look like given funding parameters, they highlighted that OHA "trusts our organization to be able to do the things that they want us to do with this grant, and they're allowing us to have the freedom to do that" (COC CBO Focus Group). At the local level, another CBO participant reflected on their relationship with the LPHA in their jurisdiction, saying "it's not that I don't trust – they haven't been dismissive – but I'd like to have a more stable, inclusive, back and forth type of relationship" (OPP CBO Focus Group). An LPHA participant described building trust with local CBOs they had not worked with in the past through provision of funding, saying "we built trust in our CBOs – these brand-new ones that we had never heard of – through their really excellent work together with us" and clarified that "we had trust in each other, but only the LPHA had zero trust in OHA" (Rural LPHA Focus Group).

One CBO participant was careful to distinguish between the trust that CBOs receiving Public Health Equity Funding have with LPHAs and OHA and the trust that marginalized community members have in government institutions: "I feel more at ease engaging with LPHAs and OHA. I don't know that I've seen much change in the actual community and especially BIPOC communities. I think there is a little bit more trust, but I don't think that if we were to measure it on a scale of 1 to 10, it is definitely in the low fives or under five" (OPP CBO Focus Group). The participant further explained that while government funding was made available

during the COVID-19 response to support underserved communities, the result that many organizations began to hire BIPOC people to engage with those communities felt tokenistic given "the culture of the organization is not ready to have that change, so it feels very superficial, it's kind of ugly" (OPP CBO Focus Group). The participant further explained that "in the eyes of the state, in the eyes of the public health departments, there is engagement happening, but in reality it is extremely superficial so there's no relational trust. And here we are perpetuating that cycle of lack of relational trust between underserved, marginalized communities and public health agencies" (OPP CBO Focus Group).

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> – Other Priority Populations CBO Focus Group

Trust-Building Opportunities

All participant groups described opportunities for trust-building, including both individual actions and organizational supports. As described in the shared governance theme, LPHA participants emphasized that a formal acknowledgement of past harms, primarily related to excluding LPHAs from funding decisions post-COVID-19, would help rebuild trust. One LPHA participant commented "I think there is a way we can move forward and rebuild that trust. There just has to kind of be a willingness and an openness to that [from OHA]. And maybe a little bit of admission of…you held all the power and how can we rebuild that differently?" (Urban

LPHA Focus Group). The LPHA participant concluded that to date, acknowledgement of past harms from OHA has come in "bits and pieces, but not like a whole-hearted apology or real effort to rebuild trust" (Urban LPHA Focus Group). Complementary to the desire for OHA to explicitly address past harms, one LPHA participant hoped that with a new permanent public health division director "we will hear a clear commitment of support for local public health and understanding the value and the distinction in roles, that would be really helpful" (Urban LPHA Focus Group).

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>
> – Urban LPHA Focus Group

All participant groups described organization-level considerations for trust-building. Both LPHA and CBO participants commented on OHA staff turnover as a barrier to developing trusting relationships. One CBO participant distinguished between the transactional trust based in OHA's provision of resources to CBOs and relational trust arising from authentic connections: "a further challenge with the public health funding specifically is that a lot of that trust was built initially through transactional trust-building. Like, here are some resources, you're doing great work, let me fund you. But it's still new, so there's a lot of deeper relationship building that needs to be built and that's been disrupted in my experience and observation by this constant staff transitions" (OPP CBO Focus Group). (As described in the Framework for Aligning Sectors,

transactional trust is earned through interactions and give-and-take, whereas relational trust is earned through shared experiences and backgrounds.[1]) An LPHA participant affirmed the negative impact of staff turnover on trust, saying "a lot of turnover in staff kind of erodes the trust. Like, people aren't committed to the work, they're here, and then they get as frustrated as everybody else and they want to just move on" (Rural LPHA Focus Group).

One OHA leader acknowledged staff turnover within OHA and also reflected on the role of turnover within LPHAs on building trust: "…since the beginning of the pandemic, something like more than a third of local public health authorities have new leadership. And we've been through similar significant leadership transitions in the public health division here. I think that's a piece where it has been a loss in some of the relationships and sort of organizational trust, as well as people trust" (OHA Leadership KII 1). Relatedly, the leader reflected on how OHA's Local and Tribal Public Health Manager has been able to cultivate "a really authentic relationship" with local and tribal health leaders and affirmed the need for staffing stability given these relationships were "not something that she developed in a year, it's something that she developed over a decade or longer" (OHA Leadership KII 1). The OHA leader further described how OHA and its partners are able to move through difficult decisions when trusted relationships are in place, saying "…it's a trusted relationship and it's an authentic relationship. And when decisions are made, there's trust in the communication between [OHA Local and Tribal Public Health Manager] and the tribal health directors about why the decision was made and everything, so the relationship doesn't get interrupted" (OHA Leadership KII 1).

In addition to OHA staff retention, one CBO participant emphasized that "trust doesn't start until you have a true understanding of who your partner is" and suggested that OHA can foster trust with CBOs by clarifying organizational structures and the roles and responsibilities of

OHA staff: “I don't think it's very easy to understand how and who and where and why to talk to the right person within OHA for the right reasons. They're simple things like organization structures, roles and responsibilities, who to call, for what, and when, FAQs. Those are super simple things that government entities could do. And they might exist, but I don't know where they are and that makes it hard to navigate” (OPP CBO Focus Group). The CBO participant further emphasized that a better understanding of OHA’s organizational structure might ensure that a “CBO is not left in the dark” when inevitable changes in OHA staff occur (OPP CBO Focus Group). The CBO participant also commented “constantly changing reporting requirements, budget requirements…that’s really disrupting that deeper trust-building process” and affirmed that trust-building requires “having reliable understanding of expectations, having consistency, and timely follow through for contracts, resources, funding deliverables from OHA that CBOs rely on” (OPP CBO Focus Group). The participant’s reflection hints at constraints on OHA staff capacity – in addition to staff retention – impacting trust between OHA and funded partners.

Another LPHA participant emphasized that it is “tricky” to rebuild trust with OHA when staff do not understand, and therefore value, the role of LPHAs in Modernization, recalling “OHA hired these community engagement coordinators and I thought it was to help bring LPHAs and CBOs together, kind of like facilitate the conversation, facilitate the connection, anything like that. Recently reached out to one of the CECs and quote, ‘I don't know much about LPHAs or what they do’” (Rural LPHA Focus Group). The LPHA participant acknowledged that while “I don’t think this person meant it malicious, they were just talking,” the interaction nonetheless “further eroded trust that I had in OHA and their genuine effort to make amends and make this work for everyone” (Rural LPHA Focus Group). The participant’s experience strongly

suggests a need for more robust onboarding to Modernization that emphasizes the distinct but complementary roles of all public health system partners. Similarly, an OHA program staff participant acknowledged that trust may be limited by "our team just not understanding all the players accurately and fully" and recommended a "dedicated person that can really focus their energies on bridging and trust" because OHA staff currently share this responsibility and "everyone's doing it on top of a billion other things on the to do list and that's not going to cut it" (OHA Program Staff Focus Group).

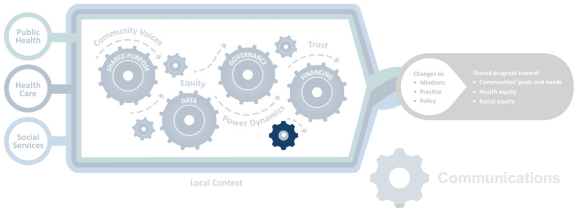
Complementary to staffing considerations, one LPHA participant emphasized that "trust is really relational" and contrasted the pre-pandemic work context in which "program staff [at OHA] would come out to LPHAs" to build relationships and trust with post-pandemic virtual work that offers fewer opportunities to develop personal and in-person connections (Urban LPHA Focus Group). Relatedly, another LPHA participant recalled the impacts on trust-building when the previous public health director's plans to visit all LPHAs were interrupted by the COVID-19 pandemic: "She had talked about visiting all of the counties as well, but did not do that. And there was a pandemic, so we can give her a break…once that happened, it was not possible to heal or do things differently or take a different turn. But we do we do need to do things differently now" (Urban LPHA Focus Group). One OHA leader understood the need for staff to be more present in local communities to build relationships with partners and better understand the context in which they work: "it behooves us [OHA] to get into communities, not just community-based organization events, but into local public health authorities and their work to really understand the context of what it is like to do public health in all different parts of the state with many different dynamics, geographies, political affiliations, because we often don't

understand those since they're not necessarily the communities in which we live and work" (OHA Leadership KII 2).

Trust Similarities and Differences Across Partner Types

LPHA participants described a current lack of trust with OHA, primarily due to OHA's unilateral decision to fund CBOs for Modernization. In contrast, CBO participants expressed trust in OHA or more specifically, trust in the OHA program staff with which they interact for the Public Health Equity Grant. Both LPHA and CBO participants distinguished between positive relationships with individual OHA staff and more negative experiences with senior leadership and OHA as a larger organization. While LPHA and CBO participants emphasized their trust in individual staff with which they interact, they also agreed that consistent turnover in OHA staff has served as a barrier to developing trusting relationships. LPHA and CBO participants differed in their perception of OHA's trust in them; while one LPHA participant commented that OHA's trust in LPHAs has decreased over time, a CBO participant emphasized that OHA trusts their organization to implement funded work and gives them "the freedom to do that."

LPHA and CBO participants described opportunities for OHA to build trust with funded partners; however, LPHA participants suggested conversations with OHA about past harms and commitments from OHA leadership to heal and move forward together, while CBOs desired more consistent grant processes (e.g., questions asked for activity reporting) and improved access to information on OHA's organizational structure and staff roles. All participant groups acknowledged that trust is relational and agreed that building trusted relationships requires that OHA staff are more physically present in local communities to develop personal connections with LPHAs and CBOs.



Power Dynamics

The Framework for Aligning Sectors acknowledges that aligning across sectors is challenging because of the "inherent differences in dominance among sectors and between sectors and individuals" and notes that these differences in power can result from "imbalances in resources, perceived value, historical practices, influence, or experience." Four themes relating to power dynamics were identified. Themes relate to 1) power sharing between partners during the early days of Modernization implementation and a concentration of power with OHA over time; 2) processes and structures that reinforce unequal power for decision-making between Modernization partners; 3) OHA leveraging unequal power dynamics to working beyond their prescribed role for Modernization; and 4) opportunities to mitigate unequal power dynamics between partners.

Early Power-Sharing

OHA and LPHA participants recounted several examples of power sharing, primarily in the earlier days of Modernization implementation. OHA leader participants described several components of Modernization that facilitate power sharing across partners. One OHA leader asserted power sharing was present in the founding of Modernization and recalled an early "key legislator and champion" who wondered "how we build a bigger table for support for public health, so that it's not just governmental public health talking to governmental public health, but we have broader interest in the fate of the public health system in Oregon" (OHA Leadership KII

2). The OHA leader further reflected on the establishment of Oregon's Public Health Advisory Board as a "a shift in power and governance structure that placed more of the 30,000-foot level direction for the public health system into the Public Health Advisory Board" rather than decision-making power residing solely in long-standing bodies like the Conference of Local Health Officials (OHA Leadership KII 2). Another OHA leader emphasized increased power sharing within PHAB over time, describing the re-opening of Oregon statutes in 2023 to change the required composition of PHAB to include representation from CBOs and health equity experts (OHA Leadership KII 1). The same OHA leader, however, acknowledged that despite this progress, OHA must interrogate its current model of convening partners and transition from "our governmental way, like come to our meeting, at this time, here's what we will talk about" to "hearing from communities, putting them in a leadership role, letting communities tell us what they expect out of governmental public health" (OHA Leadership KII 1).

LPHA participants acknowledged that "early on, it felt like there was a lot of shared power in the sense of we were very much at the table helping make decisions" but experienced a shift that began during the COVID-19 pandemic response in which power was more centralized with OHA. The LPHA participant understood that "having to take ownership at that state level and have more of the power during COVID made sense in some ways" but asserted "we're not in that crisis anymore...so how can we shift again to where – as a governmental public health system – we have more of that shared power and decision-making moving forward" (Urban LPHA Focus Group).

> "Early on it felt like there was a lot of shared power in the sense of we were very much at the table helping make decisions and everything that we've kind of shared already. A lot of that having to take ownership at that state level and have more of the power during COVID made sense in some ways. And now we're not in that crisis anymore yet it's still remaining that way. So how can we shift again to where, as a governmental public health system, we have more of that shared power and decision-making moving forward."
>
> – Urban LPHA Focus Group

While LPHA participants generally felt power became more centralized at OHA following the COVID-19 pandemic response, OHA staff supporting Public Health Equity Grant administration described increased power sharing in recent years. OHA staff cited the increased influence of the PHAB, CLHO, and CBO Advisory Board in grant administration decisions, often counter to the preferences of OHA staff: "…the power that they [PHAB] have has really shifted our decision-making, because when they make a decision, then we implement it, right? Whether or not we agree with it. I think the same has shifted for the CBO Advisory Board. I think they're now being given more power to kind of make decisions and influence decision-making points, where and how to put money, advice on moves that we need to make" (OHA Program Staff Focus Group).

Aside from power dynamics with OHA, one LPHA participant emphasized that local public health departments have historically shared power with CBOs and cited the COVID-19 response as a recent example. The participant asserted that "…we at a local level have tried really hard to share more of the power with our local CBO partners. That became really evident

during COVID, we couldn't have done a lot of the work without them. So, I just want to emphasize that this isn't about not wanting to share that power or resources or funding with CBOs…We've done that for years and we continue to work at that (Urban LPHA Focus Group).

Unequal Power in Decision-Making

LPHA participants described power for decision-making as unequal between Modernization partners and primarily concentrated with OHA. One OHA leader commented on the institutional power – exercised through organizational rules, procedures and norms – that the state agency inherently holds. The OHA leader acknowledged that "power dynamics are pretty omnipresent" and asserted that "OHA has not focused enough on how our own power shows up and how we can identify that to continue to build relationships and authentic engagement in Public Health Modernization as a whole" (OHA Leadership KII 2). OHA and CBO participants also reflected on harmful power dynamics resulting from expert power, which refers to an individual's ability to influence people as a result of being perceived by others to be a highly skilled expert. One OHA leader commented on how expert power potentially undermines the purpose of the PHAB to share power amongst all partners – especially those with lived expertise – saying, "…there's a really natural tendency to look to the people who clearly work in public health or in governmental public health as having a level of expertise or insight that maybe should be weighted more highly than people that are outside of that governmental system. And that's really not how PHAB is supposed to be set up. The whole idea is to have those broad perspectives, because everyone's perspective is important and valuable at an equal level" (OHA Leadership KII 1).

Another OHA leader commented on how notions of "expertise" create difficult power dynamics with both LPHAs and other OHA staff. The OHA leader reflected on their early

interactions with LPHAs, saying "The dynamics with local public health is hierarchical in an interesting way…when I started this work, I really had to fight for my own credibility to be here doing this work" (OHA Leadership KII 3). The OHA leader further reflected on power dynamics internal to OHA that are rooted in conceptions of professional expertise, asserting "…there's also sometimes the sense of like 'this is my subject matter expertise and so stay in your lane' and there's not room for curiosity or criticism. I understand because I have my subject matter expertise and I'm passionate about the work I do, but I think sometimes that can be a barrier internally" (OHA Leadership KII 3).

CBO participants also reflected on how expert power influences their relationships with governmental public health. In describing why some community organizations have historically been "afraid of speaking up," one CBO participant emphasized "…when you have titles, it's really, really scary for you to open up and say, I need this and I want this kind of thing, because [community based] organizations have always been looked at as like, 'no, your job is not as important as my title' kind of thing, you know? But I think there's a reason why OHA or the county reached out to organizations because they know we can do the work and we know how to do it" (COC CBO Focus Group). Another CBO participant reflected on how expert power held by LPHAs can serve as a barrier for developing a shared language for local work: "There's that power like, 'hey, we're the local public health departments, we're the ones with master's degrees and doctorates and we got epidemiologists on our staff, and we know the data'…and a lot of times the language from CBOs is 'we're trying to work with our community, improve our community,' the language that we use is different than a local public health department" (COC CBO Focus Group).

In addition to institutional and expert power, LPHA participants emphasized that the funding model for Modernization also contributes to unequal power, with one participant recalling "the way I understand how the funding works, it's from the legislature to OHA, and then OHA has the authority or the power. I don't think there's anything in statute that says 'X percentage must go to LPHAs or CBOs' or whatever. So really all the power is with OHA and that's probably a problem" (Urban LPHA Focus Group). Another LPHA participant affirmed that "OHA holds all the power because they control the money. Sorry to be so blunt, but that's just how the power structure is set up and power is money. It's from the legislature to OHA and that's where I think OHA just holds all the power" (Urban LPHA Focus Group).

> "The way I understand how the funding works, it's from the legislature to OHA, and then OHA has the authority or the power. I don't think there's anything in statute that says 'X percentage must go to LPHAs or CBOs' or whatever. So really all the power is with OHA and that's probably a problem."
> – Urban LPHA Focus Group

One CBO participant also commented on OHA's power as a funder but viewed this dynamic as more neutral and consistent with other funders: "Obviously there's power dynamics just because OHA is the funder, they had to hold us accountable. If there's reports due at a certain time or if deadlines were met, there's always that power dynamic that's involved with these type of contracts" (COC CBO Focus Group). One OHA leader acknowledged the unequal power dynamic resulting from the flow of funding as "very real" and reflected on how Oregon's financing model differs from other states: "We're the funder, we're the state…it means all of the

funds that we get through the legislature come to OHA first and then OHA makes decisions. So that is just the way funding works in Oregon, but it's not the model in all states. Right there, it really sets up who's in control of the money, which then feels like who is making decisions about the money" (OHA Leadership KII 1).

Similar to other themes, the primary example of unequal power for decision-making cited by LPHA participants was OHA's unilateral decision to directly fund CBOs for Modernization, with one participant saying OHA's decision implied that "they needed different partners [than LPHAs] and the power dynamics were never acknowledged" (Urban LPHA Focus Group). Another LPHA participant similarly reflected on OHA directly funding CBOs and affirmed, "Clearly the LPHAs don't seem to have any power. The CBOs do have some kind of sort of funny hold over the director's office. I don't exactly understand that, but the power dynamics in this are just as screwed up as all the rest of it. You can't call ourselves partners when there's such an uneven power balance" (Urban LPHA Focus Group). OHA program staff who support Public Health Equity grant administration acknowledged the "top-down" power dynamics of early CBO grant-making in 2022 and asserted that decision-making power "has now shifted…based on feedback, based on stepping on people's toes, based on a lot of things, I think it caused a shift" (OHA Program Staff Focus Group).

Another LPHA participant distinguished between OHA leadership and program staff, asserting that power resides with leaders in the Office of the State Public Health Director, whereas if you "go down one step beneath that…those people I don't think anybody else has any power in this" (Urban LPHA Focus Group). Some OHA staff participants affirmed that "the decision-making role that programs have is very limited" and experiencing "feeling really disempowered but also feeling like I have a lot of responsibility" (OHA Program Staff Focus

Group). Reflecting on their role in decision-making for Modernization accountability metrics and the Public Health Equity grant, one OHA staff participant recounted, “I might get like, well, what do you guys think? It's up to you, you're the program. It's like, oh my gosh, like, I don't, I feel like all the decisions and things have actually been made in a different level of the organization, and so I don't know, you tell me because I don't I actually don't know, I don't know the answer to that” (OHA Program Staff Focus Group). The OHA staff participant further reflected on OHA’s tendency to “[prioritize] external partners and some of the legislature, the PHAB, now we have CBOs” at the cost of situating OHA programs “at the lowest level in terms of power and hierarchy,” including a lack of structure to share decision-making power with program leadership (OHA Program Staff Focus Group).

LPHA participants representing rural communities also described feeling “a lot less powerful in comparison to bigger counties when it comes to Modernization – just by sheer numbers – when it comes to power dynamics” (Rural LPHA Focus Group). Another LPHA participant emphasized that OHA’s CBO funding decisions concentrated power and resources in certain areas of the state, exacerbating the inherent power differential between larger and smaller county governments: “…a lot of the funded CBOs were in the metro area and there was a few counties that literally had zero CBO funding coming to their community directly…that further exemplified the power differential between the rural and the urban areas” (Rural LPHA Focus Group).

OHA Using Power to Overreach

LPHA participants further described how the unequal power dynamic has contributed to OHA working beyond their prescribed role for Modernization, with one LPHA participant reflecting,

"it has felt like OHA has reached really far into our local communities in a way that's not needed" (Urban LPHA Focus Group). Another LPHA participant noted OHA's unilateral decision-making on CBO funding as an example of overreach, saying "To make decisions on who is funded in what county without engaging local public health…it just did not feel good…the power to be able to say this CBO is funded and these aren't when you may not have a full understanding of what it looks like on the ground in any one community" (Rural LPHA Focus Group). Another LPHA participant similarly contested OHA's funding to CBOs as an example of power sharing, saying "I started hearing some staff folks refer to the work that they do as CBOs as power sharing and that was really, really, really offensive, because they [OHA] did not share their power with CBOs. They took power from local public health and gave it to CBOs" (Urban LPHA Focus Group).

> "Absolutely agree that there were issues with the power dynamics and local public health's role in our own communities and the relationships that we have with our CBOs. Definitely had direct experience with that as OHA facilitated our funded CBOs…Assuming that there were power dynamic issues between local public health and our CBOs, when really the power dynamics were now between local public health and OHA, which I had not experienced before in that way."
> – Urban LPHA Focus Group

Another LPHA participant described the activities of OHA staff who serve as liaisons between the state agency and funded CBOs as an overreach, asserting, "OHA's community engagement coordinator likes to facilitate my relationship with people, but I meet with those

people regularly, we see each other. I don't need a one-off meeting where someone else is involved in setting an agenda, because that's my work. That's the bread and butter of my work" (Rural LPHA Focus Group). Another LPHA participant similar referred to OHA staff serving as a barrier to LPHA engagement with CBOs, emphasizing that "we strive to have shared decision-making with our CBOs and our communities…so that we're identifying and co-creating strategies. What we don't want to have happen is for OHA to do that to LPHAs and hamstring us and go around us and fund CBOs and then create a problem where there isn't one" (Urban LPHA Focus Group).

OHA program staff were aware of LPHAs perceptions of overreach, with one participant reflecting, "While some LPHAs embrace partnerships with CBOs, some LPHAs have not, and they've expressed strong resistance towards what they see as OHA imposing a paradigm and specific partners upon them. That's created some real tension between OHA and LPHAs and we've been working through that" (OHA Program Staff Focus Group). While the OHA staff participant partially attributed this "resistance" to some LPHAs not wanting to partner with CBOs, this sentiment was categorically rejected by LPHA participants. Another OHA staff participant understood the source of LPHA resistance, saying "I don't think any LPHAs disagree about partnering with CBOs. I think they disagree with feeling like OHA is top-down and that started with COVID pandemic" (OHA Program Staff Focus Group). Another OHA staff participant similarly acknowledged that "…when I started I didn't fully understand the governance process and it felt very much like they were trying to top down tell OHA and CBOs what to do, and were very much interfering when we were still trying to figure out how things were going to work" (OHA Program Staff Focus Group)

Opportunities to Mitigate Unequal Power Dynamics

OHA and LPHA participants identified several ways in which unequal power dynamic can be mitigated. More generally, one OHA leader emphasized that "the way to balance the power dynamics that are real are through relationships" and cited the authentic relationship between OHA's LPHA and Tribal Public Health Manager and tribal health directors and tribal leaders, which was "not something that she developed in a year, it's something that she developed over a decade or longer" (OHA Leadership KII 1). The OHA leader further described how this "trusted relationship" mitigates tension that could arise when OHA communicates difficult decisions to tribal partners, saying "when decisions are made, there's trust in the communication between [the OHA LPHA and Tribal Public Health Manager] and the tribal health directors about why the decision was made, so the relationship doesn't get interrupted" (OHA Leadership KII 1). Similarly, another OHA leader emphasized that pre-work to build trust between partners by "meaningfully connecting, building relationships and listening to each other's unique perspectives" is essential for navigating power dynamics in shared decision-making venues: "…when we get into spaces where that power dynamic that we talked about is implicit, it is easier sometimes to not listen and hold the position. When we have done good work around trust, I think good things have happened and people have come together in a deep and meaningful way" (OHA Leadership KII 2).

In addition to more general recommendations for relationship building, one LPHA participant suggested that OHA engage an external contractor to conduct a power analysis with Modernization partners. The LPHA participant recalled that the contractor "[has] some great tools around power, power dynamics and power sharing, and do a lot of work with local public health and power sharing with community-based groups. I thought that could be great, it could

help both the relationship between state and local but also give locals the tools for also having those conversations with CBOs too, and how we do our work here locally" (Urban LPHA Focus Group). Another LPHA highlighted a regular meeting between OHA and LPHAs serving rural communities "just to be able to hear your experiences" as a way to address unequal power dynamics (Rural LPHA Focus Group). The LPHA participant recalled that the meeting was established in response to "rural folks feel[ing] voiceless" and felt "there was an understanding of the power dynamic, and that [the meeting] was something positive that helped address some of that" (Rural LPHA Focus Group).

Distinct from approaches to mitigate the harmful effects of power dynamics, one CBO participant emphasized needing to disrupt the dominant power held by governmental public health in the absence of observable efforts to share power. The CBO participant recalled needing to "really advocate and agitate and disrupt local public health processes at times to put our shared definition of Modernization into practice and to stop harm for Communities of Color," as well as "push back a lot and we give a lot of feedback" on Modernization implementation to OHA given "there are people and processes within OHA that are very aligned with Modernization, and there are people and processes that are very resistance is my experience to Modernization, especially the equity elements" (OPP CBO Focus Group). The participant also described the challenges of disrupting dominant power saying, "I think to a certain degree we're seen as troublemakers, even though we really value partnership, and we try to do it with a lot of grace and humility and understanding that the front line staff often aren't the decision makers on what the timeline is and what the budget is" (OPP CBO Focus Group). The participant further explained how their coalition is able to disrupt power dynamics given "some privilege in that we have a healthy budget, we have multiple funding streams" and noted how "not all of our partners are in a

position [to disrupt], the risk is much higher for smaller CBOs where they have fewer funding streams or they're newer and they risk their relationships with partners that they really need for their work" (OPP CBO Focus Group).

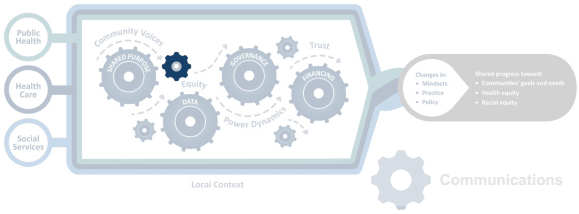
> "There are times where we have had to organize with OHA and with local public health to surface real community needs. And that feels, that's risky. I feel like our coalition has some privilege in that we have a healthy budget, we have multiple funding streams. Not all of our partners are in a position, the risk is much higher for smaller CBOs where they have fewer funding streams or they're newer and they risk their relationships with partners that they really need for their work. I think our experience has been that we have to risk funding and reputation and retaliation and loss of partnership sometimes in order to stay true to our mission and be accountable to our community and accountable to the stated shared Modernization values."
>
> – Other Priority Populations CBO Focus Group

Power Dynamics Similarities and Differences Across Partner Types

OHA and LPHA participants recounted several examples of power sharing in early Modernization implementation, including the co-development of the Modernization Manual and shared decision-making on funding allocations. Similar to shared purpose, governance, and financing, LPHA participants described a shift during the COVID-19 pandemic response in which power became more centralized with OHA, as evidenced by the unilateral decision to fund CBOs. In contrast, OHA participants supporting Public Health Equity Grant administration

described increased power sharing in recent years; these participants cited PHAB, CLHO, and the CBO Advisory Board's increased influence on grant administration decisions, which often run counter to the OHA staff preferences but are nonetheless implemented.

All participant groups acknowledged OHA's inherent institutional power as the funder; however, OHA and CBO participants viewed this dynamic neutrally, while LPHAs questioned Oregon's funding model in which OHA receives and allocates Modernization funding from the legislature. OHA and CBO participants reflected on the harmful dynamics that can result from governmental public health staff being perceived as more highly skilled than other Modernization partners. OHA and LPHA participants acknowledged a need to mitigate unequal power dynamics. While one OHA leader participant offered that harmful power dynamics can be mitigated by "building relationships and listening to each other's unique perspectives," one LPHA participant offered a more tangible recommendation to enlist the support of an external contractor to conduct a power analysis with Modernization partners.



Equity

The World Health Organization defines equity as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically." The Framework for Aligning Sectors asserts that equity "encompasses both health equity and racial equity and includes both processes and outcomes." Four themes relating to equity were identified. Themes relate to 1) equity as an early central

component of Modernization and the evolution of the equity approach over time; 2) population-specific approaches to Modernization implementation that demonstrate an equity focus; 3) the equity approach not being well understood across partners; and 4) equity capacity building at OHA.

Equity as Early Priority that Evolved Over Time

OHA participants emphasized equity as a central tenet of Oregon's Modernization approach with one OHA leader saying "…one thing that's important to know about Oregon's Public Health Modernization work is it was really designed around health equity from the very beginning in Oregon's early work" (OHA Leadership KII 1). The OHA leader further distinguished Oregon's early focus on equity compared to other states pursuing Modernization-like initiatives, highlighting that "Oregon's model stood out from everything happening nationally at that point in time. So, there are many states that have started this work, but Oregon very uniquely defined health equity and cultural responsiveness as a foundational capability in our model back in 2015. Since then, the national model has been updated to include health equity and many other states have gone in that direction as well" (OHA Leadership KII 1). Another OHA leader highlighted OHA's strategic goal to eliminate health inequities by 2030 as "a galvanizing opportunity for us in public health and in OHA generally to think about how we meaningfully work toward that goal" and complementary to Oregon's equity-centered approach to Modernization (OHA Leadership KII 2).

> "Oregon's model stood out from everything happening nationally at that point in time. So, there are many states that have started this work, but Oregon very uniquely defined health equity and cultural responsiveness as a foundational capability in our model back in 2015. Since then, the national model has been updated to include health equity and many other states have gone in that direction as well."
>
> – OHA Leadership Key Informant Interview 1

Another OHA leader participant also noted how PHAB policies and procedures, both existing and in development, have reinforced an equity approach to Modernization implementation. The OHA leader emphasized that PHAB has had a health equity policy and procedure since 2018 that "they use it in all of their decision-making and takes them through a process of thinking about who is engaged in decisions, what inequities are being addressed, what potential unintended consequences there will be" (OHA Leadership KII 1). The OHA leader further emphasized that within the health equity policy and procedure, PHAB has taken a leading with race approach that "really just recogniz[es] that within any inequities that exist, race, racism is always going to be a layer in there" and "acknowledge[s] geographic inequities across the state of Oregon" (OHA Leadership KII 1). The OHA leader further highlighted that as a complement to the health equity policy and procedure, PHAB adopted the Oregon Health Policy Board's and OHA's definition for health equity and adheres to OHA's agency goal of eliminating health inequities by 2030, which the leader described as "some of the framing around PHAB's intentions around health equity" (OHA Leadership KII 1). Lastly, the OHA leader described

ongoing work by the PHAB to develop a health equity framework "that's more broad for the entire public health system" with the goal "to define the roles of all of the partners, the funded partners in our public health system…How we all work together to eliminate inequities and how our unique roles play together to do that" (OHA Leadership KII 1).

OHA leader participants described the role of early assessment and planning activities in understanding system-level gaps in equity and opportunities for improvement. OHA leader participants recalled key findings from the 2016 Modernization capacity and cost assessment that found "we had the greatest gaps in health equity and cultural responsiveness" (OHA Leadership KII 2) and consequently "recognizing that we needed to be putting resources there very intentionally" (OHA Leadership KII 1). The OHA leader further reflected on more recent experiences responding to the COVID-19 pandemic that "allowed us to see more of what we didn't know…in terms of the scope and scale of what it takes to more meaningfully implement health equity and cultural responsiveness," which led the public health system to begin "working with greater intention towards elimination of health inequities" (OHA Leadership KII 2).

Responding to assessment findings that revealed limited capacity and expertise for health equity and cultural responsiveness foundational capability, one OHA leader participant noted that "our very first deliverable we ever had with Modernization funding going out were for every local public health authority to complete a health equity assessment and then develop a plan based off of that" (OHA Leadership KII 1). The OHA leader further emphasized that the intention of required local equity assessments and plans was "to be a little bit of an internal look to the local public health authority to understand their policies and their practices that were either contributing to equity or sort of a barrier to equity and then developing plans for changing those" (OHA Leadership KII 1). One LPHA participant noted, however, that these planning

requirements have made the equity capability feel ad hoc rather than a core component of their work, saying "we, of course, want health equity to be the base of everything we do, so it feels a little clunky to me to have these one off plans…that feel like they're just kind of like add-ons to a main plan [referencing the local community health improvement plan]" (Rural LPHA Focus Group).

While Modernization began with an explicit focus on equity, one OHA leader described OHA's response to the COVID-19 pandemic as an evolution of how the agency understood the essential partners for ensuring equitable public health services in communities: "…many of the strategies that we put into place to prevent spread of COVID-19 were missing a level of cultural and linguistic access that fully took into consideration structural racism and structural determinants of health, so that led us in sort of an unprecedented investment in COVID-19 relief to additionally include community-based and culturally-specific organizations in the state's COVID-19 response" (OHA Leadership KII 2). The investment in CBOs during the COVID-19 response served as the precursor to OHA's Public Health Equity Grant, which maintained the equity throughline and a "lens that we function through…in terms of pushing out money to specific communities or specific needs" (OHA Program Staff Focus Group). Another OHA leader similarly explained that while "health equity has never been an add-on for our work – it's always been at the center of our work – our ways of getting there has definitely changed over time" including direct funding to CBOs (OHA Leadership KII 1). Affirming OHA's evolved understanding of the partners needed to advance equity goals, one CBO participant emphasized that CBOs "have been doing a lot of the elements of Modernization before it was cool…especially leading with equity and looking at upstream social determinants of

health…aspects of Modernization that the Regional Health Equity Coalition I work for really leans into" (OPP CBO Focus Group).

Population-Specific Approaches Demonstrate Equity Focus

All participant types described population-specific approaches to delivering public health programs as examples of Modernization equity. One OHA leader reflected on how aspects of OHA's culturally-specific approach to the COVID-19 response were carried forward as considerations for Modernization implementation, saying "…there are ongoing opportunities to ensure that public health work and interventions are culturally and linguistically responsive, and that there's bidirectional communication and focus between communities, community-based organizations, and governmental public health to respond to public health priorities" (OHA Leadership KII 2). The leader further highlighted recent communicable disease response experiences as concrete examples of this approach to Modernization: "other communicable diseases we've been working to address [like] mpox, sexually transmitted infections, etc. all in similar means with culturally and linguistically responsive information to communities and supports for the public health system" (OHA Leadership KII 2). A LPHA participant similarly highlighted how their organization's new community partnership program is "dedicated to nurturing and expanding the relationships that we developed during COVID to better serve communities that have historically been marginalized" (Urban LPHA Focus Group).

Another OHA leader discussed Modernization equity in the context of the Public Health Equity grant, emphasizing how grant allocation priorities evolved over time to address gaps in the first round of funding: "we realized there were gaps…so we made that a priority in the second round to prioritize rural communities…there were some specific communities, like the

disability community, that we wanted to increase funding resources to…part of it is genuinely making sure we're distributing funds equitably across the state" (OHA Leadership KII 3).

> "We realized there were gaps…so we made that a priority in the second round to prioritize rural communities…there were some specific communities, like the disability community, that we wanted to increase funding resources to…part of it is genuinely making sure we're distributing funds equitably across the state."
> – OHA Leadership Key Informant Interview 3

In addition to the community-specific approach to allocating Modernization funds, CBO participants described how their Modernization-funded work supports specific populations that experience a disproportionate burden of poor health outcomes. One CBO participant recalled the different populations that benefitted from work to distribute air conditioners during excessive heat events: "our agency is very grateful because of all the communities that we have been able to serve, including the migrant farm workers, refugees, and the low-income community and the underserved communities" (COC CBO Focus Group). Another CBO participant similarly detailed their work to distribute air conditioners to certain communities in need, saying "we were able to pass out over 200 air conditioners to folks that had health problems or were low income or had small children or were pregnant or anything like that that didn't have air conditioning. And it was so miraculous for these folks because it was hot." (COC CBO Focus Group). One CBO participant recounted delivering air purifiers to mitigate the negative health impacts of wildfire smoke to a retirement center "where folks are low income and elderly" (COC CBO Focus Group), while another CBO described how their staff "support students and really the

priority is to get them vaccinated or provide immunizations to the community" (COC CBO Focus Group).

Equity Approach Not Shared or Understood Across Partners

Despite participant comments that center equity as a core component of Modernization, participants also described ways in which equity priorities are not shared or well understood across partner types. One OHA leader described the lack of a common definition for equity – including in Oregon's statutes – as a fundamental barrier to partners understanding how to equitably implement Modernization (OHA Leadership KII 1). The leader recalled how the governmental public health system has "used the term [equity] differently at different points in time" and described how different interpretations of equity can make decisions such as funding allocations difficult: "we're talking about equitably distributing funds to local public health authorities, which can mean a whole lot of things, but equitably distributing probably means that every LPHA gets their fair share. At the same time, there are pieces baked into the statutes around how Modernization funds go out to local public health that are trying to get to the equity piece…We want to make sure the funding that we have is being directed to those areas where there's more resources needed to address inequities that exist…all of these terms kind of overlay each other functionally" (OHA Leadership KII 1). One LPHA participant affirmed "we all have a different definition [of equity] that we're working from" and asserted that while "we all agree that equity is important, and reaching the hardest to reach people is important…the way in which we modernize looks different depending on who you're asking" (Rural LPHA Focus Group).

> "…it makes it tricky because if we all have a different definition from what we're working from, it's hard to have a shared purpose. What I would say is we all agree that equity is important, and reaching the hardest to reach people is important, and that is a priority outcome. But I think the way in which we modernize looks different depending on who you're asking."
>
> – Rural LPHA Focus Group

OHA staff who administer the Public Health Equity Grant reflected on how a shared purpose rooted in improving health equity is a "work in progress" and questioned "Even just that overarching improving health inequities [goal], okay, what is that?" (OHA Program Staff Focus Group). The OHA staff participant asserted that equity has "been a focal point, even though I don't feel like we're all on the same page" and described the lack of clarity as both an issue internal to OHA and external with Modernization partners: "[We're] trying to get everybody at the table and share our purpose and agree upon a shared purpose when it comes to the internal collaboration between programs, community engagement team, fiscal, leadership, and then layered on to that getting coordination and collaborated with the LPHAs and CBOs and the various advisory boards, governance" (OHA Program Staff Focus Group). Another OHA staff participant affirmed that "99.99% of [partners are] really, really passionate about their community and improving their community. What that actually means is really, really varied. How people conceptualize what serving their community or being equitable in their community are just super, super varied" (OHA Program Staff Focus Group).

LPHA participants agreed that equity is an important component of Modernization but questioned the vision behind OHA's funding of CBOs to advance this priority. One LPHA participant asserted "…if you don't start with a shared vision, nothing else is going to work. And we never had this shared vision about how CBOs would interact in improving health equity" (Rural LPHA Focus Group). One OHA leader acknowledged that "we did not have a conversation with local public health about how that [CBO funding] would operate or the intent and purpose or anything like that" (OHA Leadership KII 2). Another LPHA participant affirmed that the shared purpose of the Modernization "switched to a health equity focus, which is not wrong, but it's different from before" and was not accompanied by complementary changes to the Modernization Manual (Rural LPHA Focus Group). Lastly, another LPHA participant questioned OHA dedicating funding to "vague CBO projects" and contended that the Modernization investment "isn't being spent on issues that we know are clear equity issues," cited lead poisoning, sexually transmitted infections, and viral hepatitis as "three of the biggest public health equity issues" that are not receiving targeted investment from the state. The participant highlighted that "we're saying we're poor and can't address these health equity issues at a time when the state has gotten more money in public health funding than they've ever had before" (Urban LPHA Focus Group).

Only one CBO participant commented on equity not being shared or well understood by state and local governmental public health partners. The participant described OHA's commitment to the equity elements of Modernization as mixed, saying "there are people and processes within OHA that are very aligned with Modernization, and there are people and processes that are very resistant" (OPP CBO Focus Group). The participant further noted that though they often feel aligned with OHA on equity approaches conceptually, this often does not

translate during implementation, especially when OHA has limited time or resources. The participant summarized their experience with OHA, saying “It feels like we are on the same page as long as things go best case scenario, but when things get tough, the equity components of Modernization seem to be the first casualty” (OPP CBO Focus Group).

LPHA and CBO participants also noted external parties that do not share an understanding of or commitment to equity as a central component of Modernization. One LPHA participant described the difficulty of maintaining a new community partnerships program within their public health department given the conservative movement, both locally and nationally, to interrogate any program seen to advance DEI. The participant explained, “I live in a county that is fairly conservative and rural and I'm getting a lot of questions about how much money we dedicate to DEI efforts now with our budget committees. Because they're looking at other states and other places where they're cutting DEI programs and funding and wanting also to go down that path. So that's part of the struggle here locally when it comes to Modernization as well and maintaining the gains that we've made” (Urban LPHA Focus Group). Another LPHA participant described feeling “a disconnect between what is said or expected at OHA around equity and what the reality is at the local level” and offered several examples of this reality: “Even in [Urban County]…we lost our county Office of Equity and Inclusion. We have to do things creatively to even do our equity assessment. We can't put the word equity in certain contracts. It's very, very challenging right now and I feel like sometimes that's lost” (Urban LPHA Focus Group).

> "…of course equity is at the center of all our work, it's obviously a huge priority. But we face many barriers to carrying that work beyond public health in our counties. And I sometimes feel like there's a disconnect between what is said or expected at OHA around equity and what the reality is at the local level. Even in [Urban County]…we lost our county Office of Equity and Inclusion. We have to do things creatively to even do our equity assessment. We can't put the word equity in certain contracts. It's very, very challenging right now and I feel like sometimes that's lost. We want to do equity work and we try so hard and we always prioritize it, but we just have to be really creative and it's just not always supported beyond public health or our Health, Housing and Human Services Department."
>
> – Urban LPHA Focus Group

One CBO participant similarly recounted the difficulty of working within a more conservative political context on a county community health assessment process that sought to center health equity and explicitly address systemic racism. The participant recalled the challenge of convening partners for assessment workgroups due to the presence of equity language in the workgroup's memorandum of understanding: "…they have to sign a memorandum of understanding and county council – the attorneys for [Rural] County – have blocked staff from joining or from signing our MOU because they include OHA's definition of health equity, which specifically names racism, systemic racism, and addressing systemic racism. And the county council feels that if that ever went before review in front of our commissioners, they would block it on the basis of discrimination" (OPP CBO Focus Group).

OHA Equity Capacity Building

OHA leadership described how intentional changes to staffing and organizational structure at OHA have increased the state agency's capacity to implement Modernization equitably. One OHA leader participant reflected on the intentional hiring of bicultural and bilingual staff for the community engagement team that would serve as liaisons to CBOs receiving public health equity grant funding: "I hired a lot of folks that didn't necessarily have public health experience, but that had community experience…I prioritize being bilingual, bicultural, because I figured I could teach them everything else…I hired people that reflected the communities we serve" (OHA Leadership KII 3). Another OHA leader noted the creation of a new equity office within the OHA Office of the State Public Health Director as an organizational change that has enhanced capacity for equity: "We have an equity office, and that's a really big part of what the community specific team does is really forge connections with different communities across the state…it's very much about building relationship and trust…We can go way further in centering community voices, but I do think it's been a huge area of growth" (OHA Leadership KII 1). Complementary to staffing and structure changes within OHA, one OHA leader also highlighted changes to the composition of the Public Health Advisory Board in 2023 to include formal representation for CBOs and a member with health equity expertise as building the governance bodies capacity for equity (OHA Leadership KII 1).

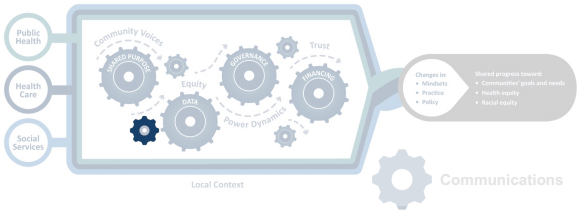
> I hired a lot of folks that didn't necessarily have public health experience, but that had community experience. I prioritize being bilingual, bicultural, because I figured I could teach them everything else, and I have. There's people who I'd like to think whose lives have been changed because they were uplifted from an admin position to an OPA2 or higher level kind of classification. So yeah, I hired people that reflected the communities we serve"
>
> – OHA Leadership Key Informant Interview 3

In addition to staffing and structural changes, one OHA leader participant also noted training efforts to build capacity for Modernization equity both within and external to OHA. The OHA leader described hiring an equity consultant to train the OHA community engagement coordinators who serve as liaisons to Modernization-funded CBOs and offering these trainings to LPHAs given "some of this tension with local public health, it became clear that they would benefit from these equity trainings that we were all doing" (OHA Leadership KII 3). Reflecting on the LPHA trainings, the OHA leader recounted "they had a cohort that was specifically for administrators of color, which I think was really good to create BIPOC space, and then another that was for white allies. I think a lot came up in those spaces about some of the tensions that they're feeling at the local level working with each other, getting consensus, understanding OHA's role, communicating what they need OHA to be doing" (OHA Leadership KII 3). The OHA leader reflected on the value of bringing in outside support to build capacity for equity, saying "I think the work we did around bringing equity consultants in has been really

key…because I think that we had some not woke people working in really racist systems" (OHA Leadership KII 3).

Equity Similarities and Differences Across Partner Types

As described in the shared purpose section, OHA and LPHA participants differed in their understanding of equity's centrality to Modernization. OHA participants described health equity as a core component of Modernization from the beginning, while LPHA participants considered health equity to be one of several workforce capabilities that became a singular focus following the COVID-19 pandemic. As described in the shared financing section, OHA and LPHA participants also differed in their conceptions of equitable funding allocations. LPHAs disagreed with OHA's view that funding to CBOs increased equity in shared financing given the approach was not informed by a shared financing strategy and the decision was not made in consultation with LPHAs or the PHAB. All participant groups agreed there is not a shared understanding of what "health equity" means in the context of Modernization, as well as what it means to equitably implement Modernization or what the approach would require from partners. Lastly, LPHA and CBO participants both noted how external parties and politics limit their ability to advance Modernization activities equitably. One LPHA participant described the difficulty of maintaining a new community partnerships program in the context of local and national scrutiny of DEI. One CBO participant similarly recounted the difficulty of working in a conservative political context on a local community health assessment process that sought to center health equity and explicitly address systemic racism.



Community Voice

Under the Framework for Aligning Sectors, "active community engagement ensures that community members are heard and integrated at the beginning of the design process (e.g., co-creation)." The Framework also acknowledges that the "elevation of community voices in the design of and decision-making for aligning efforts is deeply intertwined with building trust and shifting power dynamics." Three themes relating to community voice were identified. Themes relate to 1) increased community voice in Modernization through shared governance; 2) elevation of community voice through Modernization data collection and evaluation activities; and 3) examples of how governmental public health agencies have built infrastructure to center community voice.

Community Voice Through Shared Governance

OHA staff described increased community voice within Modernization decision-making over time. One OHA leader participant reflected on the evolution of community voice in Modernization implementation, specifically moving from writing about the importance of community voice in the Modernization Manual to instituting formal mechanisms for community engagement: "When I think back to the early days of Public Health Modernization and writing the Public Health Modernization Manual…we were talking and writing a lot about elevating community voice…at that time, we really did not have mechanisms for engaging with community members…thinking back to a couple iterations of our state health improvement

plans, it was really hard to find a community member who was willing to work with us. And that's changed a lot" (OHA Leadership KII 1). OHA staff affirmed a general sense of increased community voice in agency decision-making, with one staff participant reflecting that "within all the LPHA Modernization work, within the CBO public health equity grant work, and within the PHAB accountability metrics, there have been a lot of successes and I do think great community voice is really, oh my gosh, so much more present and influential in all of the work" (OHA Program Staff Focus Group).

> "…this is an aspect of our work that I feel extremely proud of. When I think back to the early days of Public Health Modernization and writing the Public Health Modernization Manual, like even in 2015, we were talking and writing a lot about elevating community voice. It's in there in so many different ways related to public health data, relating to policy, intentionally trying to look at our policies that make it easier to bring in community voices and those that keep them out. And at that time, we really did not have mechanisms for engaging with community members, well at all, it would almost be like really trying to find a person that was willing to work with us. So not Public Health Modernization specific but thinking back to a couple iterations of our state health improvement plans, it was really hard to find a community member who was willing to work with us. And that's changed a lot.
>
> – OHA Leadership Key Informant Interview 1

OHA leadership and staff participants provided several example mechanisms for community engagement that support the elevation of community voice in Modernization decision-making. One OHA leader noted the expansion of Oregon's PHAB to include formal representation for CBOs to "really [bring] the perspective of different communities across the state to that decision-making table," as well as "all of the different steering committees and advisory boards that that we have, we have a lot of mechanisms with connecting with community at this point, and people are eager to be parts of those groups" (OHA Leadership KII 1). The OHA leader also acknowledged, however, that OHA is "still holding those [engagement opportunities] in sort of our governmental way, like come to our meeting, at this time, here's what we will talk about, right?" and described a next "wave" of shared governance in which OHA reconsiders their model of engagement by "breaking it down and thinking about how to start with the thing that we want to achieve…putting them [community] in a leadership role, letting communities tell us what they expect out of governmental public health" (OHA Leadership KII 1).

Another OHA leader participant reflected on how the community engagement approach for Modernization has influenced the inclusion of community voice in other OHA strategic initiatives: "other advisory groups that come to mind that came into fruition because of a modern public health practice include how we developed our current state health improvement plan, Healthier Together Oregon, which is very much a multi-sector, community-based advisory group" (OHA Leadership KII 2). The leader also noted the community-engaged process to communicate on and stage access to COVID-19 and mpox vaccines, recalling "the vaccine advisory committee that allowed a number of really large swath of community partners to determine COVID-19 vaccine sequencing in the state, and we used a similar model when it came

to the availability of the Jynneos vaccine for Mpox" (OHA Leadership KII 2). The leader further described a more general cultural shift across OHA programs to more robustly include community voice in decision-making, citing the convening of an advisory group of culturally-specific CBOs to design a framework and process for statewide allocation of new tobacco tax revenues as an example (OHA Leadership KII 2).

Community Voice Through Shared Data and Measurement

Complementary to shared governance examples, OHA leader and CBO participants also reflected on the elevation of community voice in shared data and measurement activities. One OHA leader recalled OHA convening community researcher and leaders to review population health data collected by the public health division for the purpose of "learning about the challenges in the data that we collect and how it's presented and how it doesn't represent those communities" and developing recommendations for "what the governmental public health system needs to be changing to have a truly community centered approach to data" (OHA Leadership KII 1). A LPHA participant similarly described how their new community partnerships program engages CBOs on public health data availability and interpretation, saying "They call them data parties, so they'll create reports on health disparities and then share it back with communities to see how that resonates or doesn't resonate with them to try to bring people together more around understanding data" (Urban LPHA Focus Group).

A CBO participant described their participation in an OHA workgroup to guide the evaluation of Modernization investments, and considered "how can we use the community engagement coordinators to help with translating that [activity reporting data] and making it more accessible…How can we help with the CEC level [to] gather the information, maybe even

tailoring it to the community" (OPP CBO Focus Group). Similarly, several CBO participants affirmed their role in elevating the voices of community members to inform OHA decision-making, saying "what our role is at the seat at that table is to be the voice of the community because they have been so siloed. They [community] don't know that they are able to talk to these agencies or these entities and say, 'hey, this is what I'm concerned about'…to have us be at the table to say to these organizations, 'hey, this is what's going on in this neighborhood and these are how these people are being impacted'" (COC CBO Focus Group). The CBO participant detailed their experience working with community members on an environmental health data project with OHA as an example of their role elevating community voice: "…we were able to collect [data] from community folks that otherwise wouldn't have trusted being able to talk to the OHA or the DEQ because of those silos that have been made. So, what we're doing is breaking those down" (COC CBO Focus Group).

> "…we were able to collect [data] from community folks that otherwise wouldn't have trusted being able to talk to the OHA or the DEQ because of those silos that have been made. So, what we're doing is breaking those down"
> – Communities of Color CBO Focus Group

Building Infrastructure to Elevate Community Voice

OHA and LPHA participants both described how their organizations have built infrastructure to elevate community voice. As described earlier, one OHA leader highlighted the creation of a new equity office within the OHA Office of the State Public Health Director as a "huge area of growth" for centering community voices in Modernization (OHA Leadership KII 1). One LPHA

participant recalled the creation of a new community partnerships program with Modernization funding that is "dedicated to nurturing and expanding the relationships that we developed during COVID to better serve communities that have historically been marginalized" (Urban LPHA Focus Group). The LPHA participant further emphasized that the community engagement activities supported by Modernization directly inform their county-wide community health assessment and planning process, saying "a lot of that work will help inform our next CHA [community health assessment]…That's community led, so it's a whole different level of community engagement. That's really where the community voice will be most strongly felt" (Urban LPHA Focus Group).

> "…we have a lot of mechanisms with connecting with community at this point…We have an equity office, and that's a really big part of what the community specific team does is really forge connections with different communities across the state…it's very much about building relationship and trust…We can go way further in centering community voices, but I do think it's been a huge area of growth."
> – OHA Leadership Key Informant Interview 1

However, the LPHA participant also expressed concern with the sustainability of the community engagement infrastructure that has been built with Modernization funding: "One of my concerns around the community partnerships program is we've had to make cuts in a number of the programs that were supported by Modernization because it hasn't been able to keep up with expenses. We've cut communications, we have cut the PHEP [Public Health Emergency

Preparedness] program, I'm really trying not to cut the community partnerships program" (Urban LPHA Focus Group).

Community Voice Similarities and Differences Across Partner Types

OHA and LPHA participants described how their organizations have leveraged Modernization to build infrastructure to elevate community voice. One OHA leader highlighted the creation of a new equity office within the OHA Office of the State Public Health Director, which houses the community engagement coordinators that serve as liaisons to funded CBOs. One LPHA participant similarly recounted the creation of a new program dedicated to nurturing and expanding on community relationships developed during the COVID-19 pandemic response. However, the LPHA participant also expressed concern with the sustainability of the new community engagement infrastructure given stagnant Modernization funding and expected decreases to local funding sources. In addition to improved community engagement infrastructure, OHA and LPHA participants also recounted opportunities to elevate community voice through data initiatives. Participants described efforts within their respective agencies to engage community members in the review and joint interpretation of public health data.

Member Checking Considerations

Preliminary findings from focus groups and key informant interviews were member checked with OHA-PHD, LPHA, and CBO participants in optional virtual listening sessions conducted over Zoom from April 7–11, 2025. Five OHA-PHD staff, one LPHA staff, and 1 CBO staff participated in their respective listening sessions. Listening session participants described which results and related recommendations resonated with them, clarified some interpretations, and

offered updates on qualitative analysis themes since the focus groups and interviews were conducted in April–May 2024. Member checking comments will be organized by the FAS core components, which is how study findings were organized and presented to listening session participants.

Shared purpose. Listening sessions participants offered a few refinements to recommendations and also affirmed certain shared purpose findings. Related to the recommendation to clarify partner roles, the LPHA participant suggested that a higher-level description of how CBOs fit within the Modernization framework (via the process to refresh the shared vision for Modernization) should come first before developing specific roles for CBOs to include in an update of the Modernization Manual. Also related to the recommendation for role clarity, the CBO participant commented that OHA staff who support Public Health Equity Grant administration "spend a great deal of time" on grant administration processes (e.g., communicating about quarterly expenditure and activity reporting), and recommended that their attention should be redirected, at least in part, to focus on linking LPHA-funded work and priorities with CBO expertise. In terms of affirming study findings, the LPHA participant asserted that a potential unintended consequence of a "muddled" shared purpose is that it puts Modernization funding at risk, particularly in the current context where DEI and "DEI-adjacent" initiatives are being scrutinized by federal, state, and local decision-makers. The CBO participant described how the current lack of shared purpose, including a shared definition and approach for how Modernization is implemented equitably, has made it difficult for CBOs and LPHAs to build connections and align funded work.

Shared governance. OHA-PHD and LPHA participants offered clarifications and updates to certain shared governance recommendations. Related to the recommendation that OHA

acknowledge past harms related to unilateral decision-making, one OHA-PHD participant commented that OHA staff have attempted to publicly recognize broken trust during the COVID-19 response, and suggested the recommendation be reframed as "the steps that OHA took to acknowledge past harms has been insufficient" to acknowledge attempts at reconciliation. Another OHA-PHD participant offered that LPHAs' perceived lack of communication and engagement from OHA during the COVID-19 response can, in part, be attributed to direction from the Governor's Office rather than intentional obfuscation by OHA.

LPHA and OHA-PHD participants offered two updates to study findings that reflect progress on collaboration since focus groups and interviews were held in 2024. Related to the recommendation that OHA-PHD leadership be more present in Modernization governance spaces, the LPHA participant described how the relatively new OHA-PHD Director has been much more present in meetings of the PHAB and CLHO and is beginning to rebuild trust with LPHAs. The other update was offered by an OHA-PHD participant who described concerted effort by OHA-PHD over the last year to engage LPHAs more formally in the development of the 2025-2027 CBO Public Health Equity Grant opportunity, saying "we've worked very hard to meet LPHAs where they are and I feel like the reception from LPHAs is they are feeling like they are part of this process."

Shared data and measurement. OHA-PHD listening session participants offered two updates to shared data and measurement recommendations. First, one OHA-PHD participant suggested that CBOs will need to be educated on Modernization and the related system of accountability before formally including CBOs in the framework and related metrics. The OHA-PHD participant described how recent attempts to apply the accountability metrics framework to CBOs through new questions in required workplans and activity reporting have proven difficult

without formal onboarding. Another OHA-PHD participant offered an update that informs the shared data recommendation to include CBOs in the Modernization accountability metrics framework and better align CBO and LPHA grant activity reporting. The OHA-PHD participant described how fewer funded CBOs are working on local data collection and assessment projects compared to a year ago, saying "I had 7-8 CBOs working on local data projects and now I only have one." The OHA-PHD participant questioned whether this shift was a result of CBO quarterly activity reporting focusing on outputs of grant-funded work rather than changes in community health behaviors and guessed that "CBOs may be getting frustrated that they collected all of this [risk behavior] data and now no one wants it." The OHA-PHD participant further wondered whether OHA-PHD may be unintentionally incentivizing CBOs to collect process measure data to the detriment of culturally-specific community health assessments. This observation is particularly interesting in contrast to the LPHA focus group finding that the outcomes orientation of the Modernization accountability metrics framework has made it difficult for some LPHA administrator to justify investments in the health equity and cultural responsiveness and community partnership development workforce capabilities. This indicates that a strategic data plan for Modernization should include both shared process and outcomes measures as there is benefit to both types of measures.

Shared financing. LPHA and OHA-PHD participants offered two clarifications to shared financing recommendations. Related to developing a shared financing strategy, the LPHA participant suggested the strategy account for the sustainability of CBO funding given Modernization funding is allocated to CBOs through a competitive grant opportunity and, therefore, cannot be guaranteed over time. The LPHA participant was particularly concerned that CBOs may have significantly "staffed up" with Modernization funding (given some

organizations received up to $500,000 grant awards) and will be "damaged" if the funding and funding levels cannot be maintained in the long term. Related to the recommendation for more collaborative development of the Modernization policy option package (POP), one OHA participant clarified that while OHA-PHD can commit to a more collaborative process, the POP ultimately "goes up to OHA leadership" and OHA-PHD staff are "often told what to do" and may receive direction that conflicts with partner preferences. The OHA participant further suggested that while collaborative development of the POP is a worthwhile goal, OHA-PHD staff will also need to be clearer with partners about what state staff do and do not have control over in the process.

Shared communications. The LPHA listening session participant offered a caveat to shared communications recommendations to develop a strategic communications plan and mass media campaign to increase Modernization awareness. The LPHA participant suggested that implementing these recommendations should be contingent on first arriving at a refreshed shared vision, saying "we need a clear view on Modernization first," and worried that OHA-PHD would move forward on strategic communications initiatives without first clarifying the vision and partner roles.

Aim 3 Delphi Survey

A Delphi survey series was used to determine consensus opinion on each partner type's roles in advancing the HECR foundational capability of the Modernization framework. The Modernization Manual specifies 56 HECR roles for OHA-PHD staff and 46 roles for LPHA staff. The Modernization Manual does not include roles for CBOs given CBOs were funded after the manual was created. The Delphi process was conducted in three phases: 1) idea generation;

2) rating role statements; and 3) prioritizing role statements. Delphi survey respondents were recruited through existing listservs of OHA-PHD staff who support Modernization implementation (N=60), LPHA public health department administrators and Modernization grant program coordinators (N=66), and CBO staff coordinating Modernization grants (N=73) (**Appendix I** includes the Delphi recruitment email). The survey series was administered from July through August 2024 (**Appendix J** includes the three Delphi surveys). The total number of respondents for the survey series was 59, with 23 respondents for the first survey, 23 for the second survey, and 13 for the third survey. Results are presented in the order of the survey series; such that results for idea generation are described first followed by role ratings and role rankings.

Generating and Modifying Roles (Survey #1)

The first round of the Delphi survey series asked participants to review the health equity and cultural responsiveness roles for OHA and LPHA staff in the Modernization Manual and suggest modifications to existing roles and new roles for consideration during the second survey round. Participants were also asked to generate roles for CBOs who were not funded for Modernization until 2023 and thus were not included in the 2017 Modernization Manual. The first survey received 23 responses, including 12 respondents (52%) from LPHAs, 6 respondents (26%) from CBOs, and 5 respondents (22%) from OHA. Only 1 respondent had been in their organization for less than a year, 9 respondents (39%) had been with their organization between 1-3 years, 8 respondents (35%) for 4-10 years, and 5 respondents (22%) for more than 10 years. Fourteen respondents (61%) had worked in one of the other sectors in the past.

Modified roles. Survey participants recommended modifications to 20 of 39 (51%) roles shared by OHA and LPHAs, 10 of 14 (71%) roles for OHA only, and 3 of 6 (50%) roles for

LPHAs only. Most suggested modifications to OHA and LPHA roles explicitly emphasized the need to collaborate with partners, including working with CBOs to ensure existing roles were fulfilled in a manner that is culturally and linguistically appropriate and that OHA collaborates with LPHAs to ensure existing roles are fulfilled in a manner that is appropriate for the local context of counties. Other modifications added more current equity language to existing roles; for example, explicitly naming racism and the political drivers of health as a factors in addressing "systems of oppression," referencing data sovereignty in roles focused on making data and information available for decision-making, coupling roles that reference the evidence base with "community-informed" measurement and strategies, and acknowledging the potential value of traditional and alternative health care practices for roles related to public health service delivery. Other suggested modifications for roles related to administering funds included applying an equity lens to funding allocation decisions and enhancing accountability to public investments by developing specific investment goals and progress measures. Lastly, participants suggested modifications to roles related to staffing, including reference to training existing staff in equity specific skills, knowledge and abilities rather than relying entirely on hiring new staff, and ensuring a safe workplace that creates a sense of belonging.

New roles. Survey participants provided 3 new roles for OHA, 5 roles for LPHAs, and 16 for CBOs to be considered in the second survey. New roles for OHA focused on serving as a bridge between LPHAs and CBOs to collaborate on Modernization-funded activities and engaging LPHAs in the processes related to funding CBOs. New roles for LPHAs included serving as a liaison between OHA and local community organizations and coordinating with funded CBOs on Modernization-funded activities. Other new roles for LPHAs focused on advancing health equity at both macro and micro levels, including identifying health equity goals

within each foundational program and capability in the Modernization framework to pursue system-wide, and convening cross-sector partners to develop a shared dialogue and strategic plan for achieving health equity locally. A new role suggested for both OHA and LPHAs focused on advancing data decolonization and sovereignty practices.

CBO role recommendations related to collaborating with OHA and LPHAs to advance various foundational capabilities, such as policy and planning, assessment and epidemiology, and communications, as well as informing public health service delivery. For example, based on respondent recommendations, CBOs would work with LPHAs to create and collaborate on shared health equity goals, share community wisdom with partners about community-specific factors that influence health, and advocate for funding and policies that support health equity (policy and planning); collect local, population-specific data on community health inequities and assets (assessment and epidemiology); support OHA and LPHAs to communicate public health information in ways that are culturally and linguistic responsive (communications); and provide public health services that are responsive to diverse cultural health beliefs and practices and preferred languages. CBO roles that fell outside the Modernization framework included a recommendation to ensure CBO staff are trained on governmental public health and foundational programs (given many Modernization-funded CBOs have not worked in public health or with governmental public health agencies) and to participate in formal decision-making spaces with OHA and LPHAs, with proper compensation. **Appendix K** shows all suggested modifications and new roles that were included in the second survey round for consideration, including the complete list of new CBO roles.

Rating Roles (Survey #2)

The second round of the Delphi survey series asked participants to review the list of roles, including those that have been modified or are new, and rate each role on its importance to advancing health equity and cultural responsiveness on a 5-point scale for OHA, LPHAs, and CBOs, separately. Average ratings for each role were then included in the third survey to inform how respondents ranked their top 5 roles for each partner type. The second survey received 23 responses, including 20 respondents (87%) from CBOs, 2 respondents (9%) from LPHAs, and 1 participant (4%) from OHA. Only 1 respondent had been in their organization for less than a year, 5 respondents (22%) had been with their organization between 1-3 years, 12 respondents (52%) for 4-10 years, and 5 respondents (22%) for more than 10 years. Ten respondents (43%) had worked in one of the other sectors in the past.

Average scores. Overall, average ratings of importance did not vary greatly across roles with average ratings ranging from a minimum of 3.80 and a maximum of 4.65. Only 2 roles received an average rating of less than 4, both OHA-only roles. These roles focused on 1) conducting an internal assessment of the state health department's capacity to act on the root causes of health inequities; and 2) conducting and disseminating community-engaged research to address the environmental, social and economic causes of health inequities. **Appendix L** shows the average ratings for each role. In addition to rating the importance of each role, four respondents provided comments on how they rated roles. Some comments referred specifically to role ratings, while others offered more general feedback on OHA's administration of Modernization funding. Specific to role ratings, one respondent who works for an LPHA asserted that "there is not a one-size fits all solution" to defining Modernization roles for governmental public health, because "some PHDs [public health divisions] are so small and

facing much different challenges than those in metro regions." This comment suggests that LPHA roles defined in the Modernization Manual may differ or be achieved to varying degrees based on the geographic service area. Another respondent who works for a CBO reflected on the set of LPHA roles, saying "There should be a mechanism to ensure the LPHA diffuses information and responsibilities to all CBOs, too often they become their own fiefdom, shutting out CBOs."

Two respondents commented more generally on OHA's administration of Modernization funding, with one LPHA respondent reflecting on the disparity in state and local governmental public health staffing: "Oregon suffers from a misunderstanding that public health is largely a state policy issue and staffs the system with that understanding. Public health is a local construct and needs to be assessed at that level, a 2-to-3 ratio of state staff to local staff is shocking considering most states are closer to 1-to-6." The other respondent who provided a survey comment worked for a CBO and suggested that OHA identify ways to simplify requirements for CBOs – especially smaller CBOs – to apply for grant funding: "How about OHA advocates for simplified requirements for trusted CBO partners. Small CBOs may be very integrated into local populations but lack the funding and resources to administer complicated grants."

Ranking Roles (Survey #3)

The third round of the Delphi survey series asked participants to review the list of roles (original, modified, and new) and rank their top 5 for OHA, LPHAs, and CBOs. The third survey received 13 complete responses, including 8 respondents (62%) from CBOs, 4 respondents (31%) from LPHAs, and 1 participant (8%) from OHA. Five respondents (38%) had been with their organization between 1-3 years, 4 respondents (31%) for 4-10 years, and 4 respondents (31%) for more than 10 years. Seven respondents (54%) had worked in one of the other sectors.

Role rankings. Respondents ranked their top 5 roles for OHA and LPHAs together (i.e., shared roles for governmental public health), OHA-only roles, LPHA-only roles, and CBO roles, separately. Respondents who ranked more than 5 roles were excluded from the analysis. The top 5 roles for each partner type are presented below and **Appendix M** includes the ranked list of all roles. Ten of 13 respondents correctly ranked their top 5 roles for OHA and LPHAs together (3 respondents ranked more than 5 roles and were excluded from the analysis for OHA and LPHA shared roles). The top 5 shared roles from highest to lowest cumulative score were as follows:

1. Support, implement, and evaluate community-informed strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements. OHA collaborates with LPHAs to ensure strategies and partnerships are appropriate at the local level (cumulative score = 14);
2. Make the economic case for health equity, including the value of investment in cultural responsiveness. LPHAs may rely on statewide return-on-investment studies/reports from OHA and other sources (cumulative score = 13);
3. Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health promoting factors (e.g., quality parks and schools) (cumulative score = 13);
4. Collaborate with partners to develop and promote shared understanding of the determinants of health, health equity and lifelong health. Work with CBOs to develop culturally and linguistically appropriate resources (cumulative score = 12); and

5. Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity. OHA collaborates with LPHAs to ensure strategies are appropriate at the local level (cumulative score = 12).

Ten of 13 respondents correctly ranked their top 5 OHA-only roles. The top 5 roles for OHA from highest to lowest cumulative score were as follows:

1. **(new role)** Connect LPHAs and CBOs to collaborate on funding, work plans, policy and other activities (score = 22);
2. Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities (score = 18);
3. Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data (score = 11);
4. Implement the Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) law, and collect and maintain meaningful, disaggregated, standardized and actionable demographic data (score = 10); and
5. Based on REALD and SOGI data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous

improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies (score = 10).

Eleven of 13 respondents correctly ranked their top 5 LPHA-only roles. The top 5 roles for LPHAs from highest to lowest cumulative score were as follows:

1. Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD (score = 25);
2. **(new role)** Identify health equity goals within each foundational and additional program and identify local, regional, or state partners to help achieve those goals (score = 22);
3. **(new role)** Act as a convener of local community members, elected officials, and organizations to create a shared dialogue and strategic plan for achieving health equity locally (score = 20);
4. Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities. Share data and resources with community that are culturally and linguistically appropriate (score = 20); and
5. **(new role)** Collaborate and coordinate with funded CBOs on funding, work plans, policy, and other activities (score = 18).

Eight of 13 respondents correctly ranked their top 5 CBO roles. The top 5 roles for CBOs from highest to lowest cumulative score were as follows:

1. Collaborate with OHA, LPHAs, and community members to collectively address health inequities, including the social determinants of health (score = 18);

2. Share community wisdom with OHA, LPHAs, and other partners about community-specific factors that influence health, including social conditions (strengths, assets and protective factors) (score = 15);
3. Participate in formal decision-making spaces with OHA and LPHAs, with proper compensation (score = 14);
4. Conduct grassroots outreach and engagement with specific populations (score = 12); and
5. Collaborate and coordinate with LPHAs on funding, work plans, policy, and other activities (score = 11).

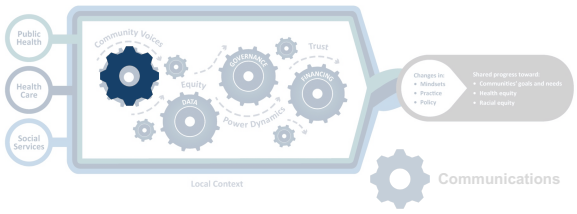
Chapter 5. Conclusions and Recommendations

Introduction

Chapter 5 begins with a restatement of the research question and study aims. The chapter then presents study conclusions and related policy and practice recommendations. Conclusions and recommendations are organized by the core components of the Framework for Aligning Sectors (FAS) rather than by study aims.[29] Conclusions related to the FAS adaptive factors and Delphi survey results are included in core component recommendations, where applicable, rather than described in standalone sections. The chapter will conclude with a description of study limitations and implications for future research.

Research Question and Aims

The research question for this study is "What factors of cross-sector alignment impede or facilitate collaboration among state and local governmental public health and communities to advance health equity?" This research question was addressed through three specific aims: 1) characterize the degree to which factors of cross-sector alignment are currently fulfilled; 2) compare similarities and differences in how partners perceive factors of cross-sector alignment; and 3) explore perceived roles of each partner in advancing health equity.



Shared Purpose Recommendations

Shared purpose is a "feature of aligned systems in which sectors share a mutual understanding and commitment to a vision and priority outcomes."[29] Oregon Health Authority Public Health Division (OHA-PHD) and local public health authority (LPHA) participants recalled collaborating on the development and maintenance of a shared vision in the early days of Modernization implementation. Both participant groups acknowledged that the shared vision became fragmented over time and pinpointed the COVID-19 pandemic and funding to community-based organizations (CBOs) as the inflection point. Most LPHA participants did not speculate on the cause of OHA-PHD's direct funding to CBOs, instead focusing on the detrimental effects of the funding to shared vision and role clarity, citing that previously there was clear acknowledgement that the community work belonged in local public health departments. In contrast, OHA leader participants attributed the ease of early shared visioning to the newness of Modernization as a systems change initiative, which allowed partners to be aspirational and focus exclusively on the governmental public health system. OHA leader participants emphasized that funding to CBOs was a natural consequence of organizational learning during the pandemic response in which community organizations supported culturally- and linguistically-responsive public health services and expanded OHA-PHD's conception of public health system partners.

Regardless of the focus on cause or effect or how charged the experience was personally, both OHA and LPHA participants emphasized that Modernization partners are not currently

working from a shared vision. This suggests the need for partners to collaborate on a vision "refresh" that acknowledges progress to date and how Modernization has changed over time, including the current social and political context, available resources, and contributing partners and sectors. Given the lack of trust in OHA-PHD described by LPHA participants, a process for refreshing the vision may best be conducted by an external facilitator that can be seen as a neutral, third-party facilitator. The process for refreshing the shared vision could be led/facilitated by the Public Health Advisory Board (PHAB) to re-establish the group's role as the primary decision-making body for Modernization, given participant comments on the unclear purpose and role of the governance group.

One LPHA participant commented on the fragmentation of shared purpose stemming from the tension between Modernization serving as a standard for public health departments and the need for local variation based on community context and need. Similarly, one OHA leader participant contrasted early aspirations that Modernization would set a floor for governmental public health practice with the reality of limited funding necessitating partial implementation of the framework and variation in counties' preferred approaches to the prioritized foundational programs. A process to refresh the shared vision could explicitly acknowledge this balance between promoting a standard across the state and the inherent need for local variation or tailoring.

While CBO participants described feeling a shared purpose with OHA-PHD, their comments centered on experiences receiving Modernization funding through the Public Health Equity Grant rather than born from an understanding of Modernization as a long-running public health system change initiative. LPHA participants similarly questioned whether CBOs receiving Modernization funding understood the core functions of the public health system and more

specifically the history and purpose of Modernization outside of the Grant program. A process to refresh the shared vision could explicitly include CBOs, who were not represented in initial visioning limited to governmental public health partners. CBO involvement in shared visioning can help make clear the role of public health and purpose of Modernization. CBOs would inherently be represented in a process to refresh the shared vision if led by the PHAB and coupled with engagement of the CBO Advisory Committee to ensure broader CBO participation.

Related to the equity adaptive factor of the FAS, there were differences in the degree to which equity was perceived as a central component of the shared purpose across participant groups. While OHA participants described equity as central to Modernization from the beginning – and enhanced by directly funding CBOs and explicit commitments from OHA to eliminate health inequities via the agency's strategic plan – LPHA participants described the centrality of health equity following the COVID-19 response as a drastic change, compounded by a lack of conversation or planning around health equity in the PHAB. LPHA participants recalled general confusion about the end goals of Modernization when "overnight it switched to a health equity focus" (Rural LPHA Focus Group). Regardless, all participant groups agreed that Modernization partners were not working from a shared understanding of and approach to health equity, which impacts understanding of the overall shared purpose.

OHA and LPHA participants differed on how Modernization equity should be operationalized; while OHA participants described equitable implementation in the context of processes like funding decisions and training and technical assistance delivery, LPHA participants described equity in the context of program areas receiving investment and related health outcomes. For example, one LPHA participant commented that Modernization funding was not addressing several known health outcome inequities, including lead poisoning and viral

hepatitis, and that funded CBOs were not required to advance work in the same prioritized foundational programs as LPHAs, which confuses shared purpose. These tensions suggest that clarifying the approach for equitable Modernization implementation should be a core component of the shared vision refresh.

To undergird this conversation, partners could familiarize themselves with existing commitments to Modernization equity, including the health equity and cultural responsiveness core functions and roles detailed in the Modernization Manual; results from the 2016 Capacity and Cost Assessment that showed a lack of capacity for health equity in the governmental public health system; and PHAB's equity policies and procedures – all of which may not be known to Modernization partners.[28] Developing a shared definition and approach to Modernization equity could also consider how best to align with existing equity plans developed and maintained by LPHAs since the first round of Modernization funding. OHA-PHD should also consider embedding the shared definition and approach to Modernization equity in existing strategic and operational plans.

Partners could consider the following concepts from the principles of Collaborating for Equity and Justice in developing a refreshed vision and related health equity definition and approach. These principles from Wolff et al. (2017) suggest the following be reflected in a shared vision: 1) focus on policy, systems, and structural change; 2) address social and economic injustice and structural racism; and 3) employ community organizing as part of process that creates the power necessary to share in decision-making. For example, community organizing principles could be embedded in a shared visioning process by including historically marginalized communities in the process as equal partners; ensuring that public health "professionals" assume a supportive role whereby they share expertise and resources but refrain

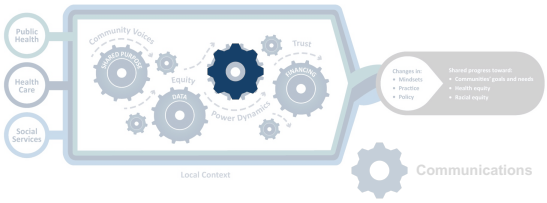
from unilaterally identifying problems and potential solutions; and exploring potential synergies with existing community organizing initiatives.[120]

While these principles could help center equity and justice in a process to refresh the Modernization shared vision, LPHA participants cautioned that shared definitions and approaches must pragmatically consider the local context and politics that challenge equity initiatives even with commitment across partners. Specifically, some LPHA participants commented that OHA-PHD does not understand local contexts that prohibit certain equity language, suggesting that shared definitions and approaches may need to serve as guidance with flexibility to adapt to local conditions. These concerns feel particularly relevant in light of the Trump administration's January 20, 2025, executive order titled "Ending Radical and Wasteful Government DEI Programs and Preferencing" focused on rolling back policies and programs to promote diversity, equity, and inclusion in government.[193]

LPHA participants also described how early supports for maintaining a shared purpose, primarily the Modernization framework and manual, became less useful for guiding local Modernization activities over time. LPHA participants attributed the decreasing relevance of these guiding frameworks to the inclusion of CBOs as funded partners in Modernization without reflecting this new partner group in the Modernization framework, manual, or accountability metrics. This suggests that updates to supportive materials based on the refreshed vision should explicitly name CBOs as funded partners and describe the unique but complementary roles of CBOs and governmental public health in Modernization. The Modernization Manual, as the primary implementation roadmap, should explicitly state the shared definition of equity, approaches to the equitable implementation of foundational programs and capabilities, and how an equity approach informs the desired outcomes of Modernization. This would address LPHA

participant comments that the manual still has value but needs to be updated to reflect the current context and partnerships.

Core components of the FAS are interrelated; a refreshed shared vision with a common definition for equity will inform updated approaches to shared governance, data and measurement, financing, and communications (described in further detail later in the chapter). For example, facilitating a collaborative process to refresh the shared vision could be the first step to re-assert the vital role of the PHAB in decision-making; understand to what measures funded partners are held accountable; inform the approach to equitable shared financing; and decide what stories to tell about Modernization and how to tell them.



Shared Governance Recommendations

Shared governance is a "feature of aligned systems in which infrastructure has leadership, appropriate roles, and defined relationships." OHA and LPHA participants described shared governance in early Modernization implementation, primarily through decision-making in the PHAB on the Modernization framework and manual and funding allocations. One OHA leader participant noted the creation of PHAB as a fundamental shift in governance that shared power for decision-making with partners from outside governmental public health. Similar to shared purpose, OHA and LPHA participants acknowledged a decrease in shared decision-making over time, with LPHA participants citing OHA-PHD's unilateral decision to fund CBOs during the COVID-19 pandemic response as the inflection point. LPHA participants recalled that OHA-

PHD's initial decision to directly fund CBOs for Modernization was made outside of the PHAB structure, which sowed confusion about the purpose, goals, and decision-making boundaries of the governance body that persists today. LPHA participants further attributed the damaged integrity of the PHAB to recent turnover in formal LPHA representation in the space. LPHA participants emphasized that funding CBOs is not necessarily the problem, but rather that decisions were made "secretly" by OHA-PHD outside of formal governance spaces. LPHA participants commented that decision-making power is now centralized in OHA-PHD, which has undermined trust in the state agency.

This suggests that a process to clarify or reaffirm the purpose and decision-making authority of the PHAB is essential to shared governance. LPHA participants described how bypassing the PHAB on funding decisions resulted in a bifurcated approach to advocacy for Modernization during the legislative session. Consequently, a process to clarify the boundaries of PHAB's decision-making authority should include the governance group's role during legislative session, including the development of policy and funding strategy. A clearer role for PHAB in legislative session could mitigate LPHA participant concerns that the lack of coordination limits governmental public health's ability to advocate for Modernization funding and confuses state and local decision-makers. Ensuring a shared legislative strategy through PHAB was identified by LPHA participants as particularly important given the increasingly resource-constrained environment. In a process to clarify the decision-making authority of the PHAB, OHA-PHD could acknowledge its inherent institutional power as the funding agency and discuss specific strategies for mitigating power dynamics moving forward. One LPHA participant also commented on OHA-PHD's inconsistent use of the Modernization funding formula for resource allocation decisions (specifically to CBOs). Conversations to reaffirm PHAB's role in shared

governance could also clarify when and how existing decision-making tools, including the funding formula, will be used moving forward. The documentation of decision-making processes may mitigate the negative power dynamics inherent to Oregon's funding model in which OHA-PHD serves as the grantmaker to partners.

Modernization partners could also draw from Archon Fung's work on institutional design for public participation to make the process for and boundaries around PHAB's decision-making more explicit.[49] As described in Chapter 2, the range of institutional designs varies along three dimensions of participation, including who participates; how participants communicate with one another and make decisions together, and how participation is linked to public policy and program outcomes. These dimensions represent decision points for "designers" of participation opportunities and could be considered in attempts to clarify the communication and decision mode of the PHAB. For example, an aggregation and bargaining mode of decision-making develops a collective choice by amassing known participant preferences but can be mediated by the influence that participants bring into the process and maintain external power imbalances. Also, participants from underrepresented communities may not enter the process with pre-formed preferences due to information asymmetries. Instead, PHAB may explicitly commit to a deliberation and negotiation mode of decision-making in which knowledge asymmetries are addressed by ensuring participants are able to "absorb educational background materials and exchange perspectives, experiences, and reasons with one another to develop their views and discover their interests."

Indeed, Ansell and Gash's model of collaborative governance asserts that asymmetries in knowledge must be addressed as a starting condition for shared decision-making.[55] PHAB members should receive a thorough onboarding to correct for potential knowledge asymmetries,

especially those who are less familiar with public health and Modernization (discussed in further detail later). A commitment to deliberation and negotiation also informs how OHA-PHD staff could fulfill the facilitative leadership component of the collaborative governance framework, which recognizes mediation and facilitation as integral to collaborative processes. OHA-PHD staff can draw from Feldman and Khademian's concept of the "inclusive public manager" to inform their support of deliberation and negotiation amongst PHAB members. The inclusive public manager engages in both informational work to broker, translate, and synthesize diverse forms of information in ways that can be appreciated across participants, as well as relational work to create connections between participants in ways that develop the potential for empathy and legitimize different perspectives.[145] Principles from Denhardt and Denhardt's "New Public Service" model of public administration could also guide OHA-PHD staff participation in collaborative spaces, including the PHAB.[32] The New Public Service model acknowledges the important role of public servants to help community members articulate and meet their shared interests rather than to control or steer decision-making to ensure efficiency and productivity. The seven principles of New Public Service that could inform OHA-PHD staff roles in the PHAB include: 1) serve rather than steer; 2) public interest is the aim rather than the by-product; 3) think strategically and act democratically; 4) serve citizens, not customers; 5) accountability is not simple; 6) value people, not just productivity; and 7) value citizenship and public service above entrepreneurship.

Partners may also clarify the authority and power for decision-making afforded to PHAB members. Based on Fung's institutional design framework and complemented by the International Association for Public Participation's public participation spectrum (both described in detail in Chapter 2),[49,48] partners could commit to co-governance rather than

advising/consulting forms of power and authority. This commitment would charge the PHAB with transitioning from consult forms of participation in which the goal is to "obtain public feedback on analysis, alternatives, and/or decisions" to collaborate forms that seek to "partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solutions." This commitment to co-governance and collaborative decision-making could also extend to agenda development for the PHAB, which was noted by one LPHA participant as being controlled by OHA-PHD. More collaborative agenda building may help with the perception that OHA-PHD holds all power for decision-making.

OHA staff and LPHA participants also emphasized that the decision to fund CBOs for Modernization was made without a clear articulation of the role that CBOs would serve alongside governmental public health, either informally through conversation in governance spaces or more formally through the inclusion of CBOs in the Modernization Manual and accountability metrics. One LPHA participant noted that prior to CBO funding, there was clear acknowledgement that "community work" belonged in local public health, while another LPHA participant questioned whether CBO Modernization-funded activities support foundational public health services. Both sentiments indicate that the role of CBOs in advancing Modernization remains unclear. In addition, one CBO participant described the role of LPHAs as a "black box," and another CBO participant questioned whether it is appropriate for OHA-PHD to guide the vision and approach to Modernization given its function and power as funder. This suggests that a process to clarify the purpose and decision-making authority of the PHAB should also clarify the roles of OHA-PHD, LPHAs, and CBOs (and potentially non-funded public health system partners) in Modernization implementation.

Given that some LPHA and CBO participants were unaware of who is supporting Modernization in their communities, a process to clarify partner roles should begin with improved access to information on which organizations are receiving Modernization funding, for what purpose, and the extent to which funded activities align with priority health outcomes established by PHAB. Transparency could be improved by posting the names and approved workplans of organizations receiving Modernization funding, either on a public-facing website or with access restricted to Modernization-funded organizations. With Modernization grantees more clearly known by all, the process to clarify roles could then proceed.

In addition to more clearly defining OHA-PHD, LPHA, and CBO roles for updates to the Modernization Manual, accountability metrics, and other supportive materials, the process can address several issues elevated by participants. One such concern from a LPHA participant was that CBOs' prominent role in Modernization is "not something other states do." This concern could be addressed by clarifying how Oregon's approach aligns with other jurisdictions pursuing foundational public health services and how it deviates based on shared commitments, such as centering health equity. Another LPHA participant concern was the absence of OHA-PHD leadership in formal governance spaces, including the PHAB. A process to clarify roles broadly could also include more specific commitments from organizational leaders to consistently participate in shared governance spaces while balancing inevitable capacity constraints. A concern from one OHA leader and several program staff participants was that LPHAs would expect CBOs to be held to the same standards as local government agencies rather than identifying distinct but complementary roles befitting community organizations. This potential tension could be elevated for discussion at the beginning of the process to set shared expectations before more specific roles are identified.

Another tension to discuss at the beginning of the process is the role of OHA-PHD in elevating community voice. While one OHA leader participant highlighted the Equity Office within the Office of the State Public Health Director and related Community Engagement Team as new OHA-PHD infrastructure to facilitate relationships with CBOs, LPHA participants asserted that "community work belong[s] in local public health" and characterized OHA-PHD's facilitation of LPHA and CBO relationships as a form of overreach. An internal, complementary process to clarify roles for OHA program staff who support Modernization is also warranted. One such OHA staff participant described feeling responsible for many aspects of Modernization, ranging from accountability metrics reporting to grantee technical assistance, while also disempowered for decision-making. OHA program staff participants also emphasized that their leaders do not have clear roles in decision-making processes or consistent opportunities for participation in governance spaces compared to staff and leaders in the Director's Office.

Results from the Delphi survey series could inform the process to clarify roles. Survey responses suggest that existing OHA-PHD and LPHA roles could be modified to elevate the need for collaboration between funded partners, including OHA-PHD and LPHAs partnering with CBOs to ensure roles are fulfilled in a manner that is culturally and linguistically appropriate. Respondents also recommended modifications to add more contemporary equity language to existing roles, including referencing data sovereignty in roles focused on making data and information available for decision-making and coupling roles that reference the evidence base with "community-informed" measurement and strategies. Respondents also suggested modifying existing roles related to grantmaking to include the use of an equity lens for allocation decisions.

Survey respondents also suggested new roles for OHA-PHD and LPHAs. New role suggestions for OHA-PHD focused on serving as a bridge between LPHAs and CBOs to collaborate on Modernization-funded activities and engaging LPHAs in processes to fund CBOs. New potential roles for LPHAs related to serving as a liaison between OHA-PHD and local community organizations and coordinating with funded CBOs on Modernization activities. Other new roles for LPHAs focused on identifying health equity goals within each foundational program and capability in the Modernization framework to pursue system-wide, convening cross-sector partners to develop a shared dialogue and strategic plan for achieving health equity locally, and advancing data decolonization and sovereignty practices.

Respondents also suggested roles for CBOs to include in the Modernization Manual or another tool that facilitates role clarity. CBO roles relate to collaborating with OHA-PHD and LPHAs to advance foundational capabilities, including working with LPHAs to advocate for funding and policies that support health equity (policy and planning) and supporting OHA-PHD and LPHAs to communicate public health information in ways that are culturally and linguistic responsive (communications). Another suggested role for CBOs is ensuring their staff have received introductory-level training on public health given many CBOs have not worked in public health or with governmental public health agencies prior to receiving Modernization funding. In addition to suggested modifications and new roles, respondents' rankings may inform the prioritization of health equity and cultural responsiveness roles given limited capacity and funding to fulfill all roles, as well as issues advancing health equity in conservative national and local political climates.

A process to re-center the role of PHAB in decision-making and clarify partner roles in Modernization implementation may address LPHA participant concerns that power has become

centralized with OHA-PHD and has led to the state's overreach into county responsibilities and relationships. OHA-PHD could also explicitly acknowledge the unequal power dynamics that enabled unilateral decision-making in the past, as well as the inherent institutional power afforded to OHA-PHD as the funding agency. As suggested by one LPHA participant, an external contractor could lead Modernization partners through a power mapping exercise to make existing power dynamics explicit as a basis for conversation. OHA-PHD's acknowledgement of unequal power dynamics should be coupled with an explicit recognition of past harms from unilateral decision-making given acknowledging histories of conflict and correcting for power asymmetries are starting conditions for effective collaborative governance.

A process to clarify roles and address unequal power dynamics could begin to repair the broken trust between LPHAs and OHA-PHD. During this process, OHA-PHD could explicitly reaffirm its confidence in LPHAs to know their communities' needs and address perceptions that trust has decreased over time between state and local governmental public health. This reaffirmation should be delivered by OHA-PHD leadership, ideally the new Public Health Division Director, given LPHA participant comments that the former Director was absent from governance spaces and that a stated commitment to collaboration could help repair trust. For their part in repairing trust, LPHAs could acknowledge past instances in which they have treated OHA-PHD staff poorly during public meetings – as described by OHA leadership and program staff participants who administer the CBO Public Health Equity Grant – and commit to a partnership founded on mutual respect moving forward. Establishing better role clarity would also increase trust with CBOs given participant comments that OHA-PHD's unclear organizational structure and staff roles undermine trust. As described in the FAS, trust may need to be rebuilt or regularly renewed, so explicit commitments to mutual respect will need to happen

more than once and could be complemented by OHA-PHD staff getting back into communities, as suggested by LPHA participants, as well as dedicating an OHA-PHD position to bridging relationships between LPHAs and CBOs.

Expanding PHAB membership to include a CBO representative and health equity expertise were emphasized by both OHA leader and LPHA participants as a positive evolution of the shared governance space that enhanced community voice within decision-making. However, one LPHA participant commented that CBO members may lack an understanding of the public health system generally and Modernization specifically. This suggests that OHA-PHD should ensure new PHAB members, and especially CBO members who have not historically had a seat at the shared governance table, receive a thorough onboarding to the public health system and the PHAB to enable participation in discussions and decision-making. A robust onboarding process that clearly describes PHAB's purpose and partner roles may mitigate the issues with member retention described by OHA and LPHA participants. In addition, the onboarding could explicitly describe the potential for unequal power dynamics in the space – e.g., expert power of governmental public health members and OHA-PHD's inherent institutional power – and how OHA-PHD and PHAB members will mitigate those imbalances. One CBO participant also recommended standard compensation for CBO participation in decision-making spaces, which could mitigate power imbalances related to the socioeconomic position of members and signal the value of lived expertise. Addressing knowledge and power asymmetries through onboarding and resource asymmetries through the provision of participation stipends are essential starting conditions for collaborative governance.

Within onboarding, and perhaps within the larger role clarity conversation, OHA-PHD leadership should make the boundaries for PHAB's decision-making explicit to avoid

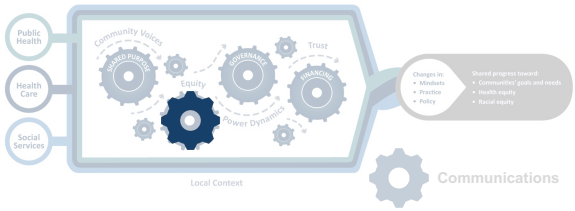
overpromising on the influence that PHAB members have on Modernization implementation. This suggestion comes as a reflection on one OHA leader's comment that the state agency implements PHAB's recommendations "to the extent that we can, and sometimes something's being asked for that we just can't do, but that that's our intention." The boundaries for shared decision-making should be made clear to PHAB members. As a complement to PHAB member onboarding, OHA staff supporting Modernization would benefit from training on Modernization, the purpose and boundaries of the PHAB as the primary decision-making body, and the distinct but complementary roles of OHA-PHD, LPHAs, and CBOs. Several OHA program staff participants who support the Public Health Equity Grant described not clearly understanding the role of the PHAB or LPHAs in Modernization, seeing the governance body and local governments as separate from their daily work and relationships with CBOs. While these OHA staff emphasized that their understanding of PHAB and LPHAs has increase over time, formal training seems warranted to institutionalize the transfer of knowledge and prevent the negative impacts to trust described by LPHA participants.

The Conference of Local Health Officials (CLHO) and the CBO Advisory Committee were described by participants as effective decision-making spaces and complements to the PHAB. However, OHA participants were inconsistent in their description of the CBO Advisory Committee's influence on Modernization decisions, and LPHA participants highlighted CLHO's prominence for local public health decision-making in the absence of trusted processes in the PHAB. Also, it is unclear how discussions and decisions within these spaces are formally introduced to PHAB members for consideration. This suggests the need to clarify the decision-making power of these complementary governance spaces and make explicit the communication channels between these spaces and PHAB. Clarity on the scope and purpose of all shared

governance bodies is essential to ensuring community voice truly informs Modernization decision-making.

Formal spaces for joint decision-making could be complemented by more informal opportunities for shared learning between LPHAs and CBOs. CBO and LPHA participants described a lack of access to one another as a barrier to shared purpose and governance, suggesting that OHA-PHD could convene communities of practice or other opportunities for funded partners to meet with and learn from one another. Shared learning spaces could mitigate the harmful power dynamics inherent to unequal access to information across partners. Spaces for CBOs and LPHAs to meet, identify shared work, and practice collaborative relationships could build trust between partners and address one CBO participant's comment that their interactions with the LPHA have felt extractive rather than reciprocal. Lastly, OHA-PHD serving as a convener – and potentially facilitator – of the shared learning spaces would fulfill the state's role as facilitative leader within a collaborative governance arrangement by bridging between partners.

As described in the previous section, core components of the FAS are interrelated. Clarifying the purpose and scope of the PHAB and roles across OHA-PHD, LPHA, and CBO partners will ensure there is a trusted space with formalized roles to determine how best to reflect all partners in a shared metrics framework, to make shared funding decisions, and determine which shared stories to tell about funded activities.



Shared Data and Measurement Recommendations

Shared data and measurement are a "feature of aligned systems that enables sectors to collectively and systematically gather, organize, and share data between entities, and the process of using this information to track progress." OHA and LPHA participants described the Modernization accountability metrics as the primary framework for shared data and measurement. However, LPHA participants emphasized that CBOs are not reflected in the shared measurement framework and described how this lack of alignment limits their ability to tell a cohesive story about the impacts of Modernization funding to local decision-makers and the state legislature. One OHA leader participant noted that the accountability metrics are being introduced to funded CBOs in existing meetings convened by OHA-PHD, and while CBOs seem interested in learning about the metrics framework and indicators, acknowledged this approach as "backwards." This suggests that CBOs should either be reflected in the existing accountability metrics framework through distinct process measures to which they will be held accountable or, at the very least, through the formal documentation of how CBOs support governmental public health in achieving health outcome indicators. One OHA leader participant also noted that only governmental public health agencies are referenced in the accountability metrics language in statute, suggesting that statute may need to be revised to properly reflect other partners receiving Modernization funding. The approach to embedding CBOs in the shared data and measurement framework will likely depend on the outcome of shared vision and role clarity conversations and could be reflected in an update to the PHAB's strategic data plan.

One LPHA participant noted that it is difficult to justify investments in diversity, equity, and inclusion (DEI) with an accountability metrics framework centered on population-level health outcomes (e.g., congenital syphilis rates, adult influenza vaccinations), particularly in a more rural and conservative context. This suggests the accountability metrics framework and/or strategic data plan would benefit from language that explicitly links upstream efforts to enhance capacity for health equity – such as hiring a community engagement team – with downstream improvements to priority health outcomes. In addition, the shared measurement framework should include equity benchmarks or guidelines for existing indicators, which aligns with recommendations from the Commission to Transform Public Health Data Systems and Data Across Sectors for Health (DASH) initiative to promote a comprehensive view of public health data by collecting information on structural and historical factors that drive persistent health inequities, such as structural racism.[163]

While one OHA leader participant believed that connecting the work of OHA-PHD, LPHAs and CBOs through a common measurement framework would "raise the profile" of CBO Modernization activities, another OHA leader participant was concerned that CBOs would be accountable to the same health outcomes as governmental public health agencies, which have statutory responsibilities to protect the public's health. The latter OHA leader suggested that new metrics be co-developed with CBOs and the process of measure selection should be flexible to account for CBO- and community-specific priorities and approaches. PHAB – which has a CBO representative – could lead the development of CBO-specific metrics and liaise with the CBO Advisory Committee to ensure a process of co-creation. PHAB could develop a menu of metrics from which CBOs can select, similar to the measure selection process for LPHAs that accommodates local preferences. With a shared measurement framework established, OHA-PHD

could also engage LPHAs and CBOs in the development of related data collection instruments, as capacity allows. Lastly, one OHA leader participant was concerned that CBOs would be expected to immediately demonstrate health outcomes if embedded in an accountability metrics framework. This suggests that the expected timeline for CBO-related outcomes should be documented, justified, and commensurate with expectations for LPHAs and OHA-PHD.

Incorporating CBO accountability metrics into the existing measurement framework aligns with recommendations from the Commission to Transform Public Health Data Systems that governmental public health should develop and maintain equitable, shared data systems with communities. These recommendations reflect the core components of a "data justice" approach in which the collection, analysis, sharing, and use of data is entirely in service of and with accountability to participants and their communities. While one OHA leader participant asserted that governmental public health has experienced a paradigm shift toward data justice in recent years, this commitment to community-centered public health data systems could be explicitly reflected in an update to PHAB's strategic data plan.

Embedding new CBO metrics in a shared measurement framework may also address concerns that current data collection activities are not adequately capturing the impact of funding. CBO participants, in particular, described a "false sense of counting" (e.g., events, partnerships) when completing quarterly activity reporting to OHA-PHD, and suggested that complementary data collection activities may be needed to more robustly characterize Modernization activities, such as through more qualitative methodologies. Related to the sentiment that OHA-PHD is over-reliant on quantitative data to describe Modernization progress, CBO participants noted the need to decolonize Modernization data practices to emphasize multiple ways knowing and value varied sources of information to tell stories of progress. A

shared definition and commitment to data decolonization could be reflected in an updated strategic data plan. Lastly, OHA leader and program staff participants emphasized that the focus on quantitative data was largely driven by requests from agency leadership and the Governor's Office, suggesting these internal and external leaders would need to be socialized and committed to a data decolonization approach.

While including CBOs in the shared data framework should support more consistent measurement between funded partners, this approach could be complemented by OHA-PHD training and funding to CBOs and LPHAs to collect their own community-level data. Indeed, empowering and resourcing partners to collect their own local data aligns with both the Commission to Transform Public Health Data Systems recommendation that governmental public health collect accurate community-level data,[183] as well as principles from the DASH initiative to build on existing community-engaged scholarship and research.[36] Empowering partners to collect local data could also complement data modernization activities led by OHA-PHD in which community researchers were engaged to discuss the strengths and limitations of population health data collected by the state public health division.

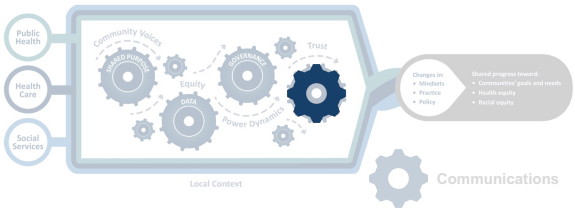
LPHA and CBO participants also commented on the limited sharing of Modernization data between OHA-PHD, LPHAs, and CBOs. CBO participants also indicated that no opportunities exist for partners to jointly interpret data and develop shared dissemination strategies. Relatedly, one LPHA participant emphasized a lack of communication and transparency on outcomes from the investment in data modernization and suggested that OHA-PHD provide partners with more opportunities to understand the initiative and consider how it complements other data sources to tell the story of Modernization progress. This suggests that updates to the strategic data plan could include explicit expectations for Modernization data

dissemination, including when, where, and how partners will interpret and develop shared stories about the data together, as well as determine how data are shared out and to whom.

A strategic data plan that reflects the contributions of all funded partners could also address CBO participant concerns that data collected by OHA-PHD through grant activity reporting is inconsistent in both content and frequency. An updated strategic data plan could specify needed measures across partners and clarify the frequency with which data are needed for reporting to interested parties. The process to jointly develop a data dissemination strategy would also allow for all partners to be involved in the analysis of risks and benefits of data sharing as recommended by the DASH initiative, as well as adhere to the Commission to Transform Public Health Data Systems recommendation to ensure a shared understanding of the data lifecycle and access to data. Establishing and hewing to shared expectations for data collection could also build back trust with CBOs and LPHAs who expressed concern with OHA-PHD's lack of data sharing.

LPHA participants described concerns that the accountability metrics may overestimate the impact of Modernization funding and underestimate needed resources for priority health outcomes. For example, one LPHA participant described how the primary source of funding for local efforts to prevent and treat syphilis is federal, whereas none of the state Modernization investment contributed to syphilis programming despite being an accountability metric. This suggests that partners may need to clarify how investments and related progress on the accountability metrics health outcome indicators are documented and reported within a shared measurement framework. OHA and LPHA participants seem to differ on the extent to which Modernization funding from the legislature must solely support work on the health outcome indicators and whether other sources of local, state, and federal funding should be considered

investments in Modernization. These tensions will be discussed further in the shared financing section. Lastly, LPHA participants were concerned that reductions in local funding would limit progress on accountability metrics given the need to focus on core service provision in ways that may deviate from Modernization health outcome indicators. This suggests a need to develop multiple funding scenarios that describe how Modernization activities can be scaled up and down while prioritizing alignment with accountability metrics to the degree possible (discussed further in shared financing).



Shared Financing Recommendations

Shared financing is defined in the Framework for Aligning Sectors as a "feature of aligned systems characterized by sustainable methods with appropriate incentives and shared accountability." OHA leader and LPHA participants described a shared financing approach early in Modernization implementation with funding decisions made collaboratively in the PHAB. This collaborative approach resulted in shared decisions on which foundational programs to focus limited funding, the regional approach to funding county health departments, and the magnitude of resources needed for the governmental public health system to fully implement the Modernization framework. One OHA leader participant noted the shared financing approach as core to Modernization from the very beginning, with guidance for collaborative decision-making on funding allocations and expected outcomes outlined in both the 2015 Task Force on the Future of Public Health Services recommendations and later codified in Oregon statute.[194,27]

However, early shared financing decisions focused exclusively on the governmental public health system. While one OHA leader participant described the expansion of Modernization funding to include Oregon's federally-recognized tribes and tribe-serving organizations and CBOs as enhancing shared financing, LPHA participants viewed OHA-PHD's direct funding to CBOs as a decrease in shared financing. Similar to other themes, the perceived decline in shared financing was primarily due to OHA-PHD's unilateral decision to directly fund CBOs for Modernization without engaging LPHAs or the PHAB.

One OHA leader participant acknowledged the lack of consultation with LPHAs on funding decisions during and immediately following the COVID-19 pandemic response. LPHA participants noted that OHA-PHD's unliteral approach to decision-making continued in the post-COVID-19 period and siloed processes that were historically shared, including the development of the Modernization policy option package for the legislature. LPHA participants also emphasized their history of directly funding CBOs and concern with the lack of a shared funding approach to ensure funding streams to CBOs are complementary. This suggests the need to develop a shared financing strategy for Modernization with the decision-making roles of OHA-PHD, LPHAs, CBOs, and the PHAB clearly defined. The financing strategy will be informed by the shared purpose and role clarity conversations described in earlier recommendations and should be led by the PHAB as the primary governance body with the engagement of CLHO and the CBO Advisory Committee to ensure broader representation of LPHAs and CBOs in decision-making.

While OHA-PHD has directly funded CBOs for Modernization to date, a shared financing strategy will likely include flexibility for LPHAs to fund CBOs rather than OHA-PHD. For example, one LPHA participant described a "passthrough pilot" in which participating

LPHAs serve as the fiscal agent for CBOs in their justification who agree to the arrangement. While the LPHA participant noted limitations to the passthrough pilot, such as not being able to charge an indirect rate for grant administration, future funding models for Modernization will benefit from multiple funding options. These options can range from OHA-PHD continuing to serve as grant administrator in jurisdictions where LPHAs have limited capacity to LPHAs serving as the fiscal agent in jurisdictions where they have ample capacity and strong relationships with CBOs. A shared financing strategy could also specify partner roles in CBO grantmaking, including how LPHAs, CBOs, and the PHAB inform eligible activities for funding, which proposals are funded, and grant amounts. One OHA leader participant attributed the absence of LPHAs in CBO grantmaking decisions on external pressure from agency leadership to quickly allocate the funding. Governmental public health leadership and legislators will need to allow for longer planning and development timelines if prioritizing more collaborative, time-intensive approaches to financing decisions.

Clarifying the role of LPHAs in CBO grantmaking could address LPHA participant concerns that they were forced to expend limited resources on aligning local efforts with CBOs. In addition, one LPHA participant emphasized that the option to fund CBOs directly – especially if mandated by OHA-PHD – could support and provide cover for LPHAs in more conservative communities to advance equity goals through partnerships with culturally-specific CBOs. More thoughtfully integrating LPHAs in CBO grantmaking and administration could also mitigate perceptions of OHA-PHD overreach into local communities and correct power asymmetries that enable such overreach. One CBO participant also questioned whether OHA-PHD is the appropriate funding agency and suggested exploring alternative funding models, such as a non-profit organization serving as a central hub for grantmaking across the public health system with

funding decisions made by the PHAB. One OHA leader participant also suggested exploring more creative financing models and referenced social impact bonds, i.e., public-private partnerships that fund effective social services through performance-based contracts. Partners could explore alternative funding models through the development of a shared financing strategy.

OHA and LPHA participants had mixed perceptions of whether Modernization financing was equitable. OHA participants viewed the expansion of funding to include CBOs as enhancing equity, while LPHA participants did not consider the inclusion of CBOs equitable given local governments are losing funding streams and have legal obligations to provide core public health services. This suggests that the shared financing strategy should clearly describe how equity is being applied to funding decisions and will be informed by the equity definition developed for the shared purpose refresh. The shared approach for equitable financing should continue to address known gaps in funding. For example, one OHA leader participant described how LPHAs and OHA-PHD identified geographic disparities in early CBO funding decisions, so prioritized proposals from CBOs serving rural and frontier communities in future rounds of funding. This demonstrates that the CBO grantmaking process is flexible enough to embed equity considerations into funding decisions. Partner conversations about equitable financing should explicitly address LPHA participant perceptions that funding to CBOs has reduced available funding to LPHAs, a tension that CBO participants felt in their interactions with OHA-PHD and LPHAs. Partners will need to thoughtfully balance the limitations of a resource scarcity mindset on developing a shared financing strategy with the reality of LPHAs needing to cut programs due to reduced local funding. These conversations could also repair trust by openly acknowledging and offering space to correct the “false narrative” that LPHAs do not want to work with CBOs.

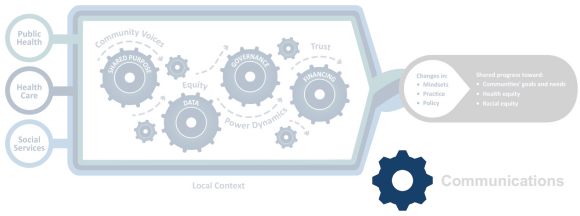
One OHA leader participant referenced the Modernization accountability metrics and related incentive payments to LPHAs as fulfilling the "appropriate incentives" component of shared financing. The OHA leader envisioned a more expansive approach to pay for performance in which more partners would benefit from improved health outcomes in the community. Indeed, a case study of an accountable communities for health (ACH) initiative in Summit County, Ohio, described how participating health care providers and community groups shared in the cost savings resulting from a diabetes initiative and reinvested the funds in other local interventions that leveraged its community assets.[195] This suggests that a shared financing strategy could include a pathway to expand incentive metrics to other funded partners or pool incentive funds across partners for shared interventions. Relatedly, LPHA participants noted that CBOs are not included in the Modernization accountability metrics framework and therefor exempt from shared accountability to the funding. OHA program staff participants did not agree with this sentiment and cited CBOs' quarterly progress and expenditures reporting as evidence of accountability; nevertheless, OHA-PHD could leverage the development of a shared financing strategy to more clearly communicate systems of accountability for CBOs and reinforce that accountability will look different for CBOs compared to governmental public health agencies. In addition, OHA-PHD can more clearly communicate the origin and purpose of Modernization funding to CBOs given some participants misclassifying some funding streams in the Public Health Equity Grant as Modernization (e.g., commercial tobacco prevention). This suggests that robust Modernization onboarding and ongoing educational opportunities could facilitate increased understanding and accountability to the funding.

OHA program staff participants who support Public Health Equity Grant administration described a lack of shared accountability to funding from OHA staff situated in programs who

are content matter experts and provide topic-specific technical assistance. OHA staff in programs attributed this disconnect to funding being concentrated in the OHA-PHD Director's Office, with some programs not receiving any monetary or non-monetary support despite their topics being tied to the accountability metrics (e.g., Oregon Immunizations Program and HIV, STI, and TB Section). This suggests that a shared financing strategy should clearly articulate the magnitude, location, and reason for funding allocations within OHA-PHD. OHA-PHD could also audit internal funding to ensure allocations align with PHAB's priorities, accountability metrics, and process measures to which the state is accountable.

OHA program staff and LPHA participants commented on the sustainability of Modernization funding. LPHA participants described how boom-and-bust cycles of public health funding disrupt and necessitate difficult cuts to programs and services. Assuming that Modernization will not be fully funded in the near-term through a mix of federal, state, and local sources, a shared financing strategy should account for this variability by describing pathways to scale up and down based on available funding. These pathways could include a set of shared core priorities that will be maintained at the most basic funding levels. Planning around scalability of Modernization programming could also make explicit the commitment to build organizational infrastructure for health equity and equitable service delivery given these efforts tend to receive budget reductions first in favor of maintaining core disease-specific programming, especially without clear connections to the accountability metrics (as described in the shared data and measurement section). One OHA program staff participant also commented on the short time horizon for CBO funding, which limits sustainability of funded projects and progress on Modernization priorities. Unlike LPHAs – all of which are guaranteed a portion of Modernization funding – CBOs are required to apply for competitive Public Health Equity Grant

funding every two years. Modernization partners could consider embedding certain elements of trust-based philanthropy into the grantmaking approach, primarily recommendations to provide multi-year funding and dedicate a portion of funds as unrestricted for an organization's infrastructure needs.



Shared Communications Recommendations

Shared communications is not a feature of the FAS but was identified as a core component for effective collaboration in the Chapter 2 literature review and thus added to the study framework. For the purposes of this study, shared communications is defined as a "feature of aligned systems in which sectors have a shared communications strategy that centers community storytelling." OHA and LPHA participants described shared communications early in Modernization implementation, including work with an external contractor to develop a communications strategy and related talking points to ensure consistent messaging with leadership and decision-makers. However, these same participants noted that shared communications decreased over time with little to no examples of current shared communications. One OHA leader participant acknowledged that communications efforts led by OHA-PHD have been a relatively small component of Modernization overall, and pointed to a disconnect between state and local governmental public health communications efforts. Further, shared communications examples provided by participants, such as CBOs providing testimony in support of Modernization funding during the 2023 legislative session, OHA-PHD sharing out program communications for

some CBOs, OHA-PHD producing videos of LPHA-CBO partnerships, were not informed by a shared strategy.

LPHA participants noted that shared communications are limited by the fragmentation of shared purpose. This suggests the need to develop a shared communications strategy based on the refreshed shared purpose and clarified partner roles. The shared communications strategy should be an undertaking of the PHAB as the primary governance body with engagement of the CBO Advisory Committee and CLHO to ensure communications efforts are aligned across governance spaces. LPHA participants described how the lack of a shared communications strategy and related materials makes it difficult to speak on Modernization in national forums and with local and state decision-makers, which impacts their relationships and trust as experts. This suggests that a shared communications strategy and plan should clarify audiences for Modernization communications and include details on the most appropriate messages, formats, channels, and messengers for each audience based on their values. Lastly, LPHA and CBO participants described not only a lack of communications materials but also commented that existing materials are difficult to find. This suggests that materials should be placed in a centralized place that can be easily accessed by partners.

Partners can consider principles from the Truth, Racial Healing, and Transformation framework – specifically the "narrative change" pillar – in developing a shared communication strategy that centers health equity.[144] The Truth, Racial Healing, and Transformation framework suggests that shared communications should actively work to disrupt dominant narratives that normalize inequity and uphold oppression; advance new narratives from communities and individuals in historically marginalized groups; and support the community to develop a full understanding and articulation of its history. Shared communications planning should also be

informed by Eve Tuck's desire-based framework for research, which calls on collaborators to "resist stories that introduce or reinforce narratives of people who experience structural oppression as broken or damaged" and instead highlight a community's assets, opportunities, and desires.[35] These principles also align with recommendations from the DASH initiative to center health equity and well-being in narrative change and minimize narratives that blame individuals or groups.[36]

One OHA leader participant described internal efforts to ensure that communications for the Public Health Equity Grant are linguistically- and culturally-accessible. These principles and expertise can not only inform the development of a shared communications strategy and plan but also serve as a goal for all Modernization communications delivered by OHA-PHD, given the participant noted this capacity was inconsistent across OHA-PHD programs. The OHA leader also highlighted OHA-PHD's provision of strategic communications training and technical assistance to CBOs. Future training and technical assistance opportunities should be informed by the shared communications strategy and plan, and OHA-PHD should ensure these capacity building opportunities are also offered to LPHAs.

Member Checking Considerations

Listening sessions with focus group and key informant interview participants were convened from April 7-11, 2025. Listening session participants identified several study recommendations to elevate for reporting and, ideally, implementation by agencies leading Modernization. In the area of shared purpose, the LPHA participant elevated the recommendation to refresh or "renew" the shared vision for Modernization as an essential first step to ensuring collaborative implementation of Modernization. The LPHA participant worried that such a process may prove

difficult if "done through committee" (referencing the recommendation that the PHAB may lead the process) and suggested that the new OHA-PHD Director may be in the best position, as the head of the implementing agency, to set the parameters for a refresh of the Modernization vision. Also related to shared purpose, the CBO participant and one OHA leader participant elevated the recommendation to offer funded CBOs a more robust onboarding to Modernization. The CBO participant described not knowing about the history of Modernization, including how long the state has been investing in the systems change initiative, while the OHA leader participant "loved" the idea and hoped the recommendation "makes its way to me so I can implement it."

In the area of shared data and measurement, one OHA participant elevated the recommendation to reflect CBOs in the Modernization accountability metrics framework and better align activity reporting between funded CBOs and LPHAs. The OHA participant described recent conversations with external funders about the Public Health Equity Grant Program and emphasized that aligning CBO grant funding to a shared set of accountability metrics with clear outcomes was "interesting and appealing," suggesting that implementing this recommendation could contribute to additional, more diverse, and sustained funding for CBOs to advance Modernization. Lastly, related to shared financing, the CBO listening session participant emphasized the recommendation to clarify the boundaries for PHAB's decision-making on funding. The CBO participant recalled participating in a PHAB subcommittee related to funding, at the request of OHA-PHD staff, and being surprised that the group would not be discussing CBO funding. The participant commented, "If I was an LPHA I would be confused too and wondering what expertise this CBO brings to a discussion of LPHA funding."

Study Limitations and Assumptions

There are several study limitations. First, focus groups and surveys with LPHA and CBO staff may not capture all possible perspectives from these partner groups given these optional opportunities are more accessible to those who have time and capacity to participate. Stipends were offered to CBO focus group participants to lower the barrier to participation for those who may experience economic instability and also honor the importance of lived experience. This limitation was also addressed, in part, by targeted recruitment to ensure LPHA perspectives included those serving both rural/frontier and urban communities and a mix of public health administrators and program staff. Similarly, targeted recruitment for CBO focus groups ensured the perspectives of organizations serving Communities of Color, first and foremost, with the second focus group comprised on CBOs serving other priority populations, including rural and frontier communities, people with disabilities, and LGBTQ+ populations. Ideally, the study would have featured separate focus groups for each of these priority populations. However, given time and resource constraints, the study was limited to two CBO focus groups and centered a lead-with-race approach by prioritizing organizations serving Communities of Color. The study also acknowledged potentially intersecting identities by allowing CBO participants to select the focus group with which they most identify.

Focus groups were offered in both English and Spanish (through simultaneous interpretation services provided by the Immigrant and Refugee Community Organization's World Language Bank) to reduce the barrier to participation for CBO and LPHA staff who primarily or exclusively speak in Spanish. Spanish was the only non-English language offered through interpretation services, so the study did not include the critical perspectives of staff who

speak other languages. The Delphi survey series was conducted exclusively in English, so was not available to participants who exclusively speak in other languages.

Another limitation is that while the study captures the perspectives of three partner types (state and local governmental public health and CBOs), the study does not reflect perspectives from other essential partners in the public health system, including tribes and tribe-serving organizations and those from other sectors, such as healthcare and education. The study is also limited in the depth of findings across all core components and adaptive factors in the FAS. The richness of description across parent codes was affected by time constraints and the order in which questions were asked (i.e., started with questions about framework core components and then adaptive factors). In several focus groups and key informant interviews, not every question was asked within the time allotted, which prioritized core components over adaptive factors in most instances and breadth over depth in general.

The openness of the Delphi survey series also served as a study limitation. The composition of respondents' demographics changed drastically across the three survey phases. While LPHAs represented 52% of respondents in the first survey (generating and modifying roles), they represented only 4% of responses in the second survey (rating roles), and 31% in the third survey (ranking roles). In contrast, CBO participation increased over survey phases, representing 26% responses in the first survey, 87% in the second survey, and 62% in the third survey. The reason for such a drastic change across survey phases is unclear given all partner types were recruited to each survey at the same time, using the same language in recruitment materials, the same channels and messengers for recruitment emails, and the same platform for survey administration. In addition, survey incentives were not offered to any partner type (unlike focus groups), so there was not a financial component to survey participation. The implications

of CBOs comprising the majority of responses in later survey phases is that role ratings could have skewed in favor of OHA-PHD and LPHA roles that focus on community engagement and health equity or higher ratings for new CBO roles compared to OHA-PHD and LPHA roles. However, this does not seem to be the case as the difference in average ratings across roles was so minimal.

The study is also limited in its exploration of health outcomes from cross-sector alignment, typically an interest of decision-makers, and instead revealed changes to mental models, relationships, power dynamics, resource flows, practice, and organizational policy. Lastly, the study's generalizability to other jurisdictions is limited by Oregon's unique implementation context, including the foundational public health services (FPHS) framework being codified in state law, the presence of a dedicated health equity and cultural responsiveness foundational capability in Oregon's framework, consistent and increasing funding from the Oregon legislature since 2017, and the allocation of Modernization funding to CBOs.

My positionality, while an asset to many parts of this study, is also a study limitation. While working for the Oregon Public Health Division benefited the study in terms of access to and pre-existing relationships with intended study participants, it could have led to participants feeling pressured to consent to study participation or not feeling comfortable speaking truthfully about negative experiences with the grant program and their relationships with the state. These challenges were mitigated by consistently communicating that participation is voluntary and they can withdraw at any time, that all data will be kept confidential and only available to the lead researcher and one other researcher who is supporting data analysis, that their names will not be included on any products associated with the research and any quotes used will be deidentified, and participation will have no impact on employment or grant funding.

My position as a white, exclusively English-speaking researcher also limited my capacity to engage participants with a need or preference for non-English languages and participants representing Communities of Color in in a manner that fosters trust and mitigates power dynamics. As a white researcher proposing a study that seeks to apply an equity lens and center the voices of people from systematically oppressed communities, particular attention was paid to data collection processes that could be extractive or appropriative. An extractive study design was mitigated by ensuring principles of co-creation were embedded throughout the data collection process where feasible. This included engaging study participants in the interpretation of preliminary results, discussing preferences for how final results are disseminated, and exploring opportunities for the co-production of study manuscripts and conference presentations.

Implications and Future Research

There are several implications of the research for public health theory, practice, and policy.

Theory implications. The study confirms the use of the Framework for Aligning Sectors (FAS) as a relevant framework to study collaboration between governmental public health and non-profit organizations for systems change initiatives. FAS core components and adaptive factors resonated with all partner groups and led to clear recommendations for policy and practice improvements. The study also suggests potential refinements to the FAS, including the addition of the shared communications core component and the use of complementary frameworks, such as the Model of Collaborative Governance,[3] that add detail to FAS components for easier application to research. This study also presents detailed examples of how the FAS core components and adaptive factors are experienced in public health practice, which may support other researchers to understand and apply the framework in their research. Refining

and better operationalizing the FAS is especially important given the relative nascency of both the framework. Although the study informs refinements to the FAS, the depth of findings across all core components and adaptive factors was limited given time constraints in focus groups and key informant interviews that did not allow for equal attention to all FAS elements. Future research could prioritize depth over breadth by focusing on a smaller set of the core components and adaptive factors, to be identified by implementation partners.

The study also confirmed hypotheses from institutional theory, social movement theory, and network theory in a governmental public health and public health practice context. First, study findings confirm the potential for "path-breaking" behavior that deviates from institutional norms and structures when system disruptions occur that change the balance of power.[67] In this case, the police killings of Black Americans and visible racial and ethnic inequities in COVID-19 outcomes brought conversations of public health's responsibility for dismantling racism and other forms of institutional oppression to the fore.[69] The related public and political pressure drove governmental public health to prioritize more collaborative forms of service delivery – as evidenced by direct funding to CBOs for culturally-specific outreach and education on COVID-19 vaccinations – in order to maintain organizational legitimacy and public trust.[176]

Further, this shift in focus empowered entrepreneurs within governmental public health – such as leadership and staff on the OHA-PHD Community Engagement Team – to subvert institutional practices that ignore inequities and focus exclusively on governmental public health's role in service delivery.[13,68] While these actors are embedded within an institution that tends to maintain the status quo, the COVID-19 pandemic served as a "focusing event" to disrupt the local policy subsystem for FPHS and change the problem definition from governmental public health's capacity to deliver high-quality programs to health inequities and the lack of

partnerships for culturally-specific service delivery.[63] Future research should determine the extent to which this "institutional dismantling" was sustained in the years following the initial focusing events. Study findings suggest a deviation back toward the status quo – with a renewed focus on rigid systems of accountability and transparency – following the most acute period of the COVID-19 response and racial justice reckoning. Lastly, network theory lends a sense of urgency to study recommendations; the burden of being in a cooperative network with governmental public health may begin to outweigh the financial benefit if inconsistencies in vision, decision-making, measurement, funding, and communications continue long-term.[83,84]

Practice implications. Study recommendations inform how governmental public health can improve collaboration with CBOs for public health transformation efforts. These recommendations are likely not limited to the implementation of FPHS and can be considered by other divisions within OHA and other state agencies in Oregon that fund or are considering funding CBOs to support culturally specific interventions. For example, OHA's Behavioral Health Division could reflect on study recommendations for the ongoing implementation of Ballot Measure 110, which allocated $260 million to expand community-based substance use treatment services.[196] A recent report from the Oregon Health Authority & Oversight and Accountability Council warned that "it is not clear how many providers of culturally specific services were funded to help serve populations most affected by the war on drugs" and recommended improvements to the grant process to better attract community-based applicants. Study recommendations could inform how state agencies balance the potentially competing roles of funder and partner in collaborative efforts with local government agencies and community organizations.[20]

Study findings also inform state-led Public Health 3.0-style initiatives across the country that focus on cross-sector partnerships and community empowerment to address health equity. This includes the 24 states that are formally implementing the FPHS framework and participating in the Public Health Accreditation Board Center for Innovation's 21st Century Learning Community.[179] While no other state is currently funding CBOs as partners in FPHS implementation, study recommendations would support their understanding of how to authentically and effectively embed CBOs in a historically governmental public health effort should they choose to do so in the future. The utility of the FAS framework may, in part, depend on the degree to which other states and local jurisdictions value public health system transformation as a collaborative effort inclusive of partners outside of governmental agencies (versus keeping transformation efforts exclusively focused on governmental public health).

Even if other states participating in the 21st Century Learning Community do not have the capacity, resources, or interest to fund CBOs as partners in FPHS implementation, the FAS framework and study findings could still inform how states (and their local government counterparts) implement the community partnership development and health equity and cultural responsiveness foundational capabilities of the FPHS framework. For example, the community partnership development capability includes responsibilities for governmental public health agencies to develop and maintain strategic partnerships with governmental and non-governmental partners and trusted relationships with communities.[197] In addition, leveraging the FAS as an assessment framework for FPHS implementation could support state health departments to more clearly characterize and communicate the process of public health system transformation to policymakers, local implementers, and community members. While the FAS framework could help states identify improvements to their collaborative processes, future

research using the FAS framework could prioritize its use in characterizing outcomes of transformation efforts, which would likely appeal to decision-makers and funders and therefore become essential to sustainable funding.

Policy implications. Policymakers who value and want to prioritize cross-sector collaboration in public health system transformation should ensure that statutes specifying FPHS implementation require administrative agencies to co-develop an implementation plan(s) with partners that specifies shared purpose; decision-making processes that include how funding will be allocated; process and outcome metrics to which funded partners are held accountable; and strategic communications goals and approaches. Policymakers who want to support the collaborative implementation of FPHS – especially if partners outside the government systems are engaged – should also advocate for longer time horizons to achieve expected outcomes and allow for more thoughtful engagement of cross-sector partners in shared planning. Lastly, FPHS implementation requires dedicated and sustained funding sources that track over time with inflation and the increasing costs of doing business to avoid the typical "boom and bust" cycle of public health funding that limits sustained progress on systems change over time.

Policymakers can support the equitable implementation of FPHS by ensuring that a focus on population-level health improvement does not come at the cost of decreasing health inequities. In Oregon, LPHA participants described how their efforts to hire staff for culturally-specific community engagement came under scrutiny by local decision-makers because Modernization accountability metrics specify improvement goals for disease-specific health outcomes, such as syphilis and immunization rates, without complementary benchmarks to decrease disparities in these priority areas. Policymakers should not only advocate for state agencies to explicitly embed equity in FPHS implementation – including in shared systems of

measurement – but also to understand that a diverse public health workforce with potentially non-traditional skillsets are required to advance both overarching population health improvement goals, as well as those related to decreasing health inequities.

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Appendix A. Institutional Review Board overview and pre-screening form

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Human Research Protection Review

FORM 1: OVERVIEW & PRE-SCREENING

SECTION 1: PROJECT OVERVIEW

A. Project Title: Governmental Public Health's Capacity for Community Collaboration in Oregon

B. Study Lead: ☐ Faculty Investigator ☒ Student Investigator with Faculty Advisor

C. Investigator(s):

Name	Department or Other Affiliation	Email	PSU Affiliation	Project Role	CITI Training Date*
Steven Fiala	HSMP	sfiala@pdx.edu	PSU Student	Student Investigator	1/8/24
Julia Goodman (primary)	HSMP	julia.goodman@pdx.edu	PSU Employee	Faculty Advisor (PI)	12/6/23
Billie Sandberg	School of Government	billie.sandberg@pdx.edu	PSU Employee	Faculty Advisor (PI)	5/2/21

*Application will not be approved until the PI, Co-I, Student Investigator or other Key Personnel listed have completed CITI Training.

D. Student Investigator: *A faculty advisor **MUST** be identified above.*
Is this project the subject of student's master's thesis or dissertation? ☒ Yes ☐ No

E. Funding: Is the proposed project funded through external funding source(s)? ☒ Yes ☐ No
List Funding Source(s): Northwest Center for Public Health Practice student collaborative project award
Provide PSU Proposal # or Banner Grant #: N/A

F. Financial Conflict of Interest: Do any of the investigators have an economic interest in, or act as an officer or director of, any outside entity whose financial interest would reasonably appear to be affected by the results of the study? ☐ Yes ☒ No
If yes, describe:

G. Proposed Project Duration: Anticipated Start Date: 03/01/24
Total Project Duration (# of months): 12

H. International Research:
Will study participants be specifically recruited from outside of the United States? ☐ Yes ☒ No
If yes, complete and submit International Research Form.

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I. Objectives: *State the **purpose and specific aims of the study**; include the hypotheses to be tested or the research questions that will guide the study. Use plain language and keep description brief; suggest use of bullet points or list format.*

Persistent population health inequities require a transformation of governmental public health practice to advance health equity. Nationally, this transformation has been envisioned as "Public Health 3.0" and emphasizes the engagement of multiple sectors and community partners to improve the social determinants of health. In Oregon, local public health authorities and community-based organizations receive funding from the state health department to advance public health transformation. There is limited academic research on collaboration between governmental public health and community partners to advance public health transformation. This proposed mixed methods study seeks to explore the factors of cross-sector alignment that impede or facilitate collaboration among state and local governmental public health and communities to advance health equity (research question). The study aims to: 1) Characterize the degree to which factors of cross-sector alignment are currently fulfilled; 2) Compare similarities and differences in how partners perceive factors of cross-sector alignment; and 3) Explore perceived roles of each partner in advancing health equity.

J. Rationale: *Provide the scientific or scholarly **background** for, **rationale** for, and **significance** of the proposed study based on existing literature and explain how it will add to existing knowledge. Briefly summarize the relevant current context of the study and gaps in current knowledge. Use plain language and keep explanation brief; suggest use of bullet points or list format.*

Background: Over time, public health interventions and high-quality clinical care in the U.S. have significantly improved the health of the general population, but population health improvements have not benefitted all groups. To advance health equity, there was a call for governmental public health transformation (called Public Health 3.0) to advance health equity by engaging multiple sectors and community partners to improve the social determinants of health. In 2017, the Oregon Health Authority developed the Public Health Modernization (PHM) framework to guide local transformation efforts and received an initial $5 million legislative investment to begin PHM, which was primarily allocated to local public health authorities (LPHAs). In 2021, Oregon received $45 million for PHM and began funding community-based organizations (CBOs) after recognizing the critical role of CBOs in a more equitable COVID-19 response and the need for sustained funding to CBOs to support local public health priorities.

Existing literature: Until 2021, PHM was an initiative of governmental public health, so the inclusion of CBOs requires careful consideration of how governmental public health agencies can effectively collaborate with community partners to advance health equity. A 2017 review of existing research on the effectiveness of multi-sector collaborative efforts to improve community health was described as having "limited usefulness" given mixed or negative findings. Despite mixed evidence of effectiveness for community health improvement, a meta-analysis of 100 case studies of citizen participation in 20 countries identified four types of democratic and developmental outcomes that can be realized when participation is done well, including strengthened practice of citizen participation and a more responsive and accountable state government. However, these citizen participation outcomes are heavily dependent on how the participation opportunities are structured by the state. Community engagement may contribute to a greater sense of exclusion if new spaces reinforce old hierarchies and participation may be linked to a sense of tokenism if not backed by outcomes.

Rationale/Significance: Most studies on public health collaboration focus on smaller-scale partnerships between local health departments and other agencies while less is known about how state health departments collaborate with organizations outside the health sector. Overall, there is limited academic,

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systematic research on cross-sector collaboration between governmental public health and community partners, so there is a unique opportunity to study this collaboration to advance health equity in Oregon. This research will inform governmental public health's approach to community collaboration to advance health equity, clarify the role of CBOs in local and national governmental public health transformation efforts, and validate and further operationalize the Framework for Aligning Sectors.

K. Subject Procedures: *Briefly describe proposed study activities and indicate how project data will be gathered or generated (i.e., use of existing data, observation, surveys, interviews, experimental/control procedures, etc.). Describe how the investigator will recruit subjects to participate and explain consent/assent procedures, if applicable.*

Study data will be gathered using online focus groups and a Delphi survey process across three participants groups, including 1) Oregon Health Authority Public Health Division (OHA-PHD) staff supporting the PHM grant program; 2) local public health authorities (LPHAs) receiving PHM grants; and 3) community-based organizations (CBOs) receiving PHM grants. For each participant type, I will recruit for two focus groups with 6-8 participants per group. Focus groups with OHA-PHD staff will be segmented by executive leadership and program staff. Focus groups with LPHA staff will be segmented by LPHAs serving rural and frontier communities and LPHAs serving urban communities. A secondary recruitment aim for LPHAs is to ensure the perspectives of both public health administrators and PHM grant program coordinators are captured. Lastly, focus groups with CBO staff will be segmented such that one group is comprised of CBOs who serve communities of color, and the other group is open to all other CBOs with the potential for targeted recruitment of CBOs serving LGBTQIA2S+ populations, rural communities, and people with disabilities. CBO focus group participants will receive a $150 stipend for the 90-mintue focus group to honor their time and expertise and to reduce any potential financial barriers to participation. Virtual Amazon gift cards will be provided to CBO focus group participants via email using the email participants use to register on Zoom for the focus group.

Focus group participants will be selected from those who respond to an open recruitment email sent through existing listservs of OHA-PHD staff supporting PHM implementation and LPHAs and CBOs receiving PHM grants. The email will specify the study purpose, the participant's role in the study, the high-level questions that will be asked, the estimated time the focus group will take, convening method (i.e., online), opportunity to review preliminary findings, and the option to suggest an alternate staff member for the focus group. A one-page fact sheet describing the study purpose and focus group process will accompany the recruitment email. The fact sheet will be tailored to the LPHA and CBO participant groups with a focus on "why they should care" about the study and potential risks of participation (which are expected to be minimal). One reminder email will be sent to participants two weeks after initial contact. Those who respond to the recruitment email confirming their interest in study participation will receive a consent form describing the study purpose and process in more detail, including my role as a student researcher (versus OHA-PHD employee), research question and aims, convening method, how long the focus group will take, process for collecting and storing data, measures to protect confidentiality in data collection and reporting, the voluntary nature of the study and the anticipated risks and benefits of participating, and the opportunity to review preliminary findings. I will ask potential participants to review and sign the consent form and return to me prior to convening the focus group. I will also begin focus groups with a more concise description of study purpose and processes, with an emphasis on procedures to maintain participant confidentiality and the potential

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benefits and risks of participation. I will then ask each participant to verbally consent to participation and offer an opportunity to exit the focus group if desired.

Participants from each participant group will be recruited to the Delphi survey process through emails to existing listservs of OHA-PHD staff who support PHM implementation, LPHA public health department administrators and PHM grant program coordinators, and CBO staff coordinating PHM grants. Focus group and Delphi survey participants will be recruited through separate emails to the same listservs of OHA-PHD staff supporting PHM implementation and LPHA and CBO staff coordinating PHM grants. OHA-PHD, LPHA, and CBO staff receiving recruitment emails can participate in both focus groups and the Delphi survey process. A one-page fact sheet describing the study purpose and Delphi survey process will accompany the open recruitment email. The recruitment email will include a link to the first survey. The online surveys will be administered via Qualtrics. The survey introduction will describe the study purpose, estimated time to complete the survey, data management and analysis procedures to maintain participant confidentiality, and potential benefits and risks to study participation. The survey introduction will then include the statement "By clicking 'next' I consent to participate in this study." Study participants will provide their consent by clicking the "next" button in the survey introduction to proceed with the survey. In the first survey, respondents will be asked to generate new and modify existing roles for state and local health department staff to fulfill the health equity and cultural responsiveness workforce capability of PHM. Existing roles come from Oregon's public health modernization manual, which was developed by the Oregon Health Authority in 2017 to operationalize the public health modernization framework for state and local governmental public health. Roles for CBOs were not included in the 2017 public health modernization manual, so survey participants will be asked to generate new ideas for CBOs roles. Subsequent surveys will ask respondents to rate (second survey) and prioritize (third survey) new and existing roles for OHA-PHD, LPHA, and CBO staff. The study will aim to recruit a minimum of 20 participants for each of three surveys. The 2023 article "Use of Delphi in health sciences research: A narrative review" published in Medicine recommends that Delphi survey panel sizes be between 8 to 23 participants, balancing response stability within multiple survey rounds and researcher time and monetary constraints. OHA-PHD, LPHA, and CBO staff who received the original recruitment emails will receive a reminder email one week after receiving the original recruitment email. The reminder email will help ensure participation does not decline drastically after the first survey round. In addition, I will have the option to attend existing partner meeting spaces (e.g., OHA-PHD Managers, Coalition of Local Health Officials, OHA-PHD CBO Advisory Committee) to promote participation in the Delphi survey process to meet the minimum of 20 participants for each survey.

Prior to sending recruitment emails, the study design will be presented to representatives from each participant group in existing meeting spaces for discussion and feedback, including standing monthly meetings of the OHA-PHD Managers, OHA-PHD Science and Epidemiology Council, Coalition of Local Health Officials (CLHO), Oregon Public Health Advisory Board (PHAB), and the OHA-PHD CBO Advisory Committee. Of note, study materials (e.g., recruitment emails, one-pagers, focus group guides) will not describe PHM in detail despite being a conceptually complicated initiative. This is because participants being recruited to the study are either administering PHM grant awards (OHA staff) or implementing PHM grant awards (LPHA and CBO staff) and thus are very familiar with the initiative.

Lastly, I recognize that CBO staff representing community members from systematically oppressed communities may be considered a “vulnerable population” and will carefully consider the appropriate steps that should be taken to protect confidentiality and prevent harm to this population. In addition, I have carefully considered (and will continue to reflect on) my position as a white, exclusively English-speaking researcher, which limits my capacity to engage participants with a preference for non-English languages and participants representing communities of color in in a manner that fosters trust and mitigates power dynamics. As a white researcher proposing a study that seeks to apply an equity lens and center the voices of people from systematically oppressed communities, particular attention must be paid to data collection processes that are extractive or appropriative. An extractive study design may be mitigated by ensuring principles of co-creation are embedded throughout the data collection process

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where feasible. This includes engaging study participants in the interpretation of preliminary results, discussing preferences for how final results are disseminated, and exploring opportunities for the co-production of study manuscripts and conference presentations. In addition, study communications will include my positionality statement to be as transparent as possible with potential study participants and easily allow for participants to not engage with a white, exclusively English-speaking researcher.

L. Data Collection, Storage, and Sharing: *What types of data will be collected and created? Where will active (live) data be stored and backed up? How will sensitive data be secured? How will the final research data be archived and shared (if applicable) after the study concludes? Please note that research projects receiving federal funding or RGS support will likely require a Data Management Plan, the details of which can be found here: https://guides.library.pdx.edu/data*

Qualitative data will be generated from focus groups. Focus groups will be held online and recorded using Zoom with participant consent. Focus group recordings will be downloaded from Zoom and stored in a secure OneDrive folder on Portland State University's network to which only I will have access. Focus group recordings will be uploaded to Sonix.ai for transcription. Focus group transcriptions are expected to be complete within one week of focus group completion. Upon receiving focus group transcriptions and verifying for accuracy against focus group recordings (anticipated to be complete within two weeks of focus group completion), focus group recordings will be deleted from the secure OneDrive folder. Focus group transcriptions and chat threads will be stored in the secure OneDrive folder. Focus group transcriptions and Zoom chat threads will be uploaded to Dedoose for data management and analysis. Transcriptions and chat threads uploaded to Dedoose for data management and analysis will only be accessible by me and one other analyst supporting double coding of qualitative data. No demographic information, identifiable private information or otherwise, will be collected from focus group participants.

Quantitative data will be generated from the Delphi survey process. Surveys will be administered using Qualtrics. Survey responses will be downloaded from Qualtrics as Excel spreadsheets and then uploaded to Stata statistical software (located on my personal computer) for data management and analysis. Raw data from the Delphi survey process (i.e., Excel spreadsheets) and Stata files will be stored on my personal computer (which is password protected) and backed up using my personal iCloud account, neither of which will be accessible to others. Delphi survey data collection will include some respondent demographics, including participant type, number of years working in their respective sector, and whether they have worked in another sector in the past, for use in subanalyses. However, the surveys will not collect identifiable private information, such as name, address, and date of birth.

Final research data will be archived on my personal computer and backed up using my personal iCloud account. Final research data will be archived for no more than 10 years and then destroyed. The study is not being supported by federal funding, so does not require a Data Management Plan.

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SECTION 2: HUMAN SUBJECTS RESEARCH PRE-SCREENING

A. RESEARCH DETERMINATION

1. Is the project intended to be an investigation, a searching inquiry to gather facts, or an examination of a phenomenon?	☒ Yes	☐ No
2. Is it systematic; involving a system, method, or plan that will be employed consistently throughout data collection?	☒ Yes	☐ No
3. Are the results of the project expected to expand the knowledge base of a scientific discipline, or other scholarly field or study, and be publicly disseminated so that the results can be used to develop, test, or support theories, principles, and statements of relationships or inform policy beyond the study?	☒ Yes	☐ No
4. Will the results be applicable to a larger population beyond the site of data collection or the individual subjects? (Check "**No**" if the conclusions will apply only to the sample population).	☒ Yes	☐ No

*If the answer to **ALL questions in Section 2A are NO**, it is likely the project does NOT meet the federal definition of research and IRB review is not required. Email this completed form to Research Integrity at psuirb@pdx.edu for confirmation.*

*If the answer to **ANY of the questions in Section 2A is YES**, it is possible this project meets the definition of research. Additional information is required. **Proceed to Section 2B** of this form.*

B. HUMAN SUBJECTS DETERMINATION

1. Will investigators use, study or analyze information (or biospecimens) **about living person(s)**?	☒ Yes	☐ No
2. Will investigators **obtain information through intervention or interaction with subjects**? **Intervention or Interaction:** • any communication or interpersonal contact between investigator and subject, such as using in-person or online questionnaires/surveys, interviews, focus groups, observations, or experimental procedures.	☒ Yes	☐ No

3. Will investigators obtain, use, study, analyze, or generate **identifiable private information** (or identifiable biospecimens)? **Identifiable private information**: • information subjects expect would not be made public, or collected within a context which an individual would not otherwise expect to be observed or recorded (*such as in their home), **AND*** • the identity of the subject is or may readily be ascertained by the investigator or associated with the information. **Identifiable biospecimen**: • biospecimen for which the identity of the subject is associated with the biospecimen or may readily be ascertained by the investigator.	☒ **Yes**	☐ **No**

*If the answer to **ALL questions in Section 2B are NO**, it is likely the research does NOT meet the federal definition of human subjects and IRB review is not required. Email this completed form to Research Integrity at psuirb@pdx.edu for confirmation.*

*If the answer to **Question 1 in Section 2B is YES and either Question 2 or Question 3 are also marked YES**, the research involves human subjects. Additional information is required:*

- *Form 1: Project Overview & Pre-Screening is now complete; **retain form for submission.***
- ***Complete Form 2: Exemption Certification** to determine if the project qualifies as exempt. NOTE: In the Revised Common Rule, previously expedited research is now exempt.*

Appendix B. Focus group consent form

Research Information Sheet (Focus Group Consent Form) for Community-based organizations Serving Communities of Color

Title of Research Study: Governmental Public Health's Capacity for Community Collaboration in Oregon

Student Investigator: Steven Fiala, PhD candidate, OHSU-PSU School of Public Health

Faculty Advisor/Advisor/Principal Investigator: Julia Goodman, PhD, Associate Professor, OHSU-PSU School of Public Health

As a community-based organization (CBO) receiving funding for public health Modernization, you are being offered the opportunity to participate in a research study. You indicated over email that you may be willing to participate in a focus group to discuss your experiences collaborating with the Oregon Health Authority (OHA) and local public health authorities (LPHAs) on public health Modernization.

The purpose of the study is to learn more about whether certain elements of successful collaboration are being fulfilled as CBOs, LPHAs, and OHA advance public health Modernization together (for example, having a shared vision and processes for shared decision-making). We are conducting focus groups with staff in CBOs, LPHAs, and OHA who are supporting public health Modernization.

The format we will use is a focus group of 6-8 staff from CBOs receiving funding for public health Modernization in any of the areas of climate and health, communicable disease prevention, or emergency preparedness. Specifically, this focus group includes CBOs who serve communities of color. There is another focus group with 6-8 staff from CBOs who serve priority populations including rural communities, disability communities, and LGBTQ2IA+ communities.

A focus group is a conversation that focuses on specific questions in a safe and confidential environment. The information we learn in the focus group will help us understand more about how public health Modernization is being implemented as a collaborative effort between CBOs, OHA, and LPHAs. Everything you say during the focus group will remain confidential, and nothing you say will be attributed to you or your organization in any reports or presentations of the study findings. I will include a summary of the focus group conversation in reporting products (likely presentation slides and published manuscripts). The conversation will be confidential. I will not share your name or connect your name with any quotes or use any other identifying information in reporting products.

The focus group will take up to 90 minutes. The focus group will be conducted virtually using Zoom, and I will video-record the conversation using Zoom. The focus group will be conducted by Steven Fiala (doctoral candidate) and Dr. Billie Sandberg, a PSU professor and member of my dissertation committee with extensive experience conducting focus groups.

The recording will be uploaded to a software for transcription (turning the audio recording into written words for data analysis). The recording and notes will help us check the accuracy of the transcription. Your name and any other identifying information will be removed from the focus group transcript and the recording will be destroyed once the interview is transcribed and checked for accuracy. What you say during the focus group will not impact your relationship with OHA, including current or future funding for your organization. No one from OHA, LPHAs, or anyone other than our study team will listen to the recording or read the transcription.

If you say anything during the focus group that you do not wish repeated, you can tell the study team and we will not include those comments in any reporting products that are developed from the focus group. All written summaries and quotes will be masked (they will not be associated with names or other personal identifiers) and presented without attributing to you or any other participant in the focus group. Quotes will be selected to illustrate themes from the focus group discussion and will be presented without connecting them to individuals.

All information collected about you during this study and that could identify you will be kept confidential to the extent possible. You will be assigned a

study identification number to be used in place of your name in the research database and study records. Your identity and any personal identifying information will not appear in the interview transcripts or any published materials arising from the research. Research records connected to you will be stored for no more than 10 years in a secure place, and then destroyed. Only our study team will have access to the study database. In addition, individuals from the Portland State University Institutional Review Board will also have access to the information, and regulatory agencies responsible for the oversight of research may inspect records related to this study.

By agreeing to participate in this study, you are giving your permission for us to collect information about you as described above. We will use your information for this study until it is over. If you change your mind, you can request that we stop using your information. Information that has been de-identified and can no longer be linked to you at the time of your request may continue to be used. We will take appropriate measures to keep your study information private and secure, but there is always the potential risk of loss of confidentiality.

Your participation in this study is voluntary. You do not have to answer any question that you do not want to answer and may still remain in the study. You may also leave the focus group at any time. Whatever decision you make about participation in the focus group, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled. Your participation will not have any impact on your relationship with either the study team or OHA.

The potential risks or discomfort of study participation are expected to be minimal. Some of the questions may be sensitive as they relate to your perceptions of how OHA and LPHAs have collaborated with CBOs to advance public health Modernization. However, you are not required to answer any questions if they make you uncomfortable.

You will not directly benefit from your participation in the research, but the results of the research may contribute to knowledge about public health Modernization in Oregon and similar work in other states. You will receive a $150 stipend at the conclusion of the focus group for participating in this research study.

This study follows the guidance provided by the PSU Human Research Protection Program. The research protocols have been approved by PSU Institutional Review Board. If you have questions or concerns about your rights as a research participant, please contact the PSU IRB at 503.725.5484 or psuirb@pdx.edu. If you have concerns about this research, please contact me at 503.349.3852 or sfiala@pdx.edu.

Thank you for your contribution,

Consent to Participate:

By signing below, you are confirming that you are 18 years of age or older, have read the above information, and voluntarily give your consent to participate in this study. You may save, request, or print a copy of this information sheet for your records. If you consent to participate, please email the signed consent form to Steven Fiala at sfiala@pdx.edu.

[Insert signature line]

Research Information Sheet (Focus Group Consent Form) for Community-based organizations Serving Other Priority Populations

Title of Research Study: Governmental Public Health's Capacity for Community Collaboration in Oregon

Student Investigator: Steven Fiala, PhD candidate, OHSU-PSU School of Public Health

Faculty Advisor/Advisor/Principal Investigator: Julia Goodman, PhD, Associate Professor, OHSU-PSU School of Public Health

As a community-based organization (CBO) receiving funding for public health Modernization, you are being offered the opportunity to participate in a research study. You indicated over email that you may be willing to participate in a focus group to discuss your experiences collaborating with the Oregon Health Authority (OHA) and local public health authorities (LPHAs) on public health Modernization.

The purpose of the study is to learn more about whether certain elements of successful collaboration are being fulfilled as CBOs, LPHAs, and OHA advance public health Modernization together (for example, having a shared vision and processes for shared decision-making). We are conducting focus groups with staff in CBOs, LPHAs, and OHA who are supporting public health Modernization.

The format we will use is a focus group of 6-8 staff from CBOs receiving funding for public health Modernization in any of the areas of climate and health, communicable disease prevention, or emergency preparedness. Specifically, this focus group includes CBOs who serve priority populations including rural communities, disability communities, and LGBTQ2IA+ communities. There is another focus group with 6-8 staff from CBOs who serve communities of color.

A focus group is a conversation that focuses on specific questions in a safe and confidential environment. The information we learn in the focus group will help us understand more about how public health Modernization is being implemented as a collaborative effort between CBOs, OHA, and LPHAs. Everything you say during the focus group will remain confidential, and nothing you say will be attributed to you or your organization in any reports or presentations of the study findings. I will include a summary of the focus group conversation in reporting products (likely presentation slides and published manuscripts). The conversation will be confidential. I will not share your name or connect your name with any quotes or use any other identifying information in reporting products.

The focus group will take up to 90 minutes. The focus group will be conducted virtually using Zoom, and I will video-record the conversation using Zoom. The focus group will be conducted by Steven Fiala (doctoral candidate) and Dr. Billie Sandberg, a PSU professor and member of my dissertation committee with extensive experience conducting focus groups.

The recording will be uploaded to a software for transcription (turning the audio recording into written words for data analysis). The recording and notes will help us check the accuracy of the transcription. Your name and any other identifying information will be removed from the focus group transcript and the recording will be destroyed once the interview is transcribed and checked for accuracy. What you say during the focus group will not impact your relationship with OHA, including current or future funding for your organization. No one from OHA, LPHAs, or anyone other than our study team will listen to the recording or read the transcription.

If you say anything during the focus group that you do not wish repeated, you can tell the study team and we will not include those comments in any reporting products that are developed from the focus group. All written summaries and quotes will be masked (they will not be associated with names or other personal identifiers) and presented without attributing to you or any other participant in the focus group. Quotes will be selected to illustrate themes from the focus group discussion and will be presented without connecting them to individuals.

All information collected about you during this study and that could identify you will be kept confidential to the extent possible. You will be assigned a study identification number to be used in place of your name in the

research database and study records. Your identity and any personal identifying information will not appear in the interview transcripts or any published materials arising from the research. Research records connected to you will be stored for no more than 10 years in a secure place, and then destroyed. Only our study team will have access to the study database. In addition, individuals from the Portland State University Institutional Review Board will also have access to the information, and regulatory agencies responsible for the oversight of research may inspect records related to this study.

By agreeing to participate in this study, you are giving your permission for us to collect information about you as described above. We will use your information for this study until it is over. If you change your mind, you can request that we stop using your information. Information that has been de-identified and can no longer be linked to you at the time of your request may continue to be used. We will take appropriate measures to keep your study information private and secure, but there is always the potential risk of loss of confidentiality.

Your participation in this study is voluntary. You do not have to answer any question that you do not want to answer and may still remain in the study. You may also leave the focus group at any time. Whatever decision you make about participation in the focus group, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled. Your participation will not have any impact on your relationship with either the study team or OHA.

The potential risks or discomfort of study participation are expected to be minimal. Some of the questions may be sensitive as they relate to your perceptions of how OHA and LPHAs have collaborated with CBOs to advance public health Modernization. However, you are not required to answer any questions if they make you uncomfortable.

You will not directly benefit from your participation in the research, but the results of the research may contribute to knowledge about public health Modernization in Oregon and similar work in other states. You will receive a $150 stipend at the conclusion of the focus group for participating in this research study.

This study follows the guidance provided by the PSU Human Research Protection Program. The research protocols have been approved by PSU Institutional Review Board. If you have questions or concerns about your rights as a research participant, please contact the PSU IRB at 503.725.5484 or psuirb@pdx.edu. If you have concerns about this research, please contact me at 503.349.3852 or sfiala@pdx.edu.

Thank you for your contribution,

Consent to Participate:

By signing below, you are confirming that you are 18 years of age or older, have read the above information, and voluntarily give your consent to participate in this study. You may save, request, or print a copy of this information sheet for your records. If you consent to participate, please email the signed consent form to Steven Fiala at sfiala@pdx.edu.

[Insert signature line]

Appendix C. Focus group recruitment email

Email Recruitment Script for Focus Groups with Oregon Health Authority Staff

Subject line: Student Research on Public Health Modernization Collaboration: Invitation to Participate in Focus Group

Email primary contact: sfiala@pdx.edu

FROM: Steven Fiala, Student, OHSU-PSU School of Public Health

Hello,

My name is Steven Fiala, and I am an Oregon Health Authority (OHA) employee and a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health. I am contacting you today in my capacity as a doctoral student.

Why am I contacting you?

To fulfill my doctoral program requirements, I am conducting dissertation research on the experiences of staff from OHA, local public health authorities (LPHAs), and community-based organizations (CBOs) who are supporting public health Modernization.

OHA staff provide strategic direction and administer funding for public health Modernization, as well as provide direct support to LPHA and CBOs advancing public health Modernization in communities in the areas of climate and health, communicable disease prevention, and emergency preparedness.

I would like to invite up to 8 OHA [program staff/managers] to participate in a focus group to discuss your experiences collaborating with LPHAs and CBOs on public health Modernization thus far. More specifically, we will focus on whether certain elements of successful collaboration are being fulfilled (for example, having a shared vision and processes for shared decision-making). Please see the attached for more information on the study purpose and design.

When, where and what's the time commitment?

The focus group will be 90 minutes and conducted virtually over Zoom in March (the specific date in March will be based on the availability of the 8 participants). The focus group will be conducted by me and Dr. Billie Sandberg, a PSU professor and member of my dissertation committee who has extensive experience conducting focus groups.

I am also conducting focus groups with LPHA and CBO staff who are supporting public health Modernization in their communities. Focus group participants will be invited to an optional virtual listening session to review preliminary findings from all focus groups, offer an opportunity to clarify findings and ask questions, and discuss which findings seem most important to highlight in reporting out the research to interested parties.

What are the risks of participation?

Participation in the focus group is completely voluntary. You can withdraw participation at any time. All data will be kept confidential and only available to me and another person who will support me with data analysis. Your feedback and participation in the focus group will have no impact on your status as an employee with OHA.

What do I do if I want to participate?

Please respond to this email confirming your participation or indicate if there is someone else in OHA who would be better suited to participate in the focus group.

After receiving your email, I will follow up with you to determine your availability for the focus group in March. I will also send you a focus group consent form that describes the study purpose and format, steps to maintain your confidentiality, and potential risks and benefits of participation. You will be asked to review this form and sign and return to me over email if you consent to participate in the focus group.

Thank you for considering,

Email Recruitment Script for Focus Groups with Local Public Health Authorities

Subject line: Student Research on Public Health Modernization Collaboration: Invitation to Participate in Focus Group

Email primary contact: sfiala@pdx.edu

FROM: Steven Fiala, Student, OHSU-PSU School of Public Health

Hello,

My name is Steven Fiala, and I am an Oregon Health Authority (OHA) employee and a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health. I am contacting you today in my capacity as a doctoral student.

Why am I contacting you?

To fulfill my doctoral program requirements, I am conducting dissertation research on the experiences of staff from local public health authorities (LPHAs), community-based organizations (CBOs), and OHA who are supporting public health Modernization.

All 33 LPHAs are receiving funding for public health Modernization in the areas of climate and health, communicable disease prevention, and emergency preparedness.

I would like to invite up to 8 LPHAs serving [rural and frontier communities/urban communities] to participate in a focus group to discuss your experiences collaborating with OHA and CBOs on public health Modernization thus far. More specifically, we will focus on whether certain elements of successful collaboration are being fulfilled (for example, having a shared vision and processes for shared decision-making). Please see the attached for more information on the study purpose and design.

When, where and what's the time commitment?

The focus group will be 90 minutes and conducted virtually over Zoom in March (the specific date in March will be based on the availability of the 8 participants). The focus group will be conducted by me and Dr. Billie Sandberg, a PSU professor and member of my dissertation committee who has extensive experience conducting focus groups.

I am also conducting focus groups with OHA staff who support CBOs and LPHAs receiving funding for public health Modernization, and CBO staff who are supporting public health Modernization in their communities. Focus group participants will be invited to an optional virtual listening session to review preliminary findings from all focus groups, offer an opportunity to clarify findings and ask questions, and discuss which findings seem most important to highlight in reporting out the research to interested parties.

What are the risks of participation?

Participation in the focus group is completely voluntary. You can withdraw participation at any time. All data will be kept confidential and only available to me and another person who will support me with data analysis. Your feedback and participation in the focus group will have no impact on current or future funding for your LPHA.

What do I do if I want to participate?

Please respond to this email confirming your participation or indicate if there is someone else in your organization who would be better suited to participate in the focus group.

After receiving your email, I will follow up with you to determine your availability for the focus group in March. I will also send you a focus group consent form that describes the study purpose and format, steps to maintain your confidentiality, and potential risks and benefits of participation. You will be asked to review this form and sign and return to me over email if you consent to participate in the focus group.

Thank you for considering,

Email Recruitment Script for Focus Groups with Community-based organizations

Subject line: Student Research on Public Health Modernization Collaboration: Invitation to Participate in Focus Group

Email primary contact: sfiala@pdx.edu

FROM: Steven Fiala, Student, OHSU-PSU School of Public Health

Hello,

My name is Steven Fiala, and I am an Oregon Health Authority (OHA) employee and a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHSU-PSU) School of Public Health. I am contacting you today in my capacity as a doctoral student.

Why am I contacting you?

To fulfill my doctoral program requirements, I am conducting dissertation research on the experiences of staff from community-based organizations (CBOs), local public health authorities (LPHAs) (county health departments), and OHA who are supporting public health Modernization.

You are receiving funding for public health Modernization through OHA's Public Health Equity grant in the areas of climate and health, communicable disease prevention, and emergency preparedness.

I would like to invite up to 8 CBOs who serve [communities of color/priority populations including rural communities, disability communities, LGBTQ2IA+ communities, and others] to participate in a focus group to discuss your experiences collaborating with OHA and LPHAs on public health Modernization thus far. More specifically, we will focus on whether certain elements of successful collaboration are being fulfilled (for example, having a shared vision and processes for shared decision-making). Please see the attached for more information on the study purpose and design.

When, where and what's the time commitment?

The focus group will be 90 minutes and conducted virtually over Zoom in March (the specific date in March will be based on the availability of the 8 participants). Participants will receive a stipend of $150 for their time and expertise. The focus group will be conducted by me and Dr. Billie Sandberg, a PSU professor and member of my dissertation committee who has extensive experience conducting focus groups.

I am also conducting focus groups with OHA staff who support CBOs and LPHAs receiving funding for public health Modernization, and LPHA staff who are supporting public health Modernization in their counties. Focus group participants will be invited to an optional virtual listening session to review preliminary findings from all focus groups, offer an opportunity to clarify findings and ask questions, and discuss which findings seem most important to highlight in reporting out the research to interested parties.

What are the risks of participation?

Participation in the focus group is completely voluntary. You can withdraw participation at any time. All data will be kept confidential and only available to me and one other person who will support me with data analysis. Your feedback and participation in the focus group will have no impact on current or future funding for your organization.

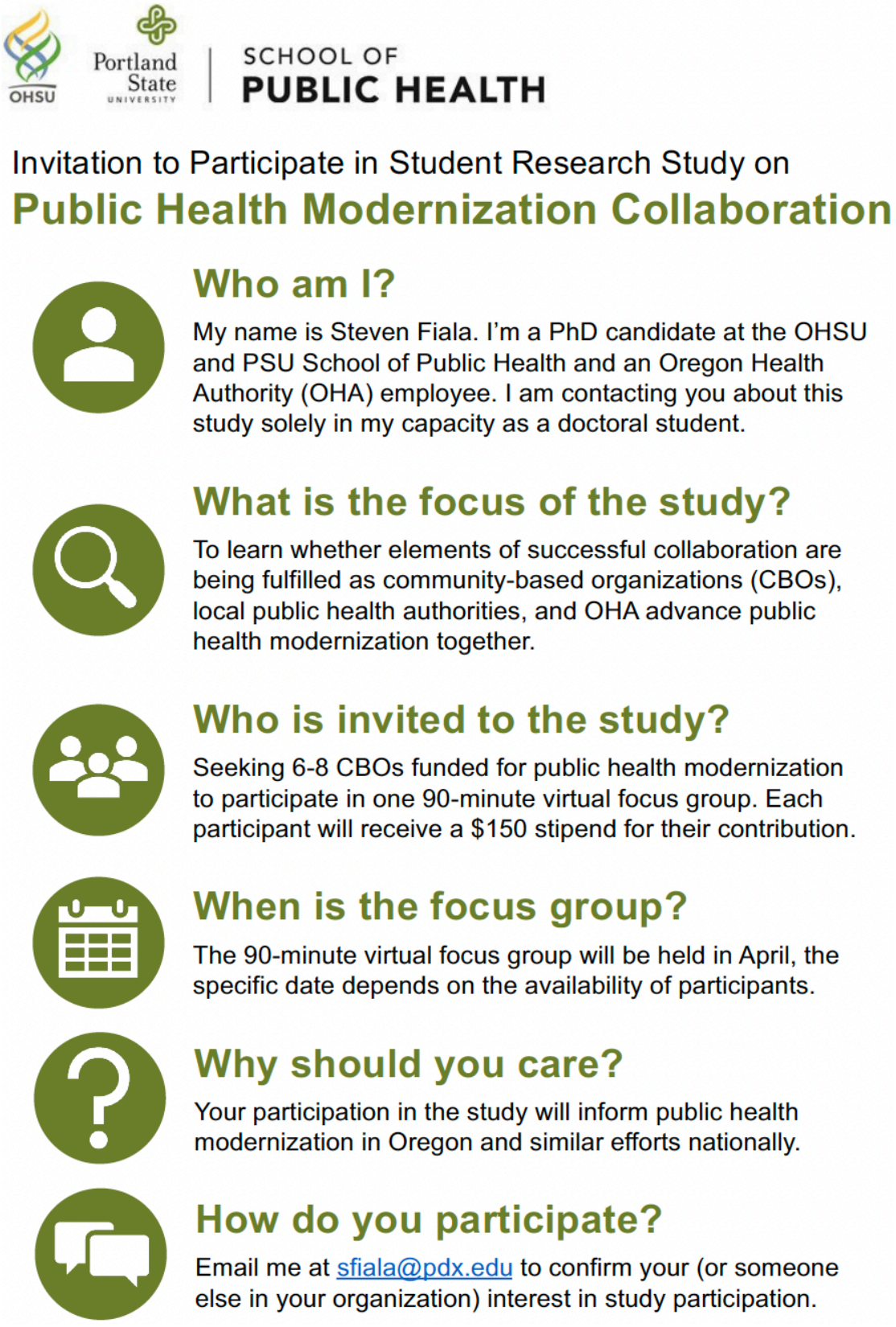
What do I do if I want to participate?

Please respond to this email confirming your participation or indicate if there is someone else in your organization who would be better suited to participate in the focus group.

After receiving your email, I will follow up with you to determine your availability for the focus group in March. I will also send you a focus group consent form that describes the study purpose and format, steps to maintain your confidentiality, and potential risks and benefits of participation. You will be asked to review this form and sign and return to me over email if you consent to participate in the focus group.

Thank you for considering,

Appendix D. CBO focus group recruitment fact sheet



Appendix E. Focus group and key Informant interview preview slides

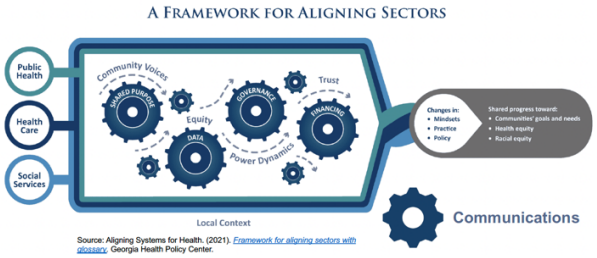
Interview Preview

Our discussion will focus on your experience working on public health modernization.

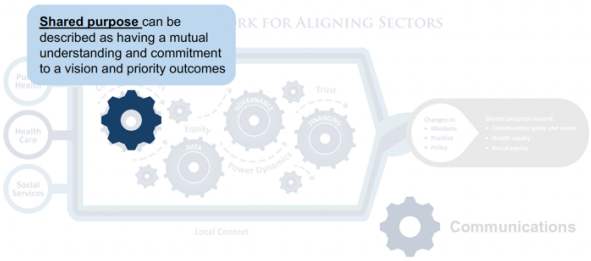
I hope to learn about whether certain elements of successful collaboration are being fulfilled as OHA, local public health authorities, and CBOs advance public health modernization together.

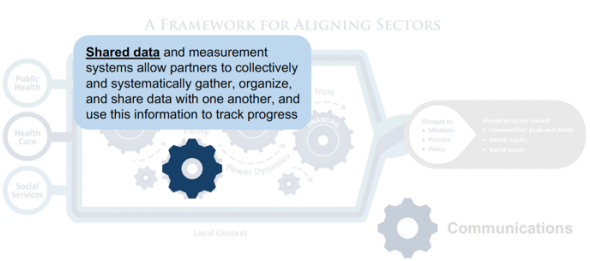
The following slides show the different elements of collaboration that we will discuss.

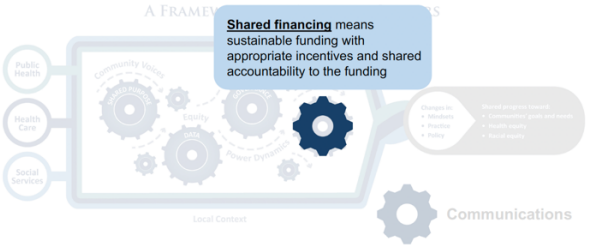
The elements of collaboration that we will discuss come from the Framework for Aligning Sectors shown below.

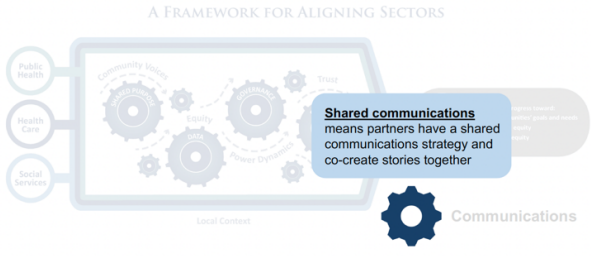


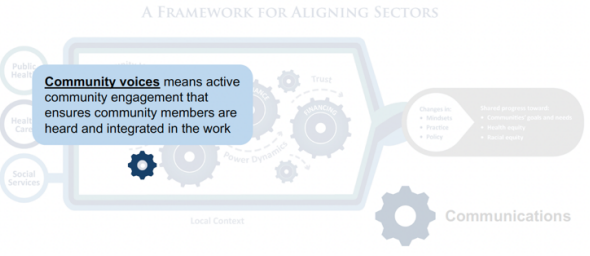
Source: Aligning Systems for Health. (2021). *Framework for aligning sectors with glossary*. Georgia Health Policy Center.

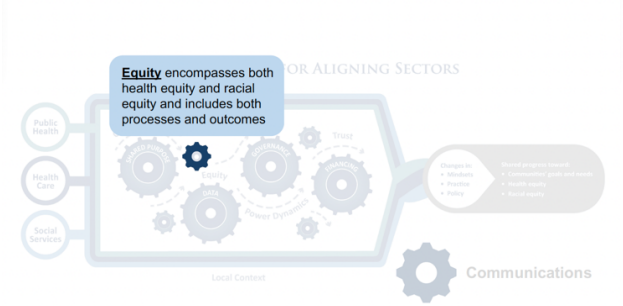


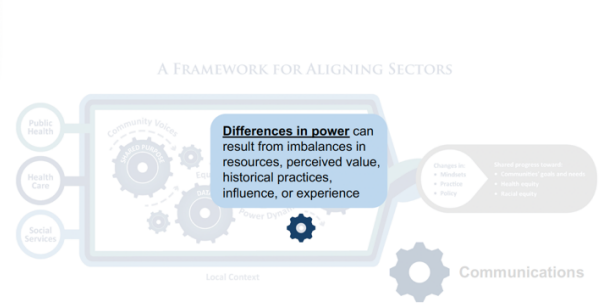












Please let me know if you have any questions after reviewing this interview preview at sfiala@pdx.edu.

Appendix F. Focus group guide for Communities of Color CBO focus group

Sign-in

As each participant enters Zoom, check their name off the list of confirmed attendees. Welcome them as they enter and thank them for attending.

Technology

*[Click **Start** to begin the interpretation sessions. After the host clicks **Start**, the interpreters will receive a message that they have been assigned a language. Interpreters and attendees can now click **Interpretation** in the meeting controls and select a language channel.]*

Before we begin, I want to note that Spanish language simultaneous interpretation available for the focus group. If you would like to use this feature, please click on **Interpretation** in the meeting controls on the bottom of your screen and select the Spanish language channel.

Introduction

Thank you all for taking the time to participate in this focus group today. My name is Steven Fiala, and I'm conducting these focus groups as part of my dissertation research for the Health Systems and Policy PhD program at the Oregon Health and Sciences University and Portland State University School of Public Health. I'm also an Oregon Health Authority (OHA) employee, but today I'm meeting with you in my capacity as a doctoral student. I will not be discussing my research with anyone at OHA.

Our discussion is going to be about your experience working on public health Modernization through the Public Health Equity funding you receive from OHA. More specifically, I hope to learn more about whether certain elements of successful collaboration are being fulfilled as community-based organizations, local public health authorities (county governments), and the Oregon Health Authority advance public health Modernization together.

These elements will be described in more detail later in the focus group.

Our discussion will last around 90 minutes, ending at 1:30 pm.

Discussion instructions

This is your discussion. My role is to facilitate the discussion and not to give answers or to take sides if there are differences of opinion. Keep in mind that there are no wrong answers. You

don’t have to answer any questions that you don’t want to, but I am very interested in what you have to say. You are the expert on your experiences, and we want to learn from you.

Please respect each other’s comments and questions, so that we can all speak freely. I also ask that we respect each other’s privacy and not tell anyone what others said in this virtual room. You can talk about your experience in general terms, but please do not use names. We hope everyone here honors this confidentiality, but please remember that what you say here today could be repeated by another focus group member. So, please don’t say anything that you absolutely need or want to keep private.

Recording and consent instructions

This discussion is going to be recorded using Zoom and then transcribed for analysis. Any personal information you give during the focus group will remain confidential and your name will not be connected to, or appear in, the transcripts, notes, or reporting products.

[Ask each participant to indicate if they grant permission to record the discussion. If anyone declines, excuse them from the focus group.]

(Start recording)

Introduction/Background

Before we get started with the first question, let’s do introductions so we know who is in the room. Let’s go around and say our names, preferred pronouns, the name of our organizations, and our role in the organization.

I’ll start…

Great, thank you for those introductions.

Framework for Aligning Sectors

Before we begin our conversation, I want to briefly walk through the framework that is guiding this research, including the questions that I will ask you today. It’s called the Framework for Aligning Sectors and includes elements known through research to be essential for successful collaboration. You received some information about the framework before our conversation today, but we’ll take a moment now to review.

[Show framework slides]

We’re about to begin with the first question. For each question, please raise your hand virtually to speak and I’ll call on you in the order that hands were raised.

You can also respond by typing in the chat. The chat thread will be downloaded and analyzed as data for this research project.

Any questions before we get started?

[We may not get to every element of the framework in our limited time, but we will try. To help us cover as many elements as possible, I may stop discussion on one element and move on to another. If this happens, please feel free to enter additional comments in the chat.]

1. Let's start with shared purpose which can be described as having a mutual understanding and commitment to a vision and priority outcomes. How have you experienced, if at all, a "shared purpose" in your work on Modernization with OHA and CBOs?

   Prompts:

   - *[priority]* How have you experienced "shared decision-making" in your work on Modernization with OHA and CBOs?

     [If needed: shared governance can be described as having a structure for shared decision-making with clear leadership, appropriate roles for all partners, and defined relationships.]

   - [priority] How have you experienced shared data and measurement in your work on Modernization with OHA and CBOs?

     [If needed: shared data and measurement systems allow partners to collectively and systematically gather, organize, and share data with one another, and use this information to track progress.]

   - How have you experienced shared financing in your work on Modernization with OHA and CBOs?

     [If needed: shared financing means sustainable funding with appropriate incentives and shared accountability to the funding.]

   - How have you experienced shared communications in your work on Modernization with OHA and CBOs?

     [If needed: shared communications means partners have a shared communications strategy.]

Now we're going to talk about some of the other framework elements. These elements, which include power and trust, may be more sensitive topics. While they are important areas of collaboration to explore, I want to make sure you're all comfortable in this space, so want to remind everyone that you don't have to answer any questions that you don't want to.

2. *[priority]* How have you experienced power dynamics in your work on Modernization? How have differences in "power" between LPHAs, OHA, and CBOs been addressed, if at all?

   [If needed: differences in power can result from imbalances in resources, perceived value, historical practices, influence, or experience.]

3. *[priority]* How have you experienced trust in your work on Modernization with OHA and CBOs? How, if at all, have LPHAs, OHA, and CBOs built or renewed their trust in one another through Modernization work?

   [If needed: this could be relational trust – earned through shared experiences and backgrounds – or transactional trust – earned through interactions and give-and-take. Trust may need to be rebuilt or regularly renewed.]

4. In your experience, how has your shared work on Modernization with OHA and CBOs been approached equitably? How consistently has equity been applied to Modernization work across LPHAs, OHA, and CBOs?

   [If needed: equity encompasses both health equity and racial equity and includes both processes and outcomes.]

5. In your experience, how has your shared work on Modernization with OHA and CBOs centered community voice? How consistently has community voice been considered in the Modernization work across LPHAs, OHA, and CBOs?

   [If needed: community voices means active community engagement that ensures community members are heard and integrated in the work.]

Outcomes *[only ask if time allows]*

6. What are the most important outcomes of public health Modernization so far?

   Prompt: "Outcomes" of public health Modernization could include one or more of the following changes:

   - *How staff think about partnerships and collaboration*
   - *New or strengthened (or weakened) relationships/connections between your LPHA and external partners, including OHA-PHD and CBOs*
   - *Power dynamics between your LPHA and external partners, including OHA-PHD and CBOs*
   - *Resource flows (including staffing, funding) within your LPHA or within OHA-PHD*
   - *Practices of staff in your LPHA and/or OHA-PHD staff*
   - *Organizational policies within your LPHA or within OHA-PHD*
   - *Changes related to social determinants of health*

Concluding the discussion

We are nearing the end of the focus group. Is there anything that we haven't discussed that you feel is important for me to know about your experiences collaborating with OHA and local public health authorities on public health Modernization?

[Additional question if there is time: What is one change you would recommend to address barriers to collaboration based on our discussion?]

[Additional question if there is time: If you could share one lesson learned from your work on public health Modernization, what would it be?]

(Stop recording)

That's the end of the focus group. Thank you all so much for your participation! The information you've provided will be combined with information gathered in the other focus groups with CBOs, local public health authorities, and OHA staff.

Once data collection and analysis are completed (expected by the end of May), everyone who participated in focus groups will be invited to attend a virtual listening session to review preliminary findings from all focus groups. The listening session will offer an opportunity to clarify findings, ask questions, and discuss which findings seem most important to highlight in reporting out the research.

Lastly, I will send you all an email later today confirming that your $150 stipend has been sent, which will come in the form of a Visa e-gift card.

Thank you again and please reach out to me with any questions or additional thoughts.

[End focus group]

Appendix G. Qualitative analysis preliminary codebook

Framework for Aligning Sectors Element	Indicator	Equity Considerations from Secondary Frameworks and Principles
Shared purpose	Partners share a mutual understanding and commitment to a vision and priority outcomes	Shared purpose… • Focuses on policy, systems, structural change • Explicitly addresses social and economic injustice and structural racism • Employs community organizing as an intentional strategy
Shared data and measurement	Partners collectively and systematically gather, organize, and share data between entities, and the process of using this information to track progress	Shared data and measurement… • Developed and maintained with community • Measure structural racism and other inequities, including accurate community-level data • Ensure a shared understanding of the data lifecycle and access to data • Ensure all partners are involved in analysis of risks and benefits of data sharing • Advance holistic, comprehensive view of public health data by collecting information on disparities *and* underlying causes • Center health equity and well-being in narrative change and minimize narratives that blame individuals or groups • Build on existing community-engaged scholarship and research

Shared governance	Partnership infrastructure is shared and has leadership, appropriate roles, and defined relationships	Shared governance…
		• Addresses starting conditions, including:
		  o Power-resource-knowledge asymmetries
		  o Incentives for and constraints on participation
		  o Prehistory of cooperation or conflict
		• Includes facilitative leadership based on:
		  o Concepts of the inclusive public manager
		  o New Public Service administration model
		• Considers institutional design with:
		  o Selective recruitment of participants
		  o Deliberation and negotiation decision-making
		  o Co-governance forms of power and authority
		• Established collaborative processes with:

		○ Face-to-face dialogue ○ Trust-building ○ Commitment to process ○ Shared understanding ○ Intermediate outcomes
Shared financing	Partners have sustainable methods of financing with appropriate incentives and shared accountability	• Provide multi-year unrestricted funding • Proactively identify prospective • Simplify and streamline paperwork • Be honest and transparent in communications • Solicit and act on feedback • Provide non-monetary supports that bolster organizational leadership and capacity
Shared communications	Partners have a shared communications strategy that centers community storytelling	• Actively working to disrupt dominant narratives that normalize inequity and uphold oppression • Advance new narratives from communities and individuals in historically marginalized groups • Support community to develop full understanding and articulation of its history

Appendix H. Summary of focus group and key informant interview qualitative analysis themes and representative quotes

Note: Parent themes are highlighted in light blue followed by related child themes. The table footnote includes a list of abbreviations.

Theme	Meaning/Explanation	Quote
Shared Purpose	Sectors share a mutual understanding and commitment to a vision and priority outcomes.	
Early shared purpose	Experiences of shared purpose during the early days of Modernization implementation.	"There was a lot of time spent on…developing the roadmap, and there were videos done, and there was a lot of effort put into having a shared communication strategy. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. It felt like a good collaboration" (Urban LPHA Focus Group)
Shared purpose supports	Descriptions of multiple structures that support the development and maintenance of shared purpose with partners.	"…the actual creation of the Public Health Modernization Manual…the deeper definitions of each foundational capability and program. That work was all done completely collaboratively with Public Health Division at OHA, content experts and local public health administrators so that those definitions really reflected a shared approach and then similarly vetted by an overarching working group." (OHA Leadership KII 2)
Shared purpose changed over time	Sentiments that the shared purpose of Modernization changed over time, including a change in guiding values and a different understanding of purpose across partners.	"Modernization is a complex deal with these fundamental things. We're going to change with communications, emergency preparedness, all of those domains. And then really kind of overnight it switched to a health equity focus, which is not wrong, but it's different from before. We never changed the Modernization Manual and said this is how we've changed. And so that purpose, that had changed, and I'm not saying it's good or bad, but that purpose that changed was never really discussed." (Rural LPHA Focus Group)
Shared purpose barriers	Descriptions of several barriers to developing and maintaining a shared purpose across partners.	"I have a reasonable, from my side of things, alignment with OHA around the vision, the understanding of Public Health Modernization and those things. I don't feel like I have that with our county entities, government entities. Not that they may not, but I feel like we haven't had those kinds of conversations or opportunities to even find out if we're on the same page or working toward that same goal." (OPP CBO Focus Group)

Negative impacts of unclear vision	Descriptions of several negative impacts of unclear vision for Modernization.	"I honestly don't think a lot of our legislature or our commissioners, when they hear Modernization, they think 'we need to fund it'…there's a lot of legislators and commissioners that are also confused now of where the funding is going for Modernization" (Urban LPHA Focus Group)
Shared Governance	Aligned systems in which infrastructure has leadership, appropriate roles, and defined relationships.	
Early shared governance experiences	Experiences of shared governance during the early days of Modernization implementation.	"…we were kind of part every step of the way…Like how are we going to how are we going to communicate this? What are our talking points? What's the funding look like? What are we going to fund? What are we going to prioritize first? I felt that was very much shared decision-making. We're going to focus on communicable disease, core public health, right? It's sorely underfunded. I think that was a decision really made together…" (Urban LPHA Focus Group)
Formal governance spaces	Descriptions of several form governance spaces that facilitate shared decision-making across Modernization partners.	"The Public Health Advisory Board was also established to be the governing body for Public Health Modernization in Oregon. And that was a foundational shift in 2016 because we didn't really have a space to bring other public health experts and individuals who have an interest in public health together to guide what the public health system should be…this approach brought in not only state and local public health, but also health care, CCOs, academia, eventually a tribal member, and now currently we have CBOs and education and health equity expertise also represented on the board." (OHA Leadership KII 2)
Unclear funded partners and roles	Sentiments that there is a lack of clarity on who is funded for Public Health Modernization and the roles of funded partners.	"How CBOs fit into Modernization, specifically, I'd say, is not always as clear to all parties. CBOs provide services for community, critical services. It's not the same, it's not a 1 to 1 relationship with LPHA or OHA Modernization roles in the manual. It's just different because there are different needs and capacities for different organizations. So, I think that's where we need to have more clarity and I know LPHAs have asked for this and others have asked for this. Like, can we further define how CBOs fit into Modernization, where the work intersects and how it can foster better partnerships across different organizations. I think that's where we need to get more clarity." (OHA Program Staff Focus Group)
Lack of transparent decision-making	Descriptions of lack of transparency in decision-making processes for	"…it's not funding CBOs that's the problem. It was the decision-making that OHA or whoever, we don't actually know who made the decision

	Modernization, including changes in transparency over time.	because we were never told, but somebody decided that the definition of Modernization now included CBOs…there was no discussion about it, except later when it was like, well, that decision has been made you need to just get over it now and go forward. I think we still all have questions about go forward with what, it's not clear." (Urban LPHA Focus Group)
Expanded partner representation	Descriptions of expanded partner representation in formal decision-making spaces for Modernization.	"Another thing that PHAB has done over the past few years is really expand their membership, very specifically to include more seats for community-based organizations, bringing in expertise in health equity…I think all of this is really positive as we're reconceptualizing how we think about the public health system. PHAB is really keeping up in their space." (OHA Leadership KII 1)
Not acknowledging history of conflict	References to OHA not acknowledging a history of conflict with LPHAs as a pre-condition for shared decision-making.	"It's like bits and pieces, but not like a whole-hearted apology or real effort to rebuild trust. There's been some improvements, like there was that funding group between LPHAs and CBOs to determine the next cohort of CBOs that were funded. And through that process, there was some acknowledgement and changes to future funding, but it's just bits and pieces, it's not comprehensive, a whole situation." (Urban LPHA Focus Group)
Governance capacity building needed	Descriptions of need for capacity building to ensure partners can fully engage in shared governance spaces.	"The way the agenda is set is set by OHA and there's not great decision-making happening there because folks don't really understand the public health system either. There's a lot of more education that needs to happen there before that's possible." (Urban LPHA Focus Group)
Accessibility of governance spaces	Descriptions of ways in which formal governance spaces could be made more accessible to Modernization partners.	"I've definitely enjoyed the opportunities that have been presented to engage CBOs in work groups…there has not necessarily been a standard sort of procedure across the board… [to] offer sort of compensation for CBOs, additional compensation beyond the grant…A lot of standard standardization is not great, it takes away from the human connection, but I think there are some processes that could support continued engagement from CBOs through these various decision-making opportunities." (OPP CBO Focus Group)
Shared learning spaces needed	Descriptions of a lack of shared learning opportunities between partners, especially those that facilitate sharing between LPHAs and CBOs receiving Modernization funding.	"I would say it's a get together of the CBOs and they all get to share these really cool stories of the cool work that they're doing, and it was totally separate. LPHAs were not even invited to that. I think maybe I saw some emails come out that we could read about them after the fact." (Rural LPHA Focus Group)

Leadership absent from decision-making	Comments on the lack of OHA leadership being present in decision-making spaces.	"…it's a weird time right now because we don't have a director. And so, I feel like a lot of the work we're doing and a lot of the meetings we're having with leadership where we're trying to get buy in and move forward, I'm understanding that they're like, 'sure, and I don't really know what my next new boss is gonna want.'" (OHA Leadership KII 3)
OHA internal coordination needed	Sentiments that more internal coordination at OHA is needed to support shared governance.	"I think we have had success when we've been able to really meaningfully engage our program experts…in the public health model, in the Public Health Modernization Manual, in the collection of our cost and capacity assessment, and in design of program elements and contracts, scope of work etc. for the public health system. I think structurally we still have some opportunity for growth and advancement in terms of how we do that more seamlessly across our silos." (OHA Leadership KII 2)
Shared Data and Measurement	Sectors collectively and systematically gather, organize, and share data between entities, and use this information to track progress.	
Accountability metrics as shared measurement framework	References to the Public Health Modernization accountability metrics as the primary framework for shared data and measurement.	"These are accountability metrics on some urgent public health issues in the state of Oregon right now that we as a system are committing to being able to improve through the investments that we get and the changes that we're making through Public Health Modernization…we have statewide goals around health outcomes that we're trying to change over the coming years…within that framework that has been created, it really shows the core roles of OHA, the state public health division, local public health authorities, and what they need to be doing in their daily work to make changes." (OHA Leadership KII 1)
Metrics not aligned across partners	Comments on how accountability metrics are not applied consistently across all funded partners.	"…the accountability metrics and how that is a huge data piece that shows what we're doing and how, because there's the process measures, there's the outcome measures, and we have to either report on them or the state reports on it for us…And that does not happen with CBOs. That just has not been a component of any of their work." (Rural LPHA Focus Group)

No shared data between partners	Sentiments that Modernization data are not shared between partners.	"We kind of set what we were going to report on and we have. Not sure how that's going to be used, what that's feeding, or how that's going to be taken into account…It seems like it's an issue that we don't know what information would be helpful to them [LPHAs] or what information we should be sharing or trying to capture to kind of help the local community, so there's not a connection there, unfortunately." (COC CBO Focus Group)
Data not capturing impact of funding	Descriptions of concerns with how the data collected from Modernization grantees are not adequately describing outcomes or impacts on the public health system and community health.	"I'm not entirely sure that the questions they're asking is going to communicate whether or not we're achieving what we said we were going to achieve. I feel like it's a bit of a game instead of genuine, 'Are you doing what you want to do with the money that you asked for and that we gave you?' I'm speaking directly to counting or sharing the partnerships that you've created or that have existed amongst other CBOs. I find that to be an absurd representation of whether or not we've achieved our goals." (OPP CBO Focus Group)
Modernization driving data justice and equity practice	Comments on Modernization advancing practices for data justice and equity.	"…work around public health data is one of the areas that has changed most drastically in the past few years…My earlier career in public health was grounded in this concept of like, 'I as a public health professional own the data. I know the data. I'm an expert in the data. People need to ask me for their data'…over the past few years, you've seen a massive change to positioning us as the stewards of the data, but actually the people who are represented in those data, whose communities are represented in those data, are the experts. They own and should really be in control of all aspects of how data is collected and reported and used." (OHA Leadership KII 1)
Shared Financing	Aligned systems with sustainable methods of financing with appropriate incentives and shared accountability.	
Mixed impressions of shared financing	Experiences with shared financing for Modernization are mixed across partners.	"…from OHA's perspective, what we've tried to support PHAB to do is really think about how all of that funding is really to one purpose. It's funding different parts of the system, but we're all working toward the same goals, and we all have a different piece of it…we are a system, we are a bunch of individual organizations, but we work together as a system." (OHA Leadership KII 1)

Siloed financing over time	Sentiments that shared decision-making on funding allocations across partners decreased over time.	"I wish there had been more shared financing and this [funding to CBOs] could be more of a transparent process…we had CBOs that got money to do very specific work in our community that we've never heard of…and feels like had it been a joint effort, we could have all moved forward with the money and made sure it's going to the populations that need it most." (Rural LPHA Focus Group)
Shared accountability to funding lacking	Comments on a lack of shared accountability to Modernization funding across partners.	"There's this misconception of OHA because we're seen as free with our money…There seems to be a lack of understanding of how we hold folks accountable with the funding and how we incorporate that accountability piece…there's this misconception that we don't [hold CBOs accountability to the funding] because accountability looks different between LPHAs and CBOs, and instead of trying to understand, there's this overarching 'if it's not held accountable like ours, then it's not accountability' and that's not necessarily true." (OHA Program Staff Focus Group)
Mixed perceptions of equitable financing	Perceptions that Modernization funding is equitably allocated (based on greatest need) are mixed across partners.	"…at the beginning, a lot of the funded CBOs were in the metro area and there was a few counties that literally had zero CBO funding coming to their community directly…So that further exemplified the power differential simply between the rural and the urban areas." (Rural LPHA Focus Group)
Uncertain funding sustainability	Comments on the uncertainty of Modernization funding sustainability over time.	"…because of cost, I'm not able to keep up with Modernization and I'm really fearful this next round when we hear that OHA can only ask for a 1% increase and don't count on increase in Modernization, which means more of a decrease…when we go back to what are our core mandated services that we have to provide, which are also not keeping up, then unfortunately that's where things are going to get cut." (Urban LPHA Focus Group)
Shared Communications	Sectors have a shared communications strategy that centers community storytelling.	
Early shared communications	Experiences of shared communications during the early days of Modernization implementation.	"We all had the same messages and the same access to that type of resource. We could adapt the communications for our local context too, we had a couple graphics that we would make specific too. And then we were holding individual meetings with our legislators so that everybody was getting the same message and the same graphics and kind of knew what Modernization was. We did do that earlier. It felt like a good collaboration too." (Urban LPHA Focus Group)

Capacity for accessible communications is varied	Descriptions of efforts to ensure culturally-responsive communications as a facet of shared communications and differences in accessibility of communications across OHA.	"…we do have grantees that are Spanish speaking and that's made us push back on all the people that want us to send stuff out to our grantees when I ask, 'Do you also have it in Spanish?' I would say that's a real weakness when it comes to Modernization outside of our team [the OHA-PHD Community Engagement Team], quite frankly, is language access and it's very much an afterthought." (OHA Leadership KII 3)
Current shared communications strategy lacking	Sentiments that shared communications decreased over time and partners do not currently have a shared communications strategy.	"It's very difficult to communicate about something that you don't understand any longer, or that it doesn't mean the same thing that it meant before…from my perspective, there seems to be a disconnect with the communication from OHA and with our CBOs." (Urban LPHA Focus Group)
Supportive materials lacking	Descriptions of the lack of shared materials that describe the purpose of Modernization and funded partners serving as a barrier to collaboration.	"Every single conversation that we've had of late…the question somebody always asks from a CBO is 'Do you have a list of LPHAs who are doing this work or who have best practices or who aren't doing this work, or who need help or who don't need help?' And more often than not, the answer is no. And that makes it challenging." (OPP CBO Focus Group)
Trust	Necessary in collaborative efforts, can be both relational and transactional, and may need to be rebuilt or regularly renewed.	
Lack of trust between Oregon Health Authority and Local Public Health Authorities	Examples of how OHA has broken trust with LPHAs, how mistrust of OHA is directed at leadership rather than individual staff, perceptions that OHA's trust in LPHAs has decreased over time, and barriers to rebuilding trust.	"I would just say that when CBOs were funded without any LPHA input during COVID, we all kind of chalked it up to it was an emergency, you know, decisions had to be made. Fine, totally fine. Water under the bridge. But when all of a sudden it was sprung on us that it was now Modernization money, and I think trust was obliterated multiple times." (Rural LPHA Focus Group)
Negative impacts of broken trust on collaborative capacity	Descriptions of how broken trust with OHA has negatively impacted processes and spaces for collaboration and relationships between Modernization partners.	"There were a lot of questions and maybe some broken trust that happened during the pandemic about decisions and conversations that were happening outside of PHAB and then those happening in PHAB…I hear members continue to sort of reflect back on decisions that were made three years ago outside of PHAB and it just broke a lot of trust for people that are in that space." (OHA Leadership KII 1)
CBO trust in partners increased over time	Sentiments that CBO trust in OHA, LPHAs, and other Modernization-funded CBOs increased over time and	"I feel more at ease engaging with LPHAs and OHA. I don't know that I've seen much change in the actual community and especially BIPOC communities. I think there is a little bit more trust, but I don't think that if

	descriptions of areas for improvement.	we were to measure it on a scale of 1 to 10, it is definitely in the low fives or under five." (OPP CBO Focus Group)
Trust-building opportunities	Descriptions of opportunities for trust-building, including both individual actions and organizational supports.	"I think there is a way we can move forward and rebuild that trust. There just has to kind of be a willingness and an openness to that [from OHA]. And maybe a little bit of admission of…you held all the power and how can we rebuild that differently?" (Urban LPHA Focus Group)
Power Dynamics	Inherent differences in dominance among sectors and between sectors and individuals resulting from imbalances in resources, perceived value, historical practices, influence, or experience.	
Early power sharing decreased over time	Experiences of power sharing between partners during the early days of Modernization implementation and a concentration of power with OHA over time.	"Early on it felt like there was a lot of shared power in the sense of we were very much at the table helping make decisions and everything that we've kind of shared already. A lot of that having to take ownership at that state level and have more of the power during COVID made sense in some ways. And now we're not in that crisis anymore yet it's still remaining that way. So how can we shift again to where, as a governmental public health system, we have more of that shared power and decision-making moving forward." (Urban LPHA Focus Group)
Unequal power in decision-making	Descriptions of processes and structures that reinforce unequal power for decision-making between Modernization partners.	"The way I understand how the funding works, it's from the legislature to OHA, and then OHA has the authority or the power. I don't think there's anything in statute that says 'X percentage must go to LPHAs or CBOs' or whatever. So really all the power is with OHA and that's probably a problem." (Urban LPHA Focus Group)
OHA using power to overreach	Examples of how the unequal power dynamic between partners has contributed to OHA working beyond their prescribed role for Modernization.	"OHA's community engagement coordinator likes to facilitate my relationship with people, but I meet with those people regularly, we see each other. I don't need a one-off meeting where someone else is involved in setting an agenda, because that's my work. That's the bread and butter of my work." (Rural LPHA Focus Group)
Opportunities to mitigate unequal power dynamics	Descriptions of how unequal power dynamics between Modernization partners can be mitigated.	"I made a strong suggestion that they [OHA] contract with Health Impact Partners to do a power analysis and talk about power…they have some great tools around power, power dynamics and power sharing, and do a lot of work with local public health and power sharing with community based groups…it could help both the relationship between state and local, but also

		give locals the tools for also having those conversations with CBOs…" (Urban LPHA Focus Group)
Equity	The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.	
Equity as early priority that evolved over time	Descriptions of how advancing equity is central to the purpose of Modernization and the evolving approach to Modernization equity over time.	"Oregon's model stood out from everything happening nationally at that point in time. So, there are many states that have started this work, but Oregon very uniquely defined health equity and cultural responsiveness as a foundational capability in our model back in 2015. Since then, the national model has been updated to include health equity and many other states have gone in that direction as well." (OHA Leadership KII 1)
Population-specific approaches demonstrate equity focus	Examples of population-specific approaches that demonstrate partner commitment to equitable implementation of Modernization.	"We realized there were gaps…so we made that a priority in the second round to prioritize rural communities…there were some specific communities, like the disability community, that we wanted to increase funding resources to…part of it is genuinely making sure we're distributing funds equitably across the state." (OHA Leadership KII 3)
Equity approach not shared or understood across partners	Sentiments that the approach to advancing equity through Modernization is not shared between partners and barriers to developing a shared understanding.	"I live in a county that is fairly conservative and rural and I'm getting a lot of questions about how much money we dedicate to DEI efforts now with our budget committees. Because they're looking at other states and other places where they're cutting DEI programs and funding and wanting also to go down that path. So that's part of the struggle here locally when it comes to Modernization as well and maintaining the gains that we've made." (Urban LPHA Focus Group)
OHA equity capacity building	Descriptions of staffing and structural changes and training at OHA increased capacity to implement Modernization equitably.	"We have an equity office, and that's a really big part of what the community specific team does is really forge connections with different communities across the state…it's very much about building relationship and trust…We can go way further in centering community voices, but I do think it's been a huge area of growth." (OHA Leadership KII 1)
Community Voice	Active community engagement ensures that community members are heard and integrated at the beginning of the design process.	

Community voice through shared governance	Descriptions of increased community voice within Modernization decision-making over time.	"When I think back to the early days of Public Health Modernization and writing the Public Health Modernization Manual…we were talking and writing a lot about elevating community voice…at that time, we really did not have mechanisms for engaging with community members…thinking back to a couple iterations of our state health improvement plans, it was really hard to find a community member who was willing to work with us. And that's changed a lot." (OHA Leadership KII 1)
Community voice through shared data and measurement	Examples of increased community voice within Modernization through engagement in data collection and evaluation activities.	"…we were able to collect [data] from community folks that otherwise wouldn't have trusted being able to talk to the OHA or the DEQ because of those silos that have been made. So, what we're doing is breaking those down" (COC CBO Focus Group)
Building infrastructure to elevate community voice	Descriptions of how governmental public health organizations have built infrastructure to elevate community voice.	"…we have a lot of mechanisms with connecting with community at this point…We have an equity office, and that's a really big part of what the community specific team does is really forge connections with different communities across the state…it's very much about building relationship and trust…We can go way further in centering community voices, but I do think it's been a huge area of growth." (OHA Leadership KII 1)

Table Abbreviations

CBO Community-based organization

CCO Coordinated Care Organization

COC Communities of Color

DEQ Department of Environmental Quality

LPHA Local Public Health Authority

OHA-PHD Oregon Health Authority Public Health Division

OPP Other priority populations

PHAB Public Health Advisory Board

Appendix I. Delphi survey recruitment email

Email Recruitment Script for Delphi Survey

Subject line: Student Research on Public Health Modernization Roles for Health Equity: Invitation to Participate in Delphi Survey

Email primary contact: sfiala@pdx.edu

FROM: Steven Fiala, Student, OHSU-PSU School of Public Health

Hello,

My name is Steven Fiala, and I am an Oregon Health Authority (OHA) employee and a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health. I am contacting you today in my capacity as a doctoral student.

Why am I contacting you?

To fulfill my doctoral program requirements, I am conducting dissertation research on the perspectives of staff from community-based organizations (CBOs), local public health authorities (LPHAs), and OHA who are supporting public health Modernization.

You are invited to participate in a series of online surveys to explore the roles of OHA, LPHAs, and CBOs in fulfilling the health equity and cultural responsiveness workforce capability of public health Modernization. The survey process consists of three rounds of responses via email and uses a modified "Delphi technique". The Delphi technique is an effective method of identifying consensus opinion on a particular topic and gives all participants an equal voice in the process. We hope that you can participate in all three surveys; however, you can participate in one survey without having participated in a previous survey.

How will the survey process work?

The Delphi survey process will be conducted in three phases: 1) identifying roles; 2) rating roles; and 3) prioritizing roles. In this first survey, you will

respond to the question: What are the roles for OHA, LPHA, and CBO staff to fulfill the health equity and cultural responsiveness workforce capability? For OHA and LPHAs, the survey will include the roles for health equity and cultural responsiveness already described in the public health Modernization Manual and ask you if any of these existing roles should be modified before being considered for ratings in the second survey. In addition, you will be able to suggest other roles not currently in the Modernization Manual for consideration in the second survey. The public health Modernization Manual does not include roles for CBOs, so you will generate ideas for CBO health equity and cultural responsiveness roles for rating in the second survey.

You may access the survey by clicking the following: **[Insert survey link]**

Survey 1 will be open for 10 days and is estimated to take about 20 minutes to complete. Please respond if you are able by [insert end date of survey 1].

The second and third surveys will be sent on about [insert date of survey 2] and [insert date of survey 3]. In the second survey, you will receive an updated list of roles for health equity and cultural responsiveness based on responses to the first survey. You will be asked to rate the importance of each role on a 5-point scale. In the third survey, you will see the average rating that each role received in the second survey and will be asked to indicate your top 10 priorities from the entire list of roles.

What are the risks and benefits of participation?

Your participation is voluntary, you may choose to stop participating at any time and you may refuse to answer any of the survey questions. All responses are anonymous and cannot be linked to the participant.
Thank you in advance for your participation,

[Insert signature]

Appendix J. Delphi surveys

Delphi Surveys 1-3

Roles for Health Equity in Public Health Modernization

Survey 1 (Generating Roles)

Public Health Modernization Delphi Survey 1

Q1 Welcome!

You are invited to participate in a series of online surveys to explore the roles of the Oregon Health Authority (OHA), local public health authorities (LPHAs), and community-based organizations (CBOs) in fulfilling the health equity and cultural responsiveness workforce capability of public health Modernization. The survey process consists of three rounds of responses via email and uses a modified "Delphi technique". The Delphi technique is an effective method of identifying consensus opinion on a particular topic and gives all participants an equal voice in the process.

This project is part of my required dissertation research as a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health.

In this first survey, you will respond to the question, what are the roles for OHA, LPHA, and CBO staff to fulfill the health equity and cultural responsiveness workforce capability? The survey will include the roles for health equity and cultural responsiveness already described in the public health Modernization Manual and ask you to identify which roles should be considered for ratings in the second survey. You will also be able to suggest modifications to the current roles, as well as other new roles not currently in the Modernization Manual for consideration in the second survey. Please respond by [two weeks]. It is estimated that this survey will take about 20 minutes to complete. There are two additional surveys that will be sent based on the responses received in this first survey.

Your participation is voluntary, you may choose to stop participating at any time and you may refuse to answer any questions. All responses are anonymous and cannot be linked to you. By participating in the survey, you consent to be a participant in this study. No information that could identify participants will be included in study reporting products (for example, reports, slides or published manuscripts). There are no known risks for participating in this study, and it is unlikely that individuals will experience discomfort when participating.

This study is following the guidance provided by the PSU Human Research Protection Program, and the study has been approved by the PSU Institutional Review Board (IRB approval #248406-18). If you have concerns about this research, please contact me at 503.349.3852 or sfiala@pdx.edu. If you have questions or concerns about your rights as a research participant, please contact the PSU IRB at 503.725.5484 or psuirb@pdx.edu.

Thank you in advance for your participation. Your contributions will inform how the Oregon public health system considers the roles for state and local governmental agencies and community-based organizations in advancing health equity and cultural responsiveness. This Delphi survey process will produce three prioritized lists of health equity and cultural responsiveness roles for OHA, LPHA, and CBO staff, separately. This information will help me answer my dissertation research question about how partners perceive their roles in advancing health equity and cultural responsiveness, as well as inform public health partners exploring this question in Oregon and in other states.

Q2 I would like to collect some information about survey respondents. The information you provide will allow me to analyze survey data by different groups of partners (i.e., OHA, CBOs, LPHAs, and other partners). To protect your privacy, I am not collecting more information about survey respondents than is needed to fulfill the study purpose. All responses are anonymous and cannot be linked to individuals.

At which type of organization do you currently work?

- ○ State health department (Oregon Health Authority)
- ○ Local health department (local public health authority)
- ○ Community-based organization
- ○ Other public health system partner

Q3 How long have you been at the organization you selected above?

- ○ Less than 1 year
- ○ 1-3 years
- ○ 4-6 years
- ○ 7-10 years
- ○ More than 10 years

Q4 Have you worked in the sector in the past? (For example, if you currently work in a government agency (e.g., OHA or LPHA) have you worked for a CBO? If you currently work for a CBO have you worked in a government agency?)

- ○ Yes
- ○ No

State/Local Roles Please review the roles below for state health department (OHA) and local health department (LPHA) staff to fulfill the health equity and cultural responsiveness workforce capability. These roles are described in Oregon's public health Modernization Manual that was published by OHA in 2017.

For each role, you have the opportunity to indicate if the role for state or local health department staff should be modified to better reflect the health equity and cultural responsiveness capability and write in suggested modifications for consideration in the second survey. You will also have the opportunity to write in up to 5 roles each for state and local health departments that you do not see in this survey that should be considered in the second survey.

The public health Modernization Manual does not include roles for community-based organizations (CBO) to fulfill the health equity and cultural responsiveness workforce capability. At the end of the survey, you will have the opportunity to write in up to 10 roles for CBOs that should be considered in the second survey.

	State Health Department (OHA) Roles	Local Health Department (LPHA) Roles

Any Modifications? If yes, please describe.	Any Modifications? If yes, please describe.

Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).		
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.		
Promote a common understanding of cultural responsiveness.		
Promote understanding of the extent and consequences of systems of oppression.		
Make the economic case for health equity, including the value of investment in cultural responsiveness.		
Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.		

Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.		
Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements.		
Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.		
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.		
Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.		

Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.		
Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.		
Monitor relevant issues under discussion by governing and legislative bodies.		
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.		
Monitor funding allocations to ensure sustainable impacts on health equity.		
Increase flexible categorical and non-categorical funding to address health equity.		

Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores.		
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.		
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.		
Establish parity goals and create specific metrics with benchmarks to track progress.		
Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance.		
Establish greater flexibility in job classifications to tackle the root causes of health inequity.		

Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.		
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery.		
Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community.		
Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.		
Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.		

Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.		
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations.		
Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.		
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members.		

Increase racial and ethnic representation on councils and committees.		
Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed.		
Draw on the skills and knowledge of staff who are members of communities most affected by inequities.		
Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.		
Develop an ongoing community engagement process for recruitment.		
Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce.		

Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities).		

Q10 Please review the roles below described in the public health Modernization Manual as being for state health department (OHA) staff **only**

Indicate if the role for state health department staff should be modified to better reflect the health equity and cultural responsiveness capability and write in suggested modifications for consideration in the second survey.

	State Health Department (OHA) Roles
	Any Modifications? If yes, please describe.

Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	
Make data and reports available to local public health authorities, partners and stakeholders, and other groups.	
Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies.	
Implement the Race, Ethnicity, Language and Disability (REAL+D) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.	
Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.	
Increase the value for cultural responsiveness in PHD and among local public health authorities.	
Develop or support mass media educational efforts that uncover the fundamental social, economic and environmental causes of health inequities.	

Advocate for health equity in health system reform.	
Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions.	
Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data.	
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities.	
Develop or use an existing antidiscrimination training to build a competent workforce. Make training available to local public health authorities.	
Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational structure and culture.	

Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities.	
Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability and national origin.	
Conduct and disseminate research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.	
Work with local public health authorities when working with local communities.	

Q8 Are there any other roles for state health department (OHA) staff to fulfill the public health Modernization health equity and cultural responsiveness workforce capability that you did not see above?
Please use the fields below to write in up to 5 other roles that are important for state health department staff. These roles will be added to the second survey for further consideration.

- ☐ Additional Role #1 _____
- ☐ Additional Role #2 _____
- ☐ Additional Role #3 _____
- ☐ Additional Role #4 _____
- ☐ Additional Role #5 _____

Q11 Please review the roles below described in the public health Modernization Manual as being for local health department (LPHA) staff **only**

Indicate if the role for local health department staff should be modified to better reflect the health equity and cultural responsiveness capability and write in suggested modifications for consideration in the second survey.

	Local Health Department (LPHA) Roles
	Any Modifications? If yes, please describe.

Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	
Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD.	
Develop an ongoing process of continuous learning, training and structured dialogue for public health staff.	
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities.	
Develop or use an existing antidiscrimination training to build a competent workforce.	
Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background.	
Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities.	

Q9 Are there any other roles for local health department staff (LPHA) to fulfill the public health Modernization health equity and cultural responsiveness workforce capability that you did not see above?

Please use the fields below to write in up to 5 other roles that are important for local health department staff. These roles will be added to the second survey for further consideration.

- ☐ Additional Role #1 _____
- ☐ Additional Role #2 _____
- ☐ Additional Role #3 _____
- ☐ Additional Role #4 _____
- ☐ Additional Role #5 _____

Q13 As described earlier, the Manual does not include roles for community-based organization (CBO) staff to fulfill the health equity and cultural responsiveness workforce capability.
Please use the fields below to write in up to 10 roles that are important for community-based organization staff. These roles will be added to the second survey for further consideration.

- ☐ Role #1 _____
- ☐ Role #2 _____
- ☐ Role #3 _____
- ☐ Role #4 _____
- ☐ Role #5 _____
- ☐ Role #6 _____
- ☐ Role #7 _____
- ☐ Role #8 _____
- ☐ Role #9 _____
- ☐ Role #10 _____

Survey 2 (Rating Roles)

Public Health Modernization Delphi Survey 2 (Rating Roles)

Q1 Welcome!

You are invited to participate in the second survey to explore the roles of the Oregon Health Authority (OHA), local public health authorities (LPHAs), and community-based organizations (CBOs) in fulfilling the health equity and cultural responsiveness workforce capability of public health Modernization. The survey process consists of three rounds of responses via email and uses a modified "Delphi technique". The Delphi technique is an effective method of identifying consensus opinion on a particular topic and gives all participants an equal voice in the process. Your participation is welcome and encouraged regardless of whether you participated in the first survey.

This project is part of my required dissertation research as a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health.

In this second survey, you will review the list of roles for health equity and cultural responsiveness (including those that have been modified or are new) based on responses to the first survey. You are being asked to rate each role on its importance to advancing health equity and cultural responsiveness for OHA, LPHAs, and CBOs, separately. Please respond by [two weeks]. It is estimated that this survey will take about 20 minutes to complete.

The write-in responses from the first survey were reviewed and duplicate ideas removed. Every effort was made to retain the original language provided by survey respondents. There may still be overlap of ideas as we tried to keep the unique wording of each write-in response. At this step of the process, there is no further opportunity to add new ideas. The roles are in random order, so please review all of the survey content.

Your participation is voluntary, you may choose to stop participating at any time and you may refuse to answer any questions. All responses are anonymous and cannot be linked to you. By participating in the survey, you consent to be a participant in this study. No information that could identify participants will be included in study reporting products (for example, reports, slides or published manuscripts). There are no known risks for participating in this study, and it is unlikely that individuals will experience discomfort when participating.

This study is following the guidance provided by the PSU Human Research Protection Program, and the study has been approved by the PSU Institutional Review Board (IRB approval #248406-18). If you have concerns about this research, please contact me at 503.349.3852 or sfiala@pdx.edu. If you have questions or concerns about your rights as a research participant, please contact the PSU IRB at 503.725.5484 or psuirb@pdx.edu.

Thank you in advance for your participation. Your contributions will inform how the Oregon public health system considers the roles for state and local governmental agencies and community-based organizations in advancing health equity and cultural responsiveness.

This Delphi survey process will produce three prioritized lists of health equity and cultural responsiveness roles for OHA, LPHA, and CBO staff, respectively. This information will help me answer my dissertation research question about how partners perceive their roles in advancing health equity and cultural responsiveness, as well as inform public health partners exploring this question in Oregon and in other states.

Q2 I would like to collect some information about survey respondents. The information you provide will allow me to analyze survey data by different groups of partners (i.e., OHA, CBOs, LPHAs, and other partners). To protect your privacy, I am not collecting more information about survey respondents than is needed to fulfill the study purpose. All responses are anonymous and cannot be linked to individuals.

At which type of organization do you currently work?

- ○ State health department (Oregon Health Authority)
- ○ Local health department (local public health authority)
- ○ Community-based organization
- ○ Other public health system partner

Q3 How long have you been at the organization you selected above?

- ○ Less than 1 year
- ○ 1-3 years
- ○ 4-6 years
- ○ 7-10 years
- ○ More than 10 years

Q4 Have you worked in one of the other sectors in the past? (For example, if you currently work in a government agency have you worked for a CBO in the past?)

- ○ Yes
- ○ No

State Roles Please review the roles below for state health department (OHA) staff to fulfill the health equity and cultural responsiveness workforce capability.

Rate each role based on how important you think it is for state health department staff to fulfill the health equity and cultural responsiveness workforce capability. You will rate each role on a scale ranging from "not important at all"

to "very important".

	Not important at all	Slightly important	Somewhat important	Important	Very important
Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).	○	○	○	○	○
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	○	○	○	○	○
Promote a common understanding of cultural responsiveness.	○	○	○	○	○
Promote understanding of the extent and consequences of systems of oppression.	○	○	○	○	○
Make the economic case for health equity, including the value of investment in cultural responsiveness.	○	○	○	○	○

Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.	○	○	○	○	○
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.	○	○	○	○	○
Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements.	○	○	○	○	○

Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	○	○	○	○	○
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.	○	○	○	○	○
Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.	○	○	○	○	○
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.	○	○	○	○	○

Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.	○	○	○	○	○
Monitor relevant issues under discussion by governing and legislative bodies.	○	○	○	○	○
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.	○	○	○	○	○
Monitor funding allocations to ensure sustainable impacts on health equity.	○	○	○	○	○
Increase flexible categorical and non-categorical funding to address health equity.	○	○	○	○	○

Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores.	○	○	○	○	○
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	○	○	○	○	○
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.	○	○	○	○	○
Establish parity goals and create specific metrics with benchmarks to track progress.	○	○	○	○	○

Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance.	○	○	○	○	○
Establish greater flexibility in job classifications to tackle the root causes of health inequity.	○	○	○	○	○
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.	○	○	○	○	○
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery.	○	○	○	○	○

Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community.	○	○	○	○	○
Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.	○	○	○	○	○
Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.	○	○	○	○	○

Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.	○	○	○	○	○
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations.	○	○	○	○	○

Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.	○	○	○	○	○
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members.	○	○	○	○	○
Increase racial and ethnic representation on councils and committees.	○	○	○	○	○

Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed.	○	○	○	○	○
Draw on the skills and knowledge of staff who are members of communities most affected by inequities.	○	○	○	○	○
Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.	○	○	○	○	○
Develop an ongoing community engagement process for recruitment.	○	○	○	○	○

Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce.	○	○	○	○	○
Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities).	○	○	○	○	○
Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	○	○	○	○	○
Make data and reports available to local public health authorities, partners and stakeholders, and other groups.	○	○	○	○	○

Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies.	○	○	○	○	○
Implement the Race, Ethnicity, Language and Disability (REAL+D) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.	○	○	○	○	○
Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.	○	○	○	○	○

Increase the value for cultural responsiveness in PHD and among local public health authorities.	○	○	○	○	○
Develop or support mass media educational efforts that uncover the fundamental social, economic and environmental causes of health inequities.	○	○	○	○	○
Advocate for health equity in health system reform.	○	○	○	○	○
Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions.	○	○	○	○	○

Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data.	○	○	○	○	○

Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities.	○	○	○	○	○
Develop or use an existing antidiscrimination training to build a competent workforce. Make training available to local public health authorities.	○	○	○	○	○
Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational structure and culture.	○	○	○	○	○
Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities.	○	○	○	○	○

Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability and national origin.	○	○	○	○	○
Conduct and disseminate research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.	○	○	○	○	○
Work with local public health authorities when working with local communities.	○	○	○	○	○

Local Roles Please review the roles below for local health department (LPHA) staff to fulfill the health equity and cultural responsiveness workforce capability.

Rate each role based on how important you think it is for local health department staff to fulfill the health equity

and cultural responsiveness workforce capability. You will rate each role on a scale ranging from "not important at all" to "very important".

	Not important at all	Slightly important	Somewhat important	Important	Very important
Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).	○	○	○	○	○
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	○	○	○	○	○
Promote a common understanding of cultural responsiveness.	○	○	○	○	○
Promote understanding of the extent and consequences of systems of oppression.	○	○	○	○	○
Make the economic case for health equity, including the value of investment in cultural responsiveness.	○	○	○	○	○

Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.	○	○	○	○	○
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.	○	○	○	○	○
Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements.	○	○	○	○	○

Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	○	○	○	○	○
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.	○	○	○	○	○
Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.	○	○	○	○	○
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.	○	○	○	○	○

Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.	○	○	○	○	○
Monitor relevant issues under discussion by governing and legislative bodies.	○	○	○	○	○
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.	○	○	○	○	○
Monitor funding allocations to ensure sustainable impacts on health equity.	○	○	○	○	○
Increase flexible categorical and non-categorical funding to address health equity.	○	○	○	○	○

Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores.	○	○	○	○	○
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	○	○	○	○	○
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.	○	○	○	○	○
Establish parity goals and create specific metrics with benchmarks to track progress.	○	○	○	○	○

Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance.	○	○	○	○	○
Establish greater flexibility in job classifications to tackle the root causes of health inequity.	○	○	○	○	○
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.	○	○	○	○	○
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery.	○	○	○	○	○

Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community.	○	○	○	○	○
Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.	○	○	○	○	○
Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.	○	○	○	○	○

Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.	○	○	○	○	○
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations.	○	○	○	○	○

Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.	○	○	○	○	○
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members.	○	○	○	○	○
Increase racial and ethnic representation on councils and committees.	○	○	○	○	○

Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed.	○	○	○	○	○
Draw on the skills and knowledge of staff who are members of communities most affected by inequities.	○	○	○	○	○
Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.	○	○	○	○	○
Develop an ongoing community engagement process for recruitment.	○	○	○	○	○

Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce.	○	○	○	○	○
Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities).	○	○	○	○	○
Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	○	○	○	○	○

Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD.	○	○	○	○	○
Develop an ongoing process of continuous learning, training and structured dialogue for public health staff.	○	○	○	○	○
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities.	○	○	○	○	○
Develop or use an existing antidiscrimination training to build a competent workforce.	○	○	○	○	○

Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background.	○	○	○	○	○
Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities.	○	○	○	○	○

CBO Roles Please review the roles below for community-based organization (CBO) staff to fulfill the health equity and cultural responsiveness workforce capability.

Rate each role based on how important you think it is for community-based organization staff to fulfill the health equity and cultural responsiveness workforce capability. You will rate each role on a scale ranging from "not important at all" to "very important".

	Not important at all	Slightly important	Somewhat important	Important	Very important
[To be populated from open-text responses to Survey 1]	○	○	○	○	○

Survey 3 (Prioritizing Roles)

Public Health Modernization Delphi Survey 3 (Prioritizing Roles)
Q1 Welcome!

You are invited to participate in the third and final survey to explore the roles of the Oregon Health Authority (OHA), local public health authorities (LPHAs), and community-based organizations (CBOs) in fulfilling the health

equity and cultural responsiveness workforce capability of public health Modernization. The survey process consisted of three rounds of responses via email and uses a modified "Delphi technique". The Delphi technique is an effective method of identifying consensus opinion on a particular topic and gives all participants an equal voice in the process. Your participation is welcome and encouraged regardless of whether you participated in the first or second surveys.

This project is part of my required dissertation research as a PhD candidate in the Health Systems and Policy program at the Oregon Health and Science University and Portland State University (OHS-PSU) School of Public Health.

In this third survey, you will see the average score that each role received in the second survey, where respondents rated the importance of each role on a 5-point scale. You will be asked to prioritize the roles for OHA, LPHA, and CBO staff, separately. Please respond by [two weeks]. It is estimated that this survey will take about 20 minutes to complete.

Please review all of the roles listed and rank your top 10 by moving the items so that your top 10 are numbered 1-10. Note that you can actually rank all roles, but please know that our analysis will be limited to the ten top-ranked roles from each respondent.

Your participation is voluntary, you may choose to stop participating at any time and you may refuse to answer any questions. All responses are anonymous and cannot be linked to you. By participating in the survey, you consent to be a participant in this study. No information that could identify participants will be included in study reporting products (for example, reports, slides or published manuscripts). There are no known risks for participating in this study, and it is unlikely that individuals will experience discomfort when participating.

This study is following the guidance provided by the PSU Human Research Protection Program, and the study has been approved by the PSU Institutional Review Board (IRB approval #248406-18). If you have concerns about this research, please contact me at 503.349.3852 or sfiala@pdx.edu. If you have questions or concerns about your rights as a research participant, please contact the PSU IRB at 503.725.5484 or psuirb@pdx.edu.

Thank you in advance for your participation. Your contributions will inform how the Oregon public health system considers the roles for state and local governmental agencies and community-based organizations in advancing health equity and cultural responsiveness.

This Delphi survey process will produce three prioritized lists of health equity and cultural responsiveness roles for OHA, LPHA, and CBO staff, respectively. This information will help me answer my dissertation research question about how partners perceive their roles in advancing health equity and cultural responsiveness, as well as inform public health partners exploring this question in Oregon and in other states.

Q2 I would like to collect some information about survey respondents. The information you provide will allow me to analyze survey data by different groups of partners (i.e., OHA, CBOs, LPHAs, and other partners). To protect your privacy, I am not collecting more information about survey respondents than is needed to fulfill the study purpose. All responses are anonymous and cannot be linked to individuals.

At which type of organization do you currently work?

- ○ State health department (Oregon Health Authority)
- ○ Local health department (local public health authority)
- ○ Community-based organization
- ○ Other public health system partner

Q3 How long have you been at the organization you selected above?

- ○ Less than 1 year
- ○ 1-3 years
- ○ 4-6 years
- ○ 7-10 years
- ○ More than 10 years

Q4 Have you worked in one of the other sectors in the past? (For example, if you currently work in a government agency have you worked for a CBO in the past?)

- ○ Yes
- ○ No

State Roles Please review the roles below for state health department (OHA) staff to fulfill the health equity and cultural responsiveness workforce capability.

Note that the average score from all responses in the second survey, where respondents rated the importance of each role, is indicated at the end of each role's description.

Please rank your top 10 roles for state health department staff by moving the roles so that your top ten are numbered 1-10.

_____ Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools). Average score: X Average score: X

_____ Develop and promote shared understanding of the determinants of health, health equity and lifelong health. Average score: X Average score: X

_____ Promote a common understanding of cultural responsiveness. Average score: X

_____ Promote understanding of the extent and consequences of systems of oppression. Average score: X

_____ Make the economic case for health equity, including the value of investment in cultural responsiveness. Average score: X

_____ Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information. Average score: X

_____ Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Average score: X

_____ Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements. Average score: X

_____ Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies. Average score: X

_____ Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity. Average score: X

_____ Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness. Average score: X

_____ Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health. Average score: X

_____ Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health. Average score: X

_____ Monitor relevant issues under discussion by governing and legislative bodies. Average score: X

_____ Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms. Average score: X

_____ Monitor funding allocations to ensure sustainable impacts on health equity. Average score: X

_____ Increase flexible categorical and non-categorical funding to address health equity. Average score: X

_____ Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores. Average score: X

_____ Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities. Average score: X

_____ Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. Average score: X

_____ Establish parity goals and create specific metrics with benchmarks to track progress. Average score: X

_____ Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance. Average score: X

_____ Establish greater flexibility in job classifications to tackle the root causes of health inequity. Average score: X

_____ Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans. Average score: X

_____ Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery. Average score: X

_____ Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community. Average score: X

_____ Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it. Average score: X

_____ Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies. Average score: X
_____ Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles. Average score: X
_____ Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations. Average score: X
_____ Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government. Average score: X
_____ Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members. Average score: X
_____ Increase racial and ethnic representation on councils and committees. Average score: X
_____ Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed. Average score: X
_____ Draw on the skills and knowledge of staff who are members of communities most affected by inequities. Average score: X
_____ Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served. Average score: X
_____ Develop an ongoing community engagement process for recruitment. Average score: X
_____ Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce. Average score: X
_____ Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities). Average score: X
_____ Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health. Average score: X
_____ Make data and reports available to local public health authorities, partners and stakeholders, and other groups. Average score: X
_____ Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies. Average score: X
_____ Implement the Race, Ethnicity, Language and Disability (REAL+D) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data. Average score: X
_____ Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies. Average score: X
_____ Increase the value for cultural responsiveness in PHD and among local public health authorities. Average score: X
_____ Develop or support mass media educational efforts that uncover the fundamental social, economic and environmental causes of health inequities. Average score: X
_____ Advocate for health equity in health system reform. Average score: X
_____ Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions. Average score: X
_____ Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi.

Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data. Average score: X

_____ Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities. Average score: X

_____ Develop or use an existing antidiscrimination training to build a competent workforce. Make training available to local public health authorities. Average score: X

_____ Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational structure and culture. Average score: X

_____ Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities. Average score: X

_____ Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability and national origin. Average score: X

_____ Conduct and disseminate research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities. Average score: X

_____ Work with local public health authorities when working with local communities. Average score: X

Local Roles Please review the roles below for local health department (LPHA) staff to fulfill the health equity and cultural responsiveness workforce capability.

Note that the average score from all responses in the second survey, where respondents rated the importance of each role, is indicated at the end of each role's description.

Please rank your top 10 roles for local health department staff by moving the roles so that your top ten are numbered 1-10.

_____ Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools). Average score: X

_____ Develop and promote shared understanding of the determinants of health, health equity and lifelong health. Average score: X

_____ Promote a common understanding of cultural responsiveness. Average score: X

_____ Promote understanding of the extent and consequences of systems of oppression. Average score: X

_____ Make the economic case for health equity, including the value of investment in cultural responsiveness. Average score: X

_____ Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information. Average score: X

_____ Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Average score: X

_____ Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements. Average score: X

_____ Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies. Average score: X

_____ Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity. Average score: X

_____ Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness. Average score: X

_____ Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health. Average score: X

_____ Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health. Average score: X

_____ Monitor relevant issues under discussion by governing and legislative bodies. Average score: X

_____ Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms. Average score: X

_____ Monitor funding allocations to ensure sustainable impacts on health equity. Average score: X

_____ Increase flexible categorical and non-categorical funding to address health equity. Average score: X

_____ Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores. Average score: X

_____ Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities. Average score: X

_____ Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. Average score: X

_____ Establish parity goals and create specific metrics with benchmarks to track progress. Average score: X

_____ Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance. Average score: X

_____ Establish greater flexibility in job classifications to tackle the root causes of health inequity. Average score: X

_____ Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans. Average score: X

_____ Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery. Average score: X

_____ Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community. Average score: X

_____ Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it. Average score: X

_____ Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies. Average score: X
_____ Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles. Average score: X
_____ Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations. Average score: X
_____ Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government. Average score: X
_____ Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members. Average score: X
_____ Increase racial and ethnic representation on councils and committees. Average score: X
_____ Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed. Average score: X
_____ Draw on the skills and knowledge of staff who are members of communities most affected by inequities. Average score: X
_____ Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served. Average score: X
_____ Develop an ongoing community engagement process for recruitment. Average score: X
_____ Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce. Average score: X
_____ Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities). Average score: X
_____ Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health. Average score: X
_____ Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD. Average score: X
_____ Develop an ongoing process of continuous learning, training and structured dialogue for public health staff. Average score: X
_____ Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Average score: X
_____ Develop or use an existing antidiscrimination training to build a competent workforce. Average score: X
_____ Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background. Average score: X
_____ Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities. Average score: X

CBO Roles Please review the roles below for community-based organization (CBO) staff to fulfill the health equity and cultural responsiveness workforce capability.

Note that the average score from all responses in the second survey, where respondents rated the importance of each role, is indicated at the end of each role's description.

Please rank your top 10 roles for community-based organization staff by moving the roles so that your top ten are numbered 1-10.
_____ [To be populated from open-text responses to Survey 1] Average score: X

Appendix K. Suggested modifications to existing roles and new roles from survey #1 respondents

Note: Bold text with an underline indicates suggested additions to existing roles and bold text with a strikethrough indicates suggested deletions to existing roles.

Original text	Suggested modification	Decision to include in Survey #2 (role rating) and modification(s) to original text
State roles		
Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools)	Work with local public health to gather local data (if/when available)	This does not make sense as a modification to the role. Will include as consideration generally when reporting survey findings.
	Health resources is a confusing term. Consider changing it to health promoting factors like active transportation and parks, access to healthy food etc.	**(modified)** Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health **~~resources that affect health~~ promoting factors** (e.g., quality parks and schools)
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	Collaborate with LPHAs to develop and promote a shared understanding....	**(modified) Collaborate with partners to** develop and promote shared understanding of the determinants of health, health equity and lifelong health. **Work with CBOs to develop culturally and linguistically appropriate resources.**
	Work along with CBOs on developing cultural and language appropriate resources (include this as part of it)	
	Acknowledge and communicate that this will always be evolving.	Not going to include in a modified role. Could be used in overarching statement introducing the roles.
Promote a common understanding of cultural responsiveness.	Work with local public health to allow a definition that reflects local community.	**(modified) Collaborate with partners to develop and promote** a common understanding of cultural and **linguistic** responsiveness.
	Cultural and linguistic responsiveness	

	Add, "and organizational commitment to cultural responsiveness"	Include in reporting/recommendations, but do not use to create modified role.
	While not presuming to know, yet, what that is.	Not going to include in a modified role. Could be used in overarching statement introducing the roles.
Promote understanding of the extent and consequences of systems of oppression.	and racism	**(modified)** Promote understanding of the extent and consequences of systems of oppression, **including racism**.
Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.	Work with local public health to allow for local data to meet local needs.	I don't understand what this means, so not sure how to incorporate into a modified role. Will include comments when reporting survey findings.
	Additional line for state is to help support LPHAs to provide said information.	**(modified)** Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, **data sovereignty,** and other communication needs when releasing data and information. **OHA supports LPHAs to make data and information available.**
	Shared data; include data sovereignty as part of the process when collecting data. Explaining it in a way that is accessible to all people	
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.	Including listening to and learning about historical practices and alternative health care effectiveness.	**(modified)** Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. **This may include traditional and alternative health care practices.**
Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic,	Work with local health to ensure strategies and partnerships are appropriate on the local level.	**(modified)** Support, implement and evaluate **community-informed** strategies that tackle the root causes of health inequities through

lasting partnerships with public and private organizations and social movements.	remove social movements Change to, "...and evaluate community-informed strategies that tackle..."	strategic, lasting partnerships with public and private organizations ~~and social movements~~. **OHA collaborates with LPHAs to ensure strategies and partnerships are appropriate at the local level.**
	Expand scope of these causes that include technological, political, industrial contributions to stress, disenfranchisement and disease.	Not including in modified role, because it will make it too wordy, so will include this comment in reporting survey results.
Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.	Work with local public health to ensure partnerships are appropriate on the local level.	**(modified)** Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies. **OHA collaborates with LPHAs to ensure partnerships are appropriate at the local level.**
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.	Work with local public health to ensure locally appropriate strategies. Change to, "Work collaboratively across the public health ecosystem on..."	**(modified)** Work collaboratively across the ~~governmental~~ public health system on state and local policies, programs and strategies intended to ensure health equity. **OHA collaborates with LPHAs to ensure strategies are appropriate at the local level.**
	I think we have to creatively envision health equity before we can ensure it.	Include in reporting/recommendations, but do not use to create modified role.
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.	add political determinants of health Change to, "...existing evidence-based or community informed measures...."	**(modified)** Use existing evidence-based **or community-informed** measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social, environmental, **and political** determinants of health.
Monitor funding allocations to ensure sustainable impacts on health equity.	Use a budget equity lens when making funding decisions	**(modified)** Monitor funding allocations to ensure **efficacy and** sustainable impacts on

	Change to, "...to ensure efficacy and sustainable impacts..."	health equity. **Use equity lens when making funding allocations.**
	Monitor and influence funding allocations to ensure...	Adding “influence” does not make sense as a modification to the role, which is focused on funding accountability. Will include comments in reporting survey findings.
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.	We can begin to lean further in and start to build deliverables as well.	Include in reporting/recommendations, but do not use to create modified role.
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.	Again - I think creative visioning to create a specific goal against which to measure and compare is important.	**(modified)** Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. **Develop specific investment goals and measure progress.**
Establish parity goals and create specific metrics with benchmarks to track progress.	The language in this should be clearer. Does this mean parity in salary ("pay equity") or some other type of parity?	Include in reporting/recommendations, but do not use to create modified role.
	This is a little vague and could be made clearer	
	I don't know what this means	
Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance.	shorten! add anti-bias language	**(modified)** Increase awareness and practice of health equity **and anti-bias** among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance **and ensure a safe workplace that creates a sense of belonging for staff.**
	Add information about ensuring a safe workplace that creates a sense of belonging and provides employee resources/safe spaces	

Establish greater flexibility in job classifications to tackle the root causes of health inequity.	add "and job experience/requirements"	**(modified)** Establish greater flexibility in job classifications **and hiring requirements** to tackle the root causes of health inequity.
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.	Work with local public health to ensure strategies are appropriate locally.	**(modified)** Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans. **OHA collaborates with LPHAs to ensure integration in local strategic priorities and plans is appropriate.**
Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.	Depend more on local public health to provide the values, needs, major concerns and resources at the local level.	**(modified)** Learn about the culture, values, needs, major concerns and resources of the community. **OHA depends on LPHAs as a resource to learn about community.** Respect **and uplift** local community knowledge and seek to understand and formally evaluate it.
	Change to "Respect and uplift local community knowledge..."	
	Don't understand the purpose of this evaluation. From what lens? To what end?	Include in reporting/recommendations, but do not use to create modified role.
Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.	This could be broadened beyond just income, race, ethnicity, and disability	Include in reporting/recommendations, but do not use to create modified role.
	First step might be to understand why certain groups are hesitant to participate in such activities.	Include in reporting/recommendations, but do not use to create modified role.
Increase racial and ethnic representation on councils and committees.	This could be broadened beyond just race and ethnicity	**(modified) Partner with councils and committees to ensure diverse representation**, including but not limited to race and ethnicity, age, and geography ~~**representation on councils and committees**~~.
	Change to "diverse representation"	
	Partner with councils and committees to....	
Develop an ongoing community engagement process for recruitment.	remove; unrealistic	Include in reporting/recommendations, but do not use to create modified role.
Local roles		

Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).	This is important to do but, data is limited. Original data would need to be collected in partnership with CBOs.	Include in reporting/recommendations, but do not use to create modified role.
	How political, cultural and intergovernmental (esp tribal) interact, disconnect or are in need of better coordination	Include in reporting/recommendations, but do not use to create modified role.
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	Collaborate with OHA to develop and promote a shared understanding....	**(modified) <u>Collaborate with partners to</u>** develop and promote shared understanding of the determinants of health, health equity and lifelong health. **<u>Work with CBOs to develop cultural and language appropriate resources.</u>**
	Government cannot develop and promote a shared understanding in isolation. Must be done in partnership with others.	
	Work along with CBOs on developing cultural and language appropriate resources (include this as part of it)	
	Acknowledge and communicate that this will always be evolving.	Include in reporting/recommendations, but do not use to create modified role.
Promote a common understanding of cultural responsiveness.	Work with OHA to develop a statewide AND local understanding.	**(modified) <u>Collaborate with partners to develop and promote</u>** a common understanding of cultural and **<u>linguistic</u>** responsiveness.
	As defined by culturally diverse communities.	
	Add, "and organizational commitment to cultural responsiveness"	Include in reporting/recommendations, but do not use to create modified role.
	While not presuming to know, yet, what that is.	Not going to include in a modified role. Could be used in overarching statement introducing the roles.
Make the economic case for health equity, including the value of investment in cultural responsiveness.	Return on Investment studies / reports are expensive. Can this be done collectively as a state?	**(modified)** Make the economic case for health equity, including the value of investment in cultural responsiveness. **<u>LPHAs may rely on statewide return-on-investment studies/reports from OHA and other sources.</u>**

Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.	Work with OHA to understand a statewide perspective as well as localized needs based on data.	**(modified)** Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, **data sovereignty,** and other communication needs when releasing data and information. **OHA supports LPHAs to make data and information available.**
	Shared data; include data sovereignty as part of the process when collecting data. Explaining it in a way that is accessible to all people	
	This is challenging for LPHAs with limited data analysts / Epidemiologists. Need to train the workforce in data equity.	Include in reporting/recommendations, but do not use to create modified role.
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.	How do we know when we've accomplished this? Need investments in evaluation.	Include in reporting/recommendations, but do not use to create modified role.
	Including listening to and learning about historical practices and alternative health care effectiveness.	**(modified)** Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. **This may include traditional and alternative health care practices.**
Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements.	Change to, "...and evaluate community-informed strategies that tackle..."	**(modified)** Support, implement and evaluate **community-informed** strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations ~~**and social movements**~~. **OHA collaborates with LPHAs to ensure strategies and partnerships are appropriate at the local level.**

Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.	Change to, "Work collaboratively across the public health ecosystem on..."	**(modified)** Work collaboratively across the ~~**governmental**~~ public health system on state and local policies, programs and strategies intended to ensure health equity. **OHA collaborates with LPHAs to ensure strategies are appropriate at the local level.**
Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.	Program Elements need to be modified so public health staff across programs are focused on determinants of health.	Include in reporting/recommendations, but do not use to create modified role.
	Change to, "...existing evidence-based or community informed measures....	**(modified)** Use existing evidence-based **or community-informed** measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social, environmental, **and political** determinants of health.
Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.	Program Elements need to be modified so public health staff across programs are focused on determinants of health.	Include in reporting/recommendations, but do not use to create modified role.
Monitor relevant issues under discussion by governing and legislative bodies.	With local input?	I don't understand how local input would inform a role related to monitoring relevant issues under discussion by governing and legislative bodies, so not modifying the role.
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.	Requires partnerships with CCOs	Include in reporting/recommendations, but do not use to create modified role.
Monitor funding allocations to ensure sustainable impacts on health equity.	LPHAs need to develop and apply an equity lens	**(modified)** Monitor funding allocations to ensure **efficacy and** sustainable impacts on

	Change to, "...to ensure efficacy and sustainable impacts...	health equity. **Use equity lens when making funding allocations.**
Increase flexible categorical and non-categorical funding to address health equity.	Our LPHA feels limited by the siloed PE funding.	Include in reporting/recommendations, but do not use to create modified role.
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.	I think creative visioning to create a specific goal against which to measure and compare is important. At local levels, this may look very different across the state.	**(modified)** Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. **Develop specific investment goals and measure progress.**
Establish parity goals and create specific metrics with benchmarks to track progress.	The language in this should be clearer. Does this mean parity in salary ("pay equity") or some other type of parity?	Include in reporting/recommendations, but do not use to create modified role.
	Vague	
Establish greater flexibility in job classifications to tackle the root causes of health inequity.	add "and job experience/requirements	**(modified)** Establish greater flexibility in job classifications **and hiring requirements** to tackle the root causes of health inequity.
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.	Remove "state" from LPHA requirement	Keeping because this role is meant to be for both state and local governmental public health so needs to address both in one role.
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery.	Remove "PHD"	Keeping because this role is meant to be for both state and local governmental public health so needs to address both in one role.
Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.	Change to "Respect and uplift local community knowledge..."	**(modified)** Learn about the culture, values, needs, major concerns and resources of the community. **OHA depends on LPHAs as a resource to learn about community.** Respect

		and uplift local community knowledge and seek to understand and formally evaluate it.
Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.	work with communities to analyze data, set priorities etc. LPHAs need to learn from and share power with communities.	**(modified) ~~Provide technical assistance to~~ Collaborate with** communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.
Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.	Seems like aspirational work for large LPHAs and OHA.	Include in reporting/recommendations, but do not use to create modified role. The Modernization Manual was meant to be aspirational, correct?
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations.	Not sure I have a good suggestion on how to modify, but this seems out of the scope for LPHAs to be tracking and helping decrease civil rights violations.	Include in reporting/recommendations, but do not use to create modified role.
Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.	This could be broadened beyond just income, race, ethnicity, and disability	Include in reporting/recommendations, but do not use to create modified role.
Increase racial and ethnic representation on councils and committees.	Geographical or age representation as well for those counties with limited racial and ethnic diversity	**(modified) Partner with councils and committees to ensure diverse representation**, including but not limited to

	This could be broadened beyond just race and ethnicity Change to "diverse representation" Partner with councils and committees to....	race and ethnicity, age, and geography ~~**representation on councils and committees**~~.
Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.	Hire or train staff (because, especially in small LPHAs we have to train our own because recruitment is very difficult	**(modified)** Hire **or train** staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.
State roles only		
Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	"qualitative and quantitative data:	**(modified)** Collect and maintain **qualitative and quantitative** data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.
Make data and reports available to local public health authorities, partners and stakeholders, and other groups.	This data should be usable to LPHAs, allowing dissemination to wider groups. "available and accessible" Make data and reports available to LPHAs, partners/stakeholders and to the general public as appropriate	**(modified)** Make data and reports available **and accessible** to local public health authorities, partners/stakeholders, **and the general public as appropriate** ~~**other groups**~~.
Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies.	Add community	**(modified)** Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies, **and community organizations**.
Implement the Race, Ethnicity, Language and Disability (REAL+D)	Add SOGI in addition to REALD	**(modified)** Implement the Race, Ethnicity, Language and Disability (REAL+D) **and**

law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.		**Sexual Orientation and Gender Identity (SOGI)** law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.
Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.	Add SOGI in addition to REALD	**(modified)** Based on REAL+D **and SOGI** data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.
Increase the value for cultural responsiveness in PHD and among local public health authorities.	Not sure how the state can do this for LPHAs	Include in reporting/recommendations, but do not use to create modified role.
	"Cultural responsiveness" isn't defined and the term has been used broadly.	
	this should be more specific. What does increase the value mean?	
	I feel like this question is vague.	
Develop or support mass media educational efforts that uncover the fundamental social, economic and environmental causes of health inequities.	change to "public education or outreach efforts"	**(modified)** Develop or support mass media, **public education, or outreach** educational efforts that uncover the fundamental social, economic and environmental causes of health inequities.
Advocate for health equity in health system reform.	"Health equity" was not defined and the term has been used very broadly.	Include in reporting/recommendations, but do not use to create modified role.
Develop or use an existing antidiscrimination training to build a competent workforce. Make training available to local public health authorities.	add anti-bias	**(modified)** Develop or use an existing antidiscrimination **and anti-bias** training to build a competent workforce. Make training available to local public health authorities.

Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational structure and culture.	"and organizational, structural, and political barriers"	**(modified)** Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include **organizational, structural, cultural, and political barriers.**
Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities.	"Health equity and cultural responsiveness need to be defined and clarified what it looks like at the local level.	Include in reporting/recommendations, but do not use to create modified role.
Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability and national origin.	Geography needs to be included in the health inequities.	**(modified)** Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability, **geography,** and national origin.
Conduct and disseminate research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.	Clarity in definitions needed.	Include in reporting/recommendations, but do not use to create modified role.
	"community-engaged research"	**(modified)** Conduct and disseminate **community-engaged** research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.
Work with local public health authorities when working with local communities.	Yes- Not sure how to address, but this seems to have been forgotten.	Include in reporting/recommendations, but do not use to create modified role.
	"support LPHAs..."	This does not make sense to add as a modified role.
Local roles only		
Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.	When data is available. When not, rely on local data.	**(modified)** Collect and maintain **local qualitative and quantitative** data, or use data provided by PHD, that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.

Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD.	language could be clarified to address factors that promote health like access to health foods, transportation, clean air and water etc.	This does not make sense to add as a modified role
Develop an ongoing process of continuous learning, training and structured dialogue for public health staff.	add health equity	I don't understand how health equity can be added to this role and maintain the overall intent, so will not create modified role.
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities.	duplicative with the function above	Disagree, keep role separate.
Develop or use an existing antidiscrimination training to build a competent workforce.	Add anti-bias	**(modified)** Develop or use an existing antidiscrimination **or anti-bias** training to build a competent workforce.
Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities.	Share data and resources with community that are language, cultural, and linguistic appropriate	**(modified)** Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities. **Share data and resources with community that are culturally and linguistically appropriate.**
New state roles		
Connect LPHAs and CBOs to collaborate on funding, work plans, policy and other activities		Connect LPHAs and CBOs to collaborate on funding, work plans, policy and other activities.
Involve LPHAs in processes related to funding community-based organizations, such as work plan review, and support collaboration between LPHAs and OHA-funded CBOs.		Engage LPHAs in processes related to funding CBOs.

add a role about data decolonization	Advance data decolonization and sovereignty practices through training, policies, and partnerships.
New local roles	
Serve as the liaison between local community and the OHA.	Serve as a liaison between local community organizations and members and OHA.
add language about data decolonization	Advance data decolonization and sovereignty practices through training, policies, and partnerships.
Collaborate/coordination with CBOs.	Collaborate and coordinate with funded CBOs on funding, work plans, policy, and other activities.
Going through the CCA, we realized that a lot of the "roles" under this capability are a repeat of what is already compiled under other programs and capabilities. It might make sense to condense these roles.	Include in reporting/recommendations, but do not use to create modified role.
Act as a convener of local community members, elected officials, and organizations to create a shared dialogue and strategic plan for achieving health equity.	Act as a convener of local community members, elected officials, and organizations to create a shared dialogue and strategic plan for achieving health equity locally.
Identify health equity goals within each foundational (and non-foundational) programs and identify local, regional, or state partners to help achieve those goals	Identify health equity goals within each foundational and additional program and identify local, regional, or state partners to help achieve those goals.
New CBO roles	
Work with LHJ to address health issues within community.	Collaborate with OHA, LPHAs, and community members to collectively address health inequities, including the social determinants of health.
partner with state and local public health authorities to collectively address health inequities	
address social determinants	
Broker partnerships between community members and community organizations to advance health equity	
Share community wisdom about the factors influencing health	Share community wisdom with OHA, LPHAs, and other partners about community-specific factors that influence health, including social
Focus on the social conditions (including strengths, assets and protective factors) that influence health.	

	conditions (strengths, assets and protective factors)
Work with LPHAs to create and collaborate on shared health equity goals	Work with LPHAs to create and collaborate on shared health equity goals.
Align equity work to enhance and advance public health work	
Collaborate/coordinate with LPHAs.	Collaborate and coordinate with LPHAs on funding, work plans, policy, and other activities.
Specific populations grassroot outreach and engagement	Conduct grassroots outreach and engagement with specific populations.
Collect data on inequities	Collect local, population-specific data on community health inequities and assets.
Engage in research, writing, and data sharing of health needs, including exploring SDOH and other resources	Conduct and disseminate community-engaged research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.
Equitable access to publication and reporting/research	
Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease.	Collect and maintain data, or use data provided by PHD or LPHAs that reveal inequities in the distribution of disease.
Communication vessel for PH information	Support OHA and LPHAs to communicate public health information in ways that are culturally and linguistic responsive.
Assist in development and review of PH communications and programming for specific populations	Collaborate on development and review of public health communications for specific populations.
Develop and promote shared understanding of the determinants of health, health equity and lifelong health.	Collaborate with OHA and LPHAs to develop and promote shared understanding of the determinants of health, health equity and lifelong health.
advocate for systems and policy change; especially when governmental public health faces challenges from governing boards	Advocate for funding and policies that support health equity, especially when governmental public health faces challenges from governing boards.
advocate for funding and policies that support health equity	

Educate staff on governmental public health and foundational programs (including statutory obligations and original Modernization concept)	Ensure CBO staff are trained on governmental public health and foundational programs, including statutory obligations.
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs	Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
Provide feedback to OHA and LPHA on culturally responsive services	Provide feedback to OHA and LPHAs on culturally responsive services.
Ensure CBO have a leadership role in engaging with LPHA and OHA and are compensated for their time or opportunities	Participate in formal decision-making spaces with OHA and LPHAs, with proper compensation.
Properly compensated for time and expertise in leading work within partnerships	Include in reporting/recommendations, but do not use to create new role.

Appendix L. Average ratings for OHA, LPHA, and CBO roles from survey #2 respondents in order of appearance on survey (N = 23)

Shared OHA and LPHA roles		
Role description	Average rating	N (%)
Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health promoting factors (e.g., quality parks and schools)	4.6	23 (100%)
Collaborate with partners to develop and promote shared understanding of the determinants of health, health equity and lifelong health. Work with CBOs to develop culturally and linguistically appropriate resources	4.6	23 (100%)
Collaborate with partners to develop and promote a common understanding of cultural and linguistic responsiveness	4.6	23 (100%)
Promote understanding of the extent and consequences of systems of oppression, including racism	4.3	23 (100%)
Make the economic case for health equity, including the value of investment in cultural responsiveness. LPHAs may rely on statewide return-on-investment studies/reports from OHA and other sources	4.4	23 (100%)
Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, data sovereignty, and other communication needs when releasing data and information. OHA supports LPHAs to make data and information available	4.5	23 (100%)
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. This may include traditional and alternative health care practices	4.3	23 (100%)
Support, implement and evaluate community-informed strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements. OHA collaborates with LPHAs to ensure strategies and partnerships are appropriate at the local level	4.5	22 (96%)
Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies. OHA collaborates with LPHAs to ensure partnerships are appropriate at the local level	4.3	22 (96%)
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity. OHA collaborates with LPHAs to ensure strategies are appropriate at the local level	4.3	22 (96%)
Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness	4.1	23 (100%)

Use existing evidence-based or community-informed measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social, environmental, and political determinants of health	4.4	23 (100%)
Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health	4.5	23 (100%)
Monitor relevant issues under discussion by governing and legislative bodies	4.1	23 (100%)
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms	4.3	23 (100%)
Monitor funding allocations to ensure efficacy and sustainable impacts on health equity. Use equity lens when making funding allocations	4.3	23 (100%)
Increase flexible categorical and non-categorical funding to address health equity	4.5	23 (100%)
Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores	4.3	23 (100%)
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities	4.5	23 (100%)
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. Develop specific investment goals and measure progress	4.2	23 (100%)
Establish parity goals and create specific metrics with benchmarks to track progress	4.0	22 (96%)
Increase awareness and practice of health equity and anti-bias among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance and ensure a safe workplace that creates a sense of belonging for staff	4.3	23 (100%)
Establish greater flexibility in job classifications and hiring requirements to tackle the root causes of health inequity	4.0	23 (100%)
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans. OHA collaborates with LPHAs to ensure integration in local strategic priorities and plans is appropriate	4.2	23 (100%)
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery	4.2	23 (100%)
Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community	4.1	23 (100%)

Learn about the culture, values, needs, major concerns and resources of the community. OHA depends on LPHAs as a resource to learn about community. Respect and uplift local community knowledge and seek to understand and formally evaluate it	4.4	23 (100%)
Provide technical assistance to Collaborate with communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies	4.0	23 (100%)
Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles	4.0	23 (100%)
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations	4.2	23 (100%)
Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government	4.2	23 (100%)
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members	4.4	23 (100%)
Partner with councils and committees to ensure diverse representation, including but not limited to race and ethnicity, age, and geography. Increase racial and ethnic representation on councils and committees	4.4	23 (100%)
Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed	4.1	23 (100%)
Draw on the skills and knowledge of staff who are members of communities most affected by inequities)	4.5	23 (100%)
Hire **or train** staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served	4.4	23 (100%)
Develop an ongoing community engagement process for recruitment	4.1	23 (100%)
Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce	4.3	23 (100%)
Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities)	4.2	23 (100%)
OHA roles only		
Role description	Average rating	N (%)

Collect and maintain qualitative and quantitative data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health	4.3	20 (87%)
Make data and reports available and accessible to local public health authorities, partners and stakeholders, and the general public as appropriate other groups	4.4	20 (87%)
Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies, and community-based organizations	4.3	20 (87%)
Implement the Race, Ethnicity, Language and Disability (REAL+D) and Sexual Orientation and Gender Identity (SOGI) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data	4.3	20 (87%)
Based on REAL+D and SOGI data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies	4.0	20 (87%)
Increase the value for cultural responsiveness in PHD and among local public health authorities	4.1	20 (87%)
Develop or support mass media, public education, or outreach efforts that uncover the fundamental social, economic and environmental causes of health inequities	4.1	20 (87%)
Advocate for health equity in health system reform	4.6	20 (87%)
Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions	4.3	19 (83%)
Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data	4.3	20 (87%)
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities	4.3	20 (87%)
Develop or use an existing antidiscrimination and anti-bias training to build a competent workforce. Make training available to local public health authorities	4.2	20 (87%)
Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational, structural, cultural, and political barriers	3.8	20 (87%)

Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities	4.3	20 (87%)
Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability, geography, and national origin	4.0	20 (87%)
Conduct and disseminate community-engaged research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities	3.8	20 (87%)
Work with local public health authorities when working with local communities	4.3	20 (87%)
(new) Connect LPHAs and CBOs to collaborate on funding, work plans, policy and other activities	4.7	20 (87%)
(new) Engage LPHAs in processes related to funding CBOs	4.4	20 (87%)
(new) Advance data decolonization and sovereignty practices through training, policies, and partnerships	4.4	20 (87%)
LPHA roles only		
Role description	Average rating	N (%)
Collect and maintain local qualitative and quantitative data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health	4.4	20 (87%)
Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD	4.4	20 (87%)
Develop an ongoing process of continuous learning, training and structured dialogue for public health staff	4.3	20 (87%)
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities	4.2	20 (87%)
Develop or use an existing antidiscrimination or antibias training to build a competent workforce	4.3	20 (87%)
Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background	4.4	20 (87%)
Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities. Share data and resources with community that are culturally and linguistically appropriate	4.6	20 (87%)
(new) Serve as a liaison between local community organizations and members and OHA	4.0	20 (87%)
(new) Advance data decolonization and sovereignty practices through training, policies, and partnerships	4.3	20 (87%)
(new) Collaborate and coordinate with funded CBOs on funding, work plans, policy, and other activities	4.6	20 (87%)

(new) Act as a convener of local community members, elected officials, and organizations to create a shared dialogue and strategic plan for achieving health equity locally	4.4	20 (87%)
(new) Identify health equity goals within each foundational and additional program and identify local, regional, or state partners to help achieve those goals	4.4	20 (87%)
CBO roles		
Role description	Average rating	N (%)
Collaborate with OHA, LPHAs, and community members to collectively address health inequities, including the social determinants of health	4.7	23 (100%)
Share community wisdom with OHA, LPHAs, and other partners about community-specific factors that influence health, including social conditions	4.7	23 (100%)
Work with LPHAs to create and collaborate on shared health equity goals	4.5	23 (100%)
Collaborate and coordinate with LPHAs on funding, work plans, policy, and other activities	4.5	22 (96%)
Conduct grassroots outreach and engagement with specific populations	4.7	23 (100%)
Collect local, population-specific data on community health inequities and assets	4.3	22 (96%)
Conduct and disseminate community-engaged research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities	4.1	23 (100%)
Collect and maintain data, or use data provided by PHD or LPHAs, that reveal inequities in the distribution of disease	4.0	23 (100%)
Support OHA and LPHAs to communicate public health information in ways that are culturally and linguistic responsive	4.6	23 (100%)
Collaborate on development and review of public health communications for specific populations	4.5	23 (100%)
Collaborate with OHA and LPHAs to develop and promote shared understanding of the determinants of health, health equity and lifelong health	4.6	23 (100%)
Advocate for funding and policies that support health equity, especially when governmental public health faces challenges from governing boards	4.6	23 (100%)
Ensure CBO staff are trained on governmental public health and foundational programs, including statutory obligations	4.2	23 (100%)
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs	4.5	23 (100%)
Provide feedback to OHA and LPHAs on culturally responsive services	4.3	23 (100%)
Participate in formal decision-making spaces with OHA and LPHAs, with proper compensation	4.5	23 (100%)

Appendix M. Cumulative score for OHA, LPHA, and CBO roles based on survey #3 respondents' rankings in order of appearance on survey (N = 13)

Shared OHA and LPHA roles (n = 10 [77%])	
Role description	Cumulative score
Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health promoting factors (e.g., quality parks and schools)	13
Collaborate with partners to develop and promote shared understanding of the determinants of health, health equity and lifelong health. Work with CBOs to develop culturally and linguistically appropriate resources	12
Collaborate with partners to develop and promote a common understanding of cultural and linguistic responsiveness	0
Promote understanding of the extent and consequences of systems of oppression, including racism	0
Make the economic case for health equity, including the value of investment in cultural responsiveness. LPHAs may rely on statewide return-on-investment studies/reports from OHA and other sources	13
Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, data sovereignty, and other communication needs when releasing data and information. OHA supports LPHAs to make data and information available	5
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. This may include traditional and alternative health care practices	9
Support, implement and evaluate community-informed strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements. OHA collaborates with LPHAs to ensure strategies and partnerships are appropriate at the local level	14
Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies. OHA collaborates with LPHAs to ensure partnerships are appropriate at the local level	2
Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity. OHA collaborates with LPHAs to ensure strategies are appropriate at the local level	12
Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness	0

Use existing evidence-based or community-informed measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social, environmental, and political determinants of health	4
Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health	0
Monitor relevant issues under discussion by governing and legislative bodies	2
Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms	8
Monitor funding allocations to ensure efficacy and sustainable impacts on health equity. Use equity lens when making funding allocations	4
Increase flexible categorical and non-categorical funding to address health equity	6
Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores	6
Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities	0
Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity. Develop specific investment goals and measure progress	0
Establish parity goals and create specific metrics with benchmarks to track progress	0
Increase awareness and practice of health equity and anti-bias among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance and ensure a safe workplace that creates a sense of belonging for staff	0
Establish greater flexibility in job classifications and hiring requirements to tackle the root causes of health inequity	0
Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans. OHA collaborates with LPHAs to ensure integration in local strategic priorities and plans is appropriate	0
Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery	0
Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community	0

Learn about the culture, values, needs, major concerns and resources of the community. OHA depends on LPHAs as a resource to learn about community. Respect and uplift local community knowledge and seek to understand and formally evaluate it	7
Provide technical assistance to Collaborate with communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies	3
Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles	4
Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations	5
Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government	0
Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members	5
Partner with councils and committees to ensure diverse representation, including but not limited to race and ethnicity, age, and geography. Increase racial and ethnic representation on councils and committees	5
Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed	5
Draw on the skills and knowledge of staff who are members of communities most affected by inequities)	0
Hire **or train** staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served	6
Develop an ongoing community engagement process for recruitment	0
Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce	0
Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities)	0
OHA roles only (n = 10 [77%])	
Role description	Cumulative score

Collect and maintain qualitative and quantitative data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health	9
Make data and reports available and accessible to local public health authorities, partners and stakeholders, and the general public as appropriate other groups	8
Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies, and community-based organizations	7
Implement the Race, Ethnicity, Language and Disability (REAL+D) and Sexual Orientation and Gender Identity (SOGI) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data	10
Based on REAL+D and SOGI data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies	10
Increase the value for cultural responsiveness in PHD and among local public health authorities	3
Develop or support mass media, public education, or outreach efforts that uncover the fundamental social, economic and environmental causes of health inequities	4
Advocate for health equity in health system reform	8
Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions	1
Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data	11
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities	0
Develop or use an existing antidiscrimination and anti-bias training to build a competent workforce. Make training available to local public health authorities	4
Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational, structural, cultural, and political barriers	6

Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities	18
Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability, geography, and national origin	8
Conduct and disseminate community-engaged research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities	5
Work with local public health authorities when working with local communities	7
(new) Connect LPHAs and CBOs to collaborate on funding, work plans, policy and other activities	22
(new) Engage LPHAs in processes related to funding CBOs	6
(new) Advance data decolonization and sovereignty practices through training, policies, and partnerships	3
LPHA roles only (n = 11 [85%])	
Role description	Cumulative score
Collect and maintain local qualitative and quantitative data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health	15
Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD	25
Develop an ongoing process of continuous learning, training and structured dialogue for public health staff	14
Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities	8
Develop or use an existing antidiscrimination or antibias training to build a competent workforce	3
Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background	3
Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities. Share data and resources with community that are culturally and linguistically appropriate	20
(new) Serve as a liaison between local community organizations and members and OHA	10
(new) Advance data decolonization and sovereignty practices through training, policies, and partnerships	7
(new) Collaborate and coordinate with funded CBOs on funding, work plans, policy, and other activities	18
(new) Act as a convener of local community members, elected officials, and organizations to create a shared dialogue and strategic plan for achieving health equity locally	20

(new) Identify health equity goals within each foundational and additional program and identify local, regional, or state partners to help achieve those goals	22
CBO roles (n = 8 [62%])	
Role description	Cumulative score
Collaborate with OHA, LPHAs, and community members to collectively address health inequities, including the social determinants of health	18
Share community wisdom with OHA, LPHAs, and other partners about community-specific factors that influence health, including social conditions	15
Work with LPHAs to create and collaborate on shared health equity goals	3
Collaborate and coordinate with LPHAs on funding, work plans, policy, and other activities	11
Conduct grassroots outreach and engagement with specific populations	12
Collect local, population-specific data on community health inequities and assets	0
Conduct and disseminate community-engaged research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities	4
Collect and maintain data, or use data provided by PHD or LPHAs, that reveal inequities in the distribution of disease	0
Support OHA and LPHAs to communicate public health information in ways that are culturally and linguistic responsive	6
Collaborate on development and review of public health communications for specific populations	3
Collaborate with OHA and LPHAs to develop and promote shared understanding of the determinants of health, health equity and lifelong health	8
Advocate for funding and policies that support health equity, especially when governmental public health faces challenges from governing boards	3
Ensure CBO staff are trained on governmental public health and foundational programs, including statutory obligations	6
Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs	10
Provide feedback to OHA and LPHAs on culturally responsive services	7
Participate in formal decision-making spaces with OHA and LPHAs, with proper compensation	14