Appendix H: Preliminary Survey Analysis

OR Public Health Response to COVID-19: CBO Survey Preliminary Analysis

OR Public Health Response to COVID-19: CCO Survey Preliminary Analysis

OR Public Health Response to COVID-19: Emergency Management Survey Preliminary Analysis

OR Public Health Response to COVID-19: LPHA Survey Preliminary Analysis

OR Public Health Response to COVID-19: CBO Survey Preliminary Analysis

Introduction

The survey was distributed to 166 CBOs who received Health Equity funding from OHA (after removing undeliverable email addresses). There were a total of 66 responses, with five respondents that did not complete the survey beyond the demographic information and three respondents that submitted partial surveys, for a response rate of 37%. The three partial responses are included in the analysis.

Table 1. Demographics of CBO Survey Respondents (N=61)

Characteristics	**n (%)**
Region	*Regions equal more than 100% because respondents could select all regions that apply
Region 1	36 (59.0%)
Region 2	10 (16.4%)
Region 3	15 (24.5%)
Region 4	6 (9.8%)
Region 5	5 (8.2%)
Stage Involvement	
Stage 1 only	2 (3.3%)
Stages 1-3	2 (3.3%)
Stage 2 only	1 (1.6%)
Stages 2-4	4 (6.6%)
Stages 3-4	1 (1.6%)
Stage 4 only	3 (4.9%)
All Stages	48 (78.7%)
Role	
Director/President/COO	35 (57.4%)
Finance/Grants	5 (8.2%)
Program coordinator	10 (16.4%)
Other	14 (21.3%)
Number of employees	
Fewer than 10	28 (45.9%)
10-24	11 (18.0%)
25-49	7 (11.5%)
50-99	7 (11.5%)
100-249	4 (6.6%)

More than 250	4 (6.6%)

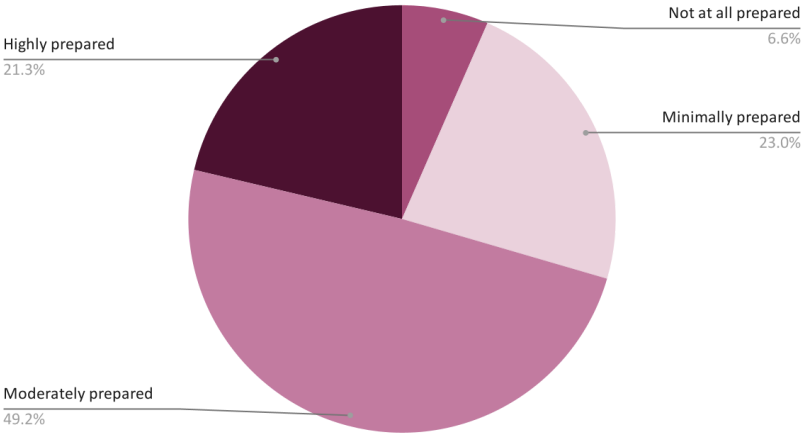
CBO Preparedness

CBO Preparedness

Most respondents (70.5%, n=43) felt that their CBO was either highly or moderately prepared for the COVID-19 pandemic (Figure XX).

Respondents reported the following reasons for the level of preparedness in their CBO:

Figure 1: CBO preparedness (N=61)



Minimally or not at all prepared:

- *"Our organization normally is a program provider for youth and families, but not around direct services"*
- *"No resources were available"*
- *"We did not have a plan for adjusting to the emergency situation at the time of the shutdown. We did adjust as it went along and were able to shift workforce to a remote environment, but that took time to adjust and develop."*
- *"Before the COVID-19 pandemic we were a Social justice and advocacy group focused specifically on Queer & Trans Pacific islanders and we heeded the call to help all members of our community."*
- *"We are front line essential services to homeless clients."*
- *"Only in the sense the community has been bounded together with our efforts, which made us kind of ready for the Covid-19 pandemic."*
- *"We didn't have emergency food, our resource wasn't up and running and we weren't prepared for a pandemic."*
- *"It was such an unprecedented event we had never considered"*
- *"Community is historically marginalized in terms of health equity."*
- *"We had the infrastructure in place to reach our community, but we lacked the resources to do so."*
- *"Pandemic fundamentally changed the way we work. Moved from in-person to telephonic assistance. We were also poised to respond to need."*
- *"Most of our churches were not even in the 21st century as far as being with it electronically. We barely had websites, let along taking contributions electronically. This was a HUGE change, but one that we were forced to make. Overall, it has been very beneficial. God works in ALL ways!"*
- *"It was all so new to everyone."*
- *"Our CBO provides affordable housing and education opportunities. We did not have experience or provide services around public health resources other than referring clients to local public health authorities."*
- *"We did have some PPE on hand, but were unprepared on how to mass distribute. This applies to community education materials very early on in the Fall of 2020."*

- *“We have a long history of responding to community violence which requires lots of communication and collaboration with multiple stakeholders but nothing like Covid-19 “*
- *“As a small organization serving the state we had some organizational capacity (personnel) to do this work, but with OHA funding we were able to increase that capacity. We also distributed covid relief funds to clients who needed it and we had never done that kind of work before.”*
- *“Most of our case management documentation is still paper based, so we weren't very prepared to work remotely with clients.”*

Moderately prepared:

- *“Our CBO is consistently performing better with each vaccine drive but there is always room for improvement.”*
- *“Not sure anyone was "highly" prepared for this pandemic”*
- *“We could never be truly prepared, but I think you've all done a great job”*
- *“While we weren’t previously involved in public health we were well positioned to quickly pivot in response to community need”*
- *“Navigating resources, guiding families, and working alsongside other community based organizations to help families who have children experiencing disability in a responsive manner is our work.”*
- *“Our organization is partnered with several communities in order to readily aid and assist community with preparedness.”*
- *“WE were familiar with our role, LPHA role and what to expect from our separate lanes”*
- *“Two of the most important factors in ability to respond to the Covid-19 pandemic were established relationships with communities most impacted and community trust. We had both of those going into the pandemic, and were able to respond quickly to connect folks to information and resources.”*
- *“We were able to move our peer service online and continue serving the community with peers and resources.”*
- *“In the beginning, we weren’t sure where to get the most reliable information and how to address the lack of access to information in multiple languages. Then, as we partnered with other CBOs and OHA our level of preparedness and access to reliable and translated information has increased. This led us to be more prepared to address question and distribute resources in different languages in our virtual English classes”*
- *“Within two weeks our agency was able to quickly develop policies and procedures for remote work, establish redundancies to prevent impact on clients, and create new programs to address the pandemic. I would have said highly prepared if those policies and procedures had already been in place.”*
- *“Being a small organization allowed us to pivot to meet the needs of our community.”*
- *“We anticipated some disruption but not to the extent that it manifested itself.”*
- *“We now have experience in one PH response. To say that our organization is highly prepared to respond to COVID-19 pandemic, without the support of local public health would be irresponsible in my opinion. In Curry County OHA is our LPHA. OHA relies on CBOs like ours to provide a level of response to the pandemic our LPHA was unable to successfully navigate.”*

- *“Our CBO is medium-sized (approx. 30 staff), and we have less capacity to respond quickly to direct community needs. We are not considered a direct service organization (in terms of rapid response services), but we are prepared to respond with communications, outreach, advocacy. A few of our programs/staff who work with directly impacted communities (elders, youth, non-English speakers, immigrants, small business owners, etc.) can respond and relay updates quickly.”*
- *“This CBO at the time of Covid-19 pandemic leadership was new and short staffed. So, only two people working part-time was difficult to get prepared, but we pivoted to do things on-line and adapted to the changes helped us to survive and continue despite the pandemic.”*
- *“Our EPP did not include pandemics, however staff experience working with youth on safety, well-being, and connection helped us be moderately prepared.”*
- *“We were able to quickly hire staff to fill the necessary positions and we were able to be responsive to OHA's scope of work.”*
- *“We have staff and resources to offer wraparound support and community education. However if incident rates returned to the high levels we previously saw it will still be a challenge to serve all the needs”*
- *“We had to learn as we were going, but the way we all connected was great.”*
- *“while we had not received funding in the past, our organization had experience in public health and emergency response and had both staff and community partners to conduct outreach and response in a proactive manner”*
- *“I would say "highly prepared" except that we are, like nearly everyone, experiencing staffing shortages.”*
- *“We are a health clinic and had just implmented EPIC as our EHR. It enabled us to transition quickly to telehealth and to be more coordinated with the hospital system and the other safety net clinics.”*
- *“I believe with the help of Oregon Health Authirity we were ready to help and had resources available to those who needed help and guidance.”*
- *“Our team was ready, willing and able to implement covid protocol at our events and in daily operations. We are an extraordinarily flexible organization with the ability to respond quickly in emergency situations.”*
- *“We had communication recourses in place”*
- *“We had deep expertise related to disability accesibility and needs especially related to developmental disabilities . It was one more place where the invisibility and opression of disability manifested and we are a social justice org with deep community roots”*
- *“We had a good infrastructure in-place to build our COVID response upon.”*
- *“We began from the beginning of the grant educating about Covid an providing sanitary kits”*
- *“Being a trans and queer focused organization, we have had a lot of practice over the years working with people who were actively in crisis. We were skilled in wraparound supports, providing health education, harm reduction, disability justice, and prevention. All of these skill sets were applied to our work during the COVID-19 pandemic”*

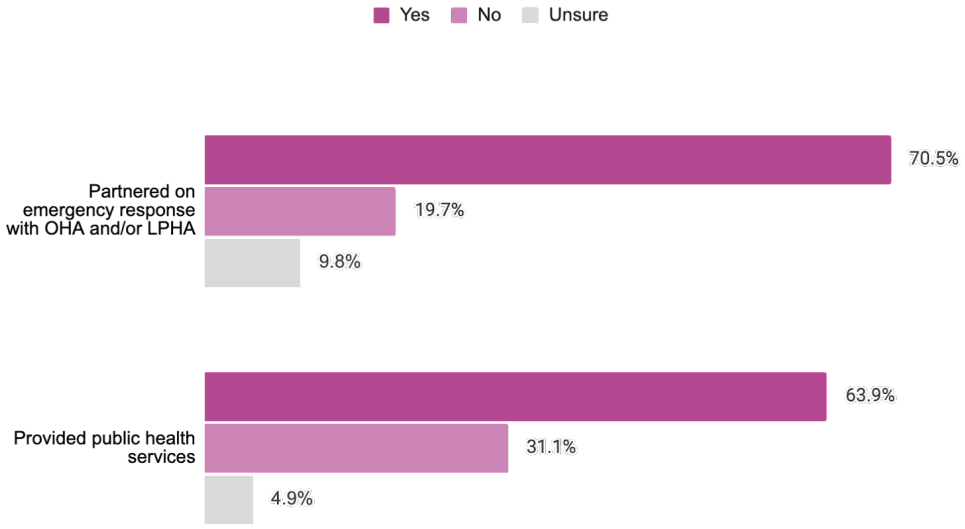
Highly prepared:

- *“With all the tools that have been giving to use we are able to support the community on a better level of understanding”*
- *“We immediately learned what we needed to do to protect our clients and the public and kept up with any updates provided by the CDC and OHA.”*
- *“I choose highly prepared because I know we are. This is due to of our length of involvement, communications, training level received and resources that has been provided to us to carry out this work.”*
- *“When covid hit our CBO's were ready to support effected families in any ways we could”*
- *“I waiver between moderately and highly prepared, but because the question says 'to date', I feel like we quickly hired staff to work solely with this grant and that they have become quite specialized at their work within our community. They see and adapt to needs as they arise.”*
- *“This organization already has an emergency plan, operational support, and services implementation system.”*
- *“We are a health clinic - and we were able to mount a testing site within 24 hours of the shut-down”*
- *“Strong clinical leadership ensure we were well prepared even when early information was still murky. Strong trust with our patients meant we were prepared to serve as a trusted resource for them.”*
- *“We implemented the strict protocol, locked down our facilities, followed strict regulations from the Office of Child Care and the Office of Head Start. We implemented specific incident and follow up protocol.”*
- *“My organization has the right information sources to share with our families, the connection with OHA to get the resources necessary to distribute to our families, and the team to support individuals and families served by our organization.”*
- *“The experience we have gained over the past 2.5 years makes us feel confident that we can address and meet future health related emergencies such as the Covid19 pandemic”*
- *“We have stood up a vaccine clinic for over a year and have provided COVID testing for the same time. ALso WRAP services and education services.”*
- *“Our current staff is prepared and trained to provide outreach, education, contact tracing, and provide Social/Wrap around services.” “Our leadership team is working directly with LPHAs and OHA still in getting Vaccines and Testing to our local communities. We are still able to provide PPE and test kits during our day-to-day work. We are able to serve a diverse population without any hesitation.”*

Previous Emergency Response Experience

Respondents were asked if they had ever partnered with Oregon Health Authority or a Local Public Health Authority/County Health Department to assist in emergency response before COVID-19 or ever provided public health resources or support. Many respondents have either partnered on emergency response or [provided public health resources or support, and almost one fifth of respondents (18%, n=11) had done both in the past.

Figure 2: Previous experience with emergency response and public health activities (N=61)



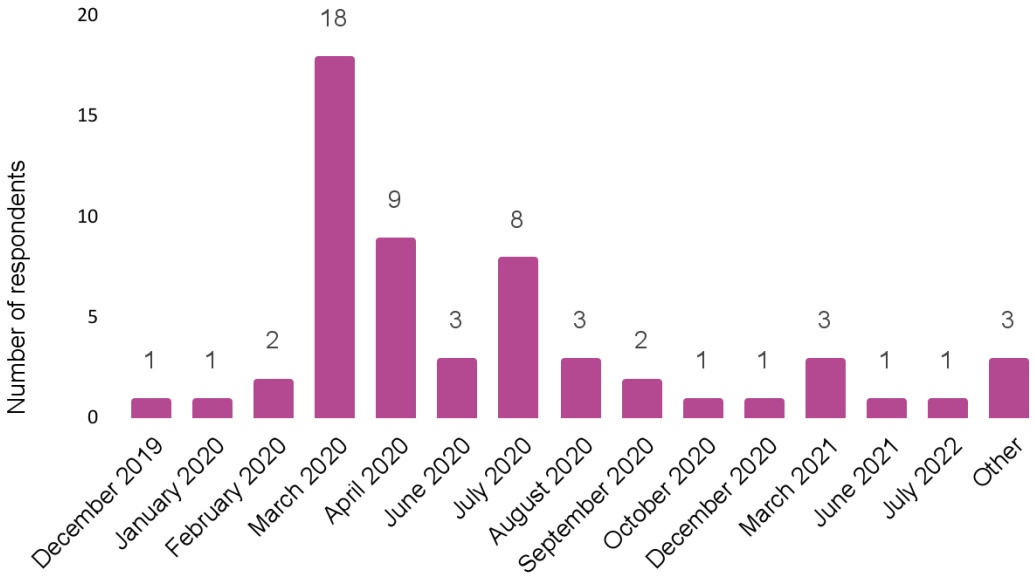
COVID-19 Response Activities

Formal start of pandemic response.

The majority of respondents began their CBOs formal COVID-19 response between March and July of 2020 (n=38). The three "other" responses were:

- *"as soon as it hit Portland, Or"*
- *"I began my position in March of 2021 and this organization had already received one waive of funding. I'm not sure of the original date."*
- *"As soon as info began to be in media and we looked at research etc from other countries."*

Figure 3: Start of CBO respondents formal COVID-19 response (N=59)



Types of Response Activities

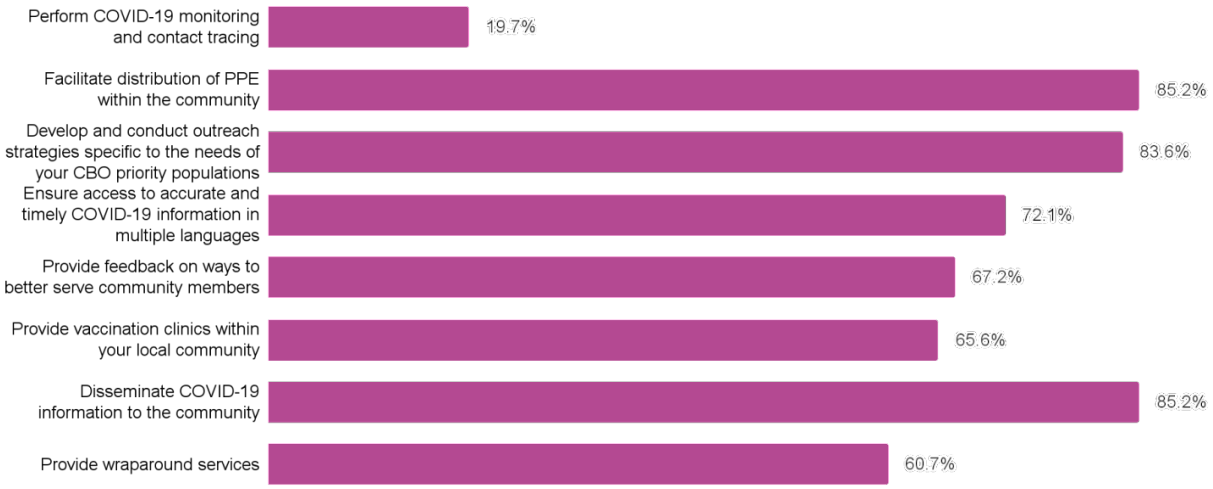
Respondents reported their CBOs were involved in an array of COVID-19 response activities. These activities are summarized in Figure 4.

Additionally, some respondents provided additional activities they engaged in:

- *"we began with testing*
- *"provide food and education kits for youth during lockdown"*
- *"Direct, low barrier cash aid targeted to low income Latino/a/x people in Josephine and Jackson Counties starting in March 2020"*
- *"Raised unrestricted funds to provide financial relief to people without Covid, provided Covid testing events"*
- *"Processed relief funds through the Oregon Worker Relief Funds"*
- *"Mediation between the mask wearers and the non-mask wearers in our congregations"*

- *"Hot Meals were delivered to our members by staff on a daily basis which also allowed to check on the health status of our members and provided and opportunity for us to help educate the public."*
- *"COVID testing and treatment, mental and behavioral health support related to COVID stress"*
- *"We often were waiting for info in other languages and visual tools we created Covid comics that bettert met our needs these were widely used and supported by OHA and CBOs"*

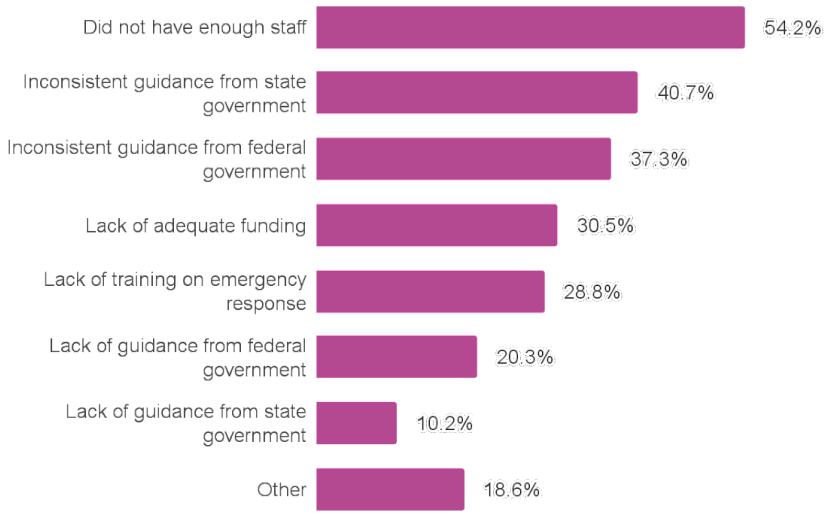
Figure 4: CBO COVID Response Activities (N=61)



Challenges and Barriers to COVID-19 Response

Almost all respondents (95.0%, n=56) reported there were challenges that hindered the effectiveness, scale, or quality of their CBO's response to the COVID-19 pandemic. A total of 3 respondents (5%) reported they did not experience any challenges that hindered the effectiveness, scale, or quality of their CBO's reponse.

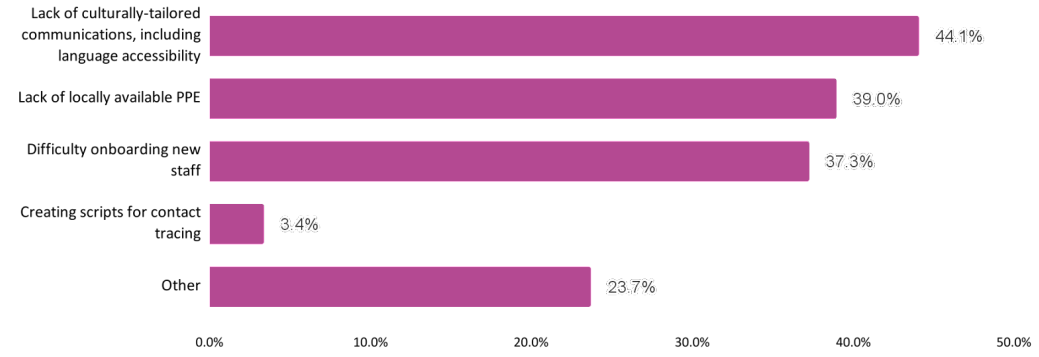
Figure 6: Challenges hindering the effectiveness, scale, or quality of CBO's response (N=59)



The percent of reported challenges are reported in Figure 6. The top 5 most frequently reported challenges include inadequate staff (54.2%), inconsistent guidance from state government (40.7%), inconsistent guidance from federal government (37.7%), lack of adequate funding (30.5%), and lack of training in emergency response (42.9%). A few respondents reported other challenges, which included the following:

"conflicting guidance between state & federal mandates"
"Lack of guidance and support from county government."
"Inconsistency/delayed response from LPHA"
"When information was chaning rapidly, urgent updates often came in English only at the local County, state, and Federal levels. We had to translate to other languages, and to plain language, slowing access to information for many during the pandemic. It also placed additional burdens for translation on CBOs."
"Health systems unwilling to change their strategies for vaccination after months of advocacy about the barriers their sites had"
"The acceptance of some large scale in person gatherings during the height of the pandemic made many rural Oregonians question the information they were receiving from public health."
"guidelines changing so often and keeping up with the demands of the clients"
"The frequency with which rules were changed throughout the pandemic made it difficult."
"Inconsistent guidance across agencies. Contract tracing never occurred for many."
"The two choices regard the beginning stages of the pandemic"
"Oppression of PWD and distressing messages from our community about how they were being treated senate bill advocacy helped"

Figure 7: Barriers, not related to funding, CBOs experienced during their response (N=59)



Respondents were also asked what barriers unrelated to funding they experienced during their CBOs COVID-19 response. The three most frequently reported barriers were a lack of culturally-tailored communications (n=26), lack of locally available PPE (n=23), and difficulty onboarding new staff (n=22). A few respondents provided additional barriers that they experienced:

"competing demands as a large multiservice ogranization"
"Vaccine providers having incorrect information (not allowing the population we served to access vaccines) created a lot of confusion for families and providers, and additional work for us."
"Confusion over the vaccine rollout prioritization"
"vaccine hesitancy"
"Changing funding guidelines."

"Difficulty in reaching some vulnerable populations when staff was mostly working remotely."
"Contacting clients to get their info while they were sick"
"Mediation between the mask wearers and the non-mask wearers in our congregations."
"staffing shortages"
"Managing numerous OHA meetings in addition to direct work with the community."
"Availability of PPE got better in 2021, and availability of testing fluctuated wildly throughout until spring 2022"
"Working with LPHAs"
"We have languages in our community that do not have "official" approved translators nor is there a program to certify translators for these specific languages."
"blatant disability prejudice early on and lack of understanding of care units family and support staff needing access to vaccines etc"

Vaccinations

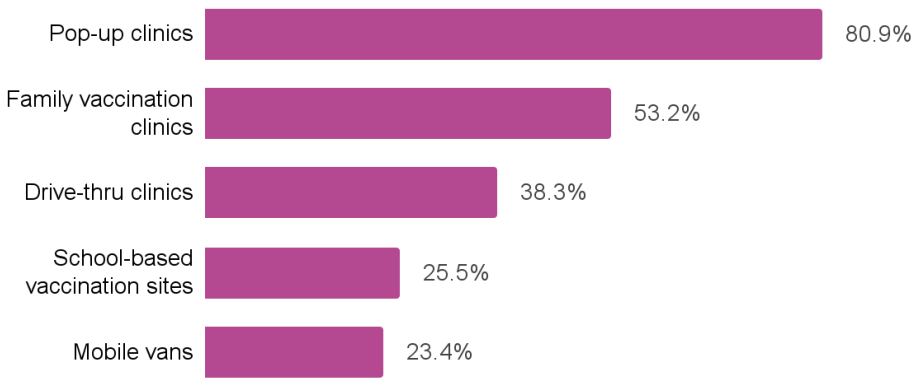
About 77% of respondents (n=43) reported they coordinated or provided vaccination clinics in their community;18% (N=11) reported their CBO did not coordinate or provide vaccination clinics. A breakdown of the vaccination distribution methods CBOs provided or supported are shown in Figure X. Some CBOs provided additional distribution methods, including the following:

We hosted vaccination events with the county using our facilities and in concert with others

- *Faith-based sites (n=3)*
- *Food give-aways (n=1)*
- *Locations serving vulnerable populations (e.g., congregate sites, disability-specific sites) (N=2)*
- *Weekly clinics, including temporary sites CBOs rented as well as permanent clinic sites (n=2)*

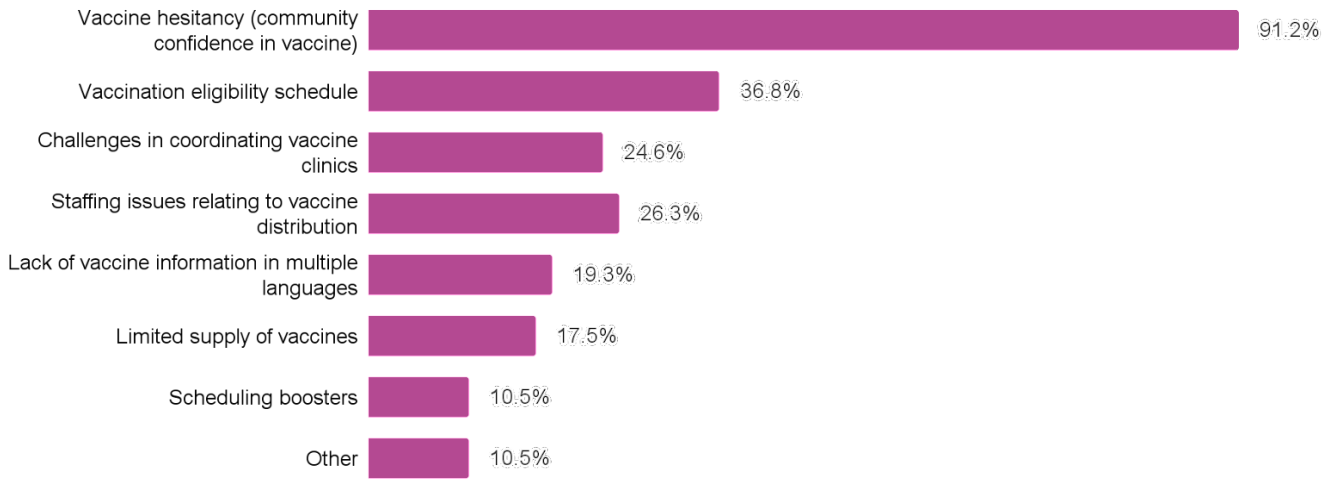
"Culturally and linguistically responsive vaccination events"

Figure 8: Vaccine distribution methods used by CBOs involved in vaccine clinic coordination and response (N=47)



Survey respondents were also asked to select from a variety of challenges they may have experienced in supporting vaccination efforts. The top five reported barriers were vaccine hesitancy (91.2%, n=52), vaccine eligibility schedule (36.8%, n=21), staffing issues related to vaccine distribution (26.3%, n=15), challenges in coordinating vaccine clinics (24.6%, n=14), and lack of vaccine information in multiple languages (19.3%, n=11).

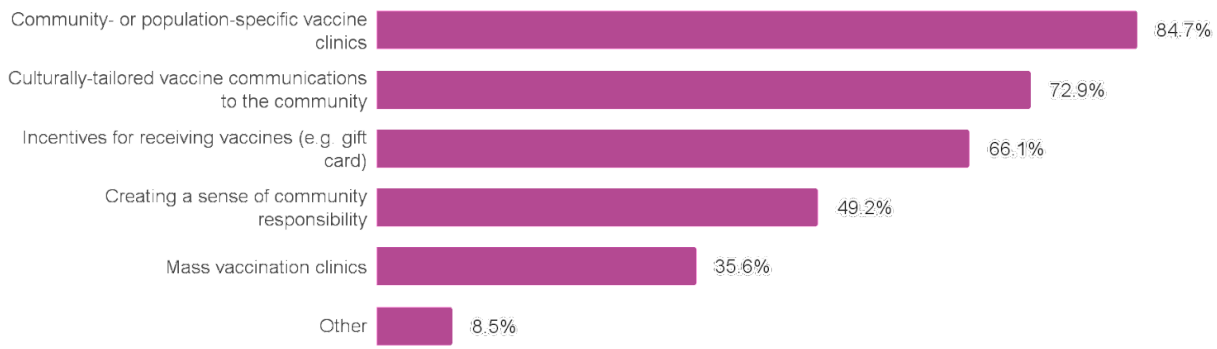
Figure 9: Barriers CBOs experienced when supporting vaccination efforts (N=57)



Respondents also provided feedback on what strategies helped increase COVID-19 vaccination uptake. The top three responses were community- or population-specific vaccine clinics (84.7%, n=50), culturally tailored vaccine communications to the community (72.9%, n=43), and incentives for receiving vaccines (66.1%, n=39). The other responses provided were:

"Drag performances doubled our attendance!"
"Created welcome for PWD [Persons with Disabilities] was vital and got better over time"
"Communicating that we are keeping ourselves vaccinated so that those that are vulnerable will be safe."
"Collaborating with a group of CBOs with the same goals"
"I don't like the idea of giving cash incentive which causes so much moral hazard in the community and make same efforts much less effective."

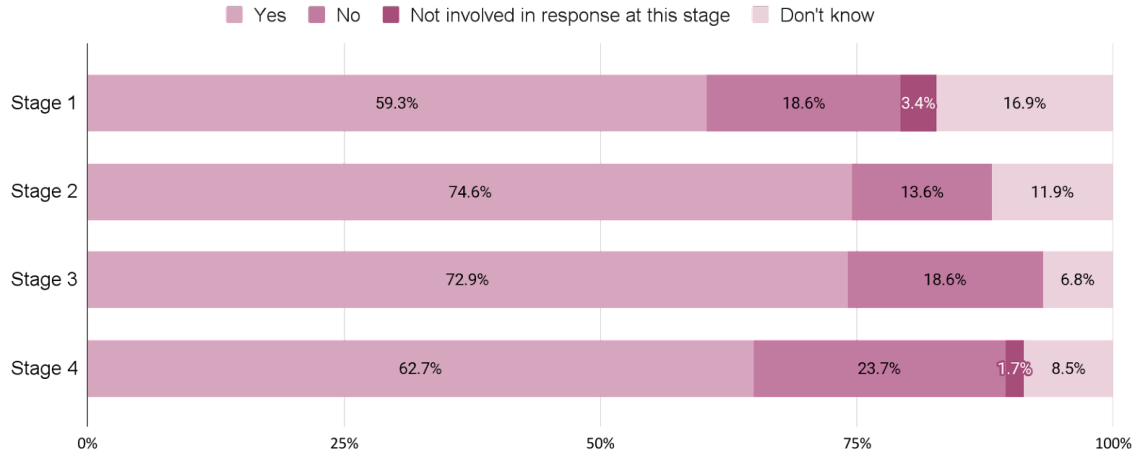
Figure 10: What was helpful in increasing the number of people who received the COVID-19 vaccine (N=55)



Supports for COVID-19 Response

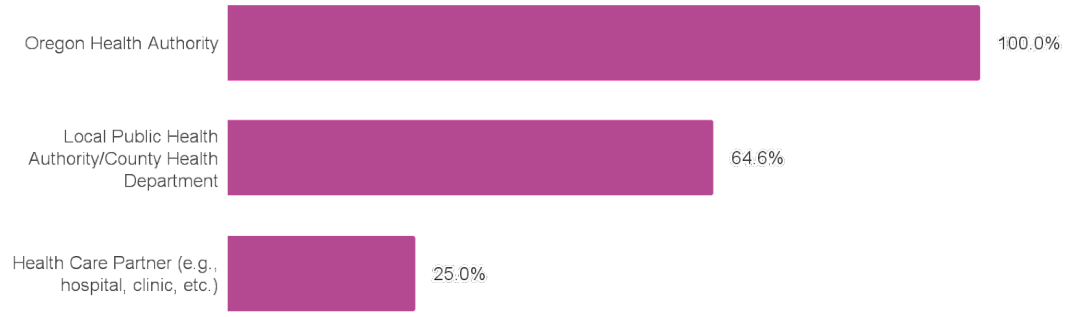
Respondents were asked if they received technical assistance for their COVID-19 response activities during each stage. Forty-eight respondents reported receiving technical assistance at any stage.

Figure 11: Technical assistance received from any organization (N=59)



Of the 48 CBOs who reported receiving technical assistance,100% reported receiving TA from OHA, 64.6% (n=31) reported receiving TA from LPHAs or the County Health Department, and 25.0% (n=12) reported receiving TA from healthcare partners. Approximately 10.4% (n=5) of respondents reported their CBO received TA from a different source. Other sources of TA included : Oregon Council on Developmental Disabilities, national disability groups and international disability research and best practices, and the Nonprofit Association of Oregon (NAO).

Figure 12: Agencies CBOs received TA from (N=48)

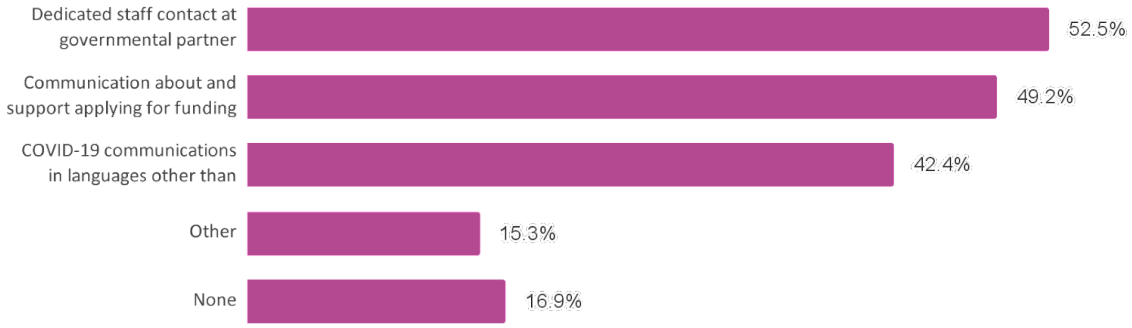


Respondents were asked to reflect on what supports would have supported their CBO when beginning their COVID-19 response. About half of respondents reported a dedicated staff contact at governmental partner organizations would have been helpful (52.5%, n=31), and almost half also reported that communication about and support applying for funding opportunities would have been helpful (49.2%, n=29). “Other” responses included:

“not closely involved in roll-out at each stage to respond accurately”
“A willingness from our LPHA to directly answer questions and support guidelines, vaccinations, etc.”
“Support for filing reports correctly, actual hand”
“Support applying for funding is only helpful if the funding opportunities are accessible, which many were not.”

"Governor, OHA and LPHAs recognizing the inequitable burden on the Latinx community and designing immediate strategies to ameliorate the issue"
"Sample policies and procedures around remote work, working with vulnerable populations, etc."
"The facts weren't shared! It felt like it was more about politics than getting help out there. There was already medicine to help, so why wasn't it allowed to be used!!! That is what I would call politics!!"
"MOre flexible funding - ability to provide support to those impacted by COVID who were not necessarily in isolation"
"An understanding of equity as intersectional and much deeper commitment to empowering person centered disability practices. An assumption that every disability group has this is also a mistake. Separating race and disability was not always helpful"

Figure 13: Supports that would have been helpful for CBOs when beginning COVID-19 response in their communities (N=59)

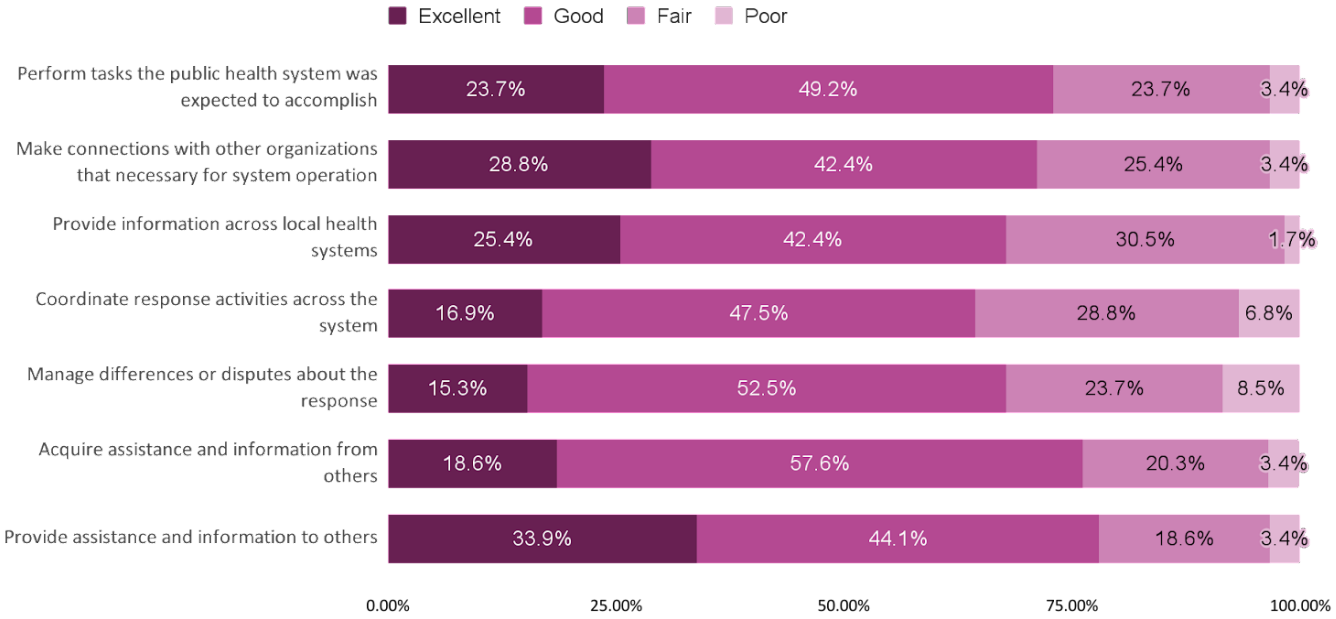


Additionally, some respondents had praise to share, captured in the "none" category on the chart. Comments included:
"Considering the lack of historic precedent (for our organization and OHA) I thought the response was amazing. The staff at OHA, through this entire experience, was one of the best teams I have ever worked with."
"None oha very helpful"
"NA - received tremendous support from our LPHA"
"Felt we were supported"
"none We had all of the previous support available"

Public Health System Response

Respondents shared their rating of how well OHA was able to perform public health activities throughout the pandemic.

Figure 14: CBO respondents rating how well OHA was able to engage in the following activities during COVID-19 response (N=59)



Funding

COVID-19 Funding Challenges

Almost all (91.8%, n=56) respondents reported challenges with COVID-19 funding (Figure 15); 8.2% of respondents (n=5) reported they did not have any challenges with COVID-19 specific funding. Some respondents reported additional challenges:

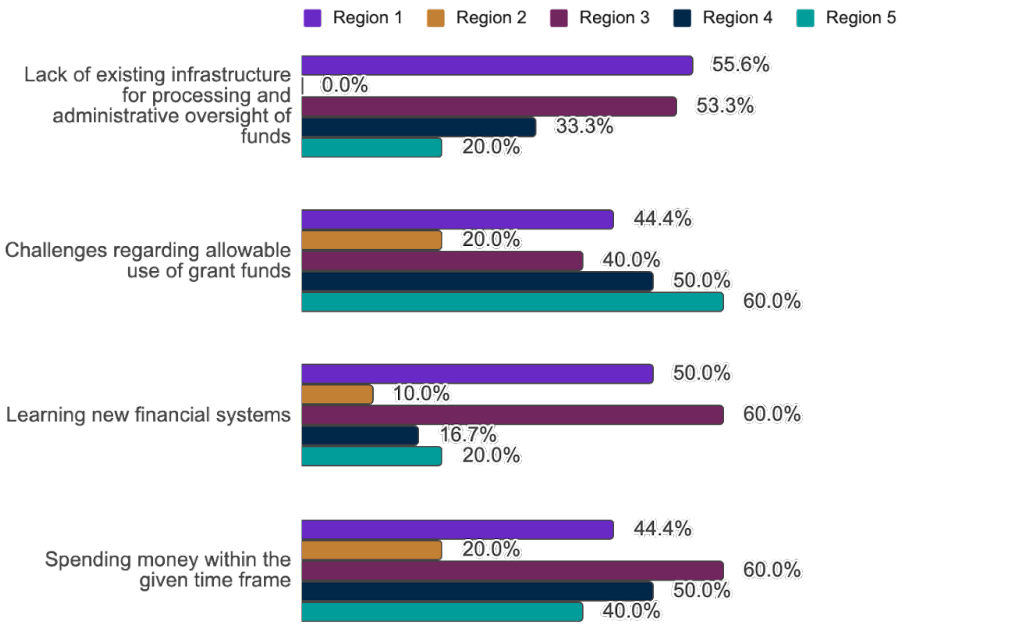
Figure 15: COVID-19-specific funding related challenges (N=61)

"Hiring and onboarding staff during the pandemic was challenging."
"I'd like to caveat that while each of these existed at one point or another, they have all been met with wonderful service at OHA. Questions were answered quickly and our staff adapted readily."
"My previous employment used grants all the time, so I was very familiar with all the processes. However, no processes were in place so I had to create processes."
"Hiring dedicated staff for undetermined term"

“changing administrative expectations and high turnover of staff we interacted with. It was very hard to keep track of it all. Also some of the informational meetings included an hour of introductions around the group, and that did not feel like a great use of time.“
“The FEMA auditor type role had people with no understanding of disability needs reviewing purchases and resources created for unique person centered needs there was a lot of learning OHA and FEMA needed to do”

Funding Challenges varied across CBOs in different regions. See Figure 16.

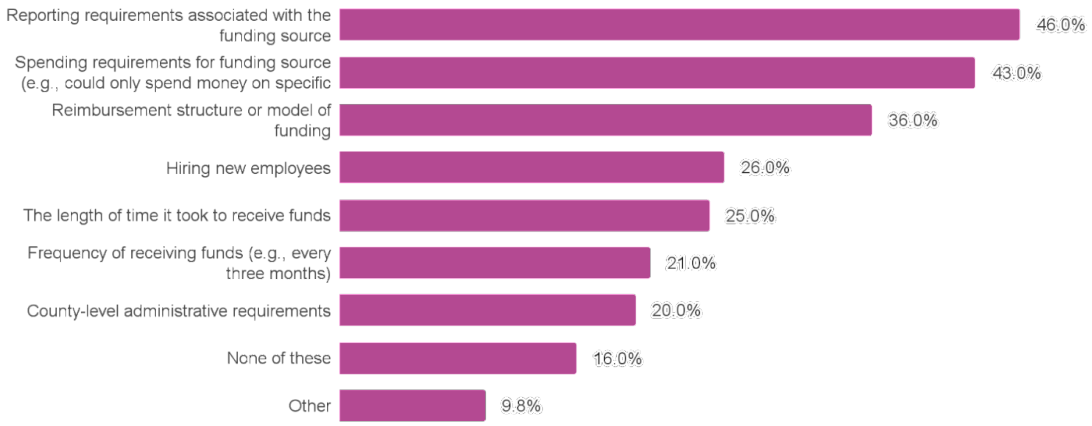
Figure 16: CBO Funding Challenges by Region (N=61)



Barriers to Efficient Use of COVID-19 Funds

Approximately 16% (n=10) of respondents reported they did not encounter any barriers to efficient use of COVID-19 funds. The majority of respondents, however, (84%, n=51) reported experiencing at least one barrier. The most commonly cited barrier to efficient use of COVID-19 Funds was reporting requirements associated with the funding source (46%, n=28), followed by spending requirements for the funding source (43%, n=26) and reimbursement structure or model of funding (36%, n=22) (Figure

Figure 17: Barriers to efficient use of COVID-19 funds (N=61)



17).

Several respondents reported additional barriers to efficient use of funds, including the following:

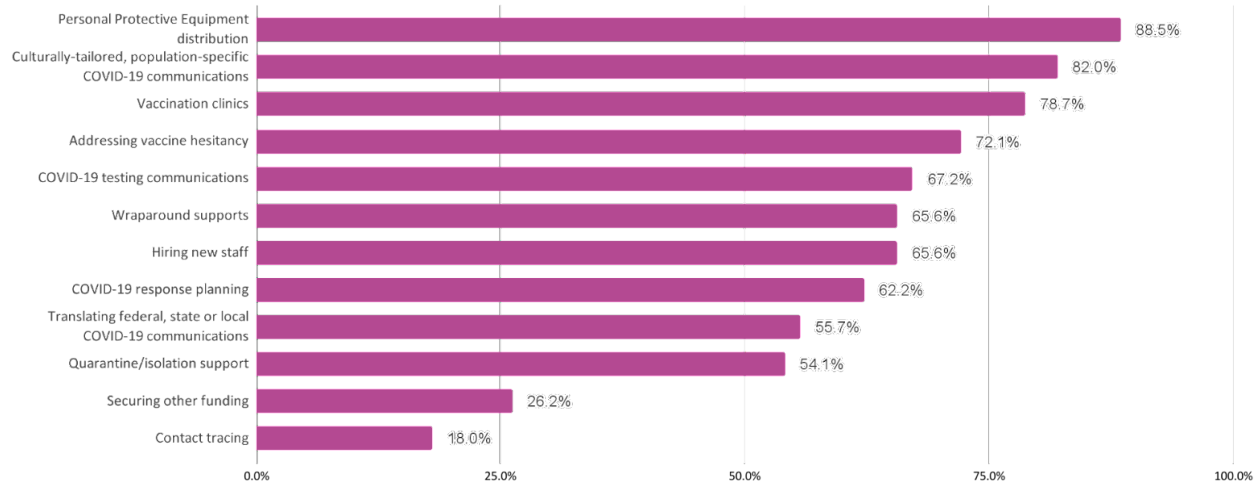
- *"Inconsistent funding timelines, frequent changes in OHA staff and poor communication between these staff members as they transitioned."*
- *"Hesitancy to hire new employees using this funding, knowing this funding had an end date"*
- *"I believe that it was clear when it comes to how the funds could be used. Changes do occur in some fundings, but I believe it was due to the fact that this is a new situation ever to happen, and we all were figuring out together."*
- *"The inability for CBO to do fundraising when everything was closed and forced to virtual non-contact interactions with the communities."*
- *"FEMA was far worse than OHA but the speed meant that retro rules hit efforts and the folks OHA employed kept coming back again and again for more info and changing rules. It was very stressful and contributed to board decision to lay off staff as we could not assure cashflow timelines we needed."*
- *"Response to changing environment: the learning curve was steep and pace of change was high."*

Funding uses

Figure 18 displays the ways that CBO survey respondents utilized their COVID-19 specific funding. The top funding use was for distribution of personal protective equipment (n=54), followed by

culturally-tailored, population-specific COVID-19 communications (n=50).

Figure 18: CBO COVID-19 Funding Uses (N=61)



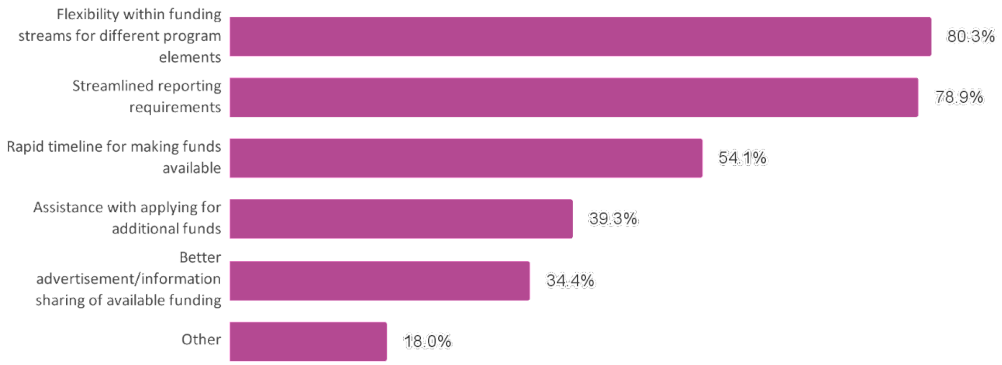
Some respondents provided additional comments related to the use of COVID-19-specific funding in their communities.

- *"Reengagement in the community (this has been especially difficult for families with children experiencing disability)."*
- *"Community engagement was our primary effort and sending literature to our constituents."*
- *"community education"*
- *"We coordinated with others who provided isolation support and wrap around services."*
- *"Created visual resources and advocacy for access to resources that did not exist." "Trained other CBOs collaborated with Brink communication Ran specific trainings for DD population in English and Spanish."*
- *"Hosing of clients"*

Ways to Reduce Fiscal Burden on CBOs

Comments provided by CBO

Figure 18: Resources needed to support CBOs in future emergency response (N=61)



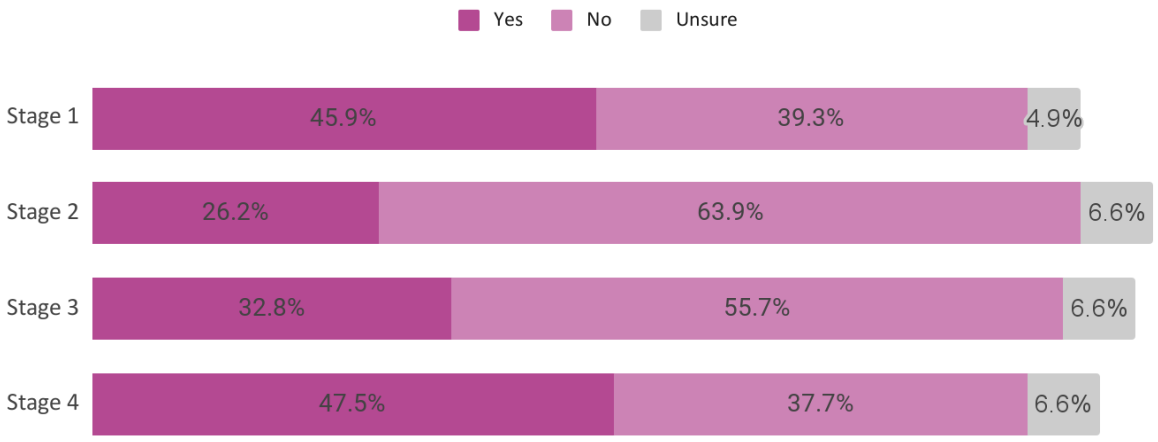
survey respondents related to resources that would support them in future emergency responses:

- *"Clear timelines (although probably impossible to predict) would have allowed for us to hire additional staff to help with education, outreach, and reengagement."*
- *"I think that instead of just assigning a community Engagement coordinator; CEC it should be someone who could help with individual reporting. Its true we have folks from the fiscal team that do help, but this way could provide more benefit to the CBO."*
- *"We were eligible for additional funding, but declined to apply due to our experience with reporting and changing requirements for our existing Covid-19 funding through OHA."*
- *"The frequency of meetings was a challenge when there were so many other pressing needs."*
- *"having somebody coaching who speaks your language."*
- *"Every reporting period the report templates changed, so you would have to re-enter the previous information because you had to download the revised template. Also, the template had errors in the formulas."*
- *"I think OHA did a good job on all of the above, at least from our perspective, but to the extent other CBOs had challenges I can see how each of the above strategies could be effective in lessening the burden."*
- *"Bigger budgets for admin and facilities costs (operations)"*
- *"Understanding that smaller CBOs do not have layers of admin support and specialization in accounting / reporting. the specific requirements were not always a perfect fit for the work we do, and we were not reimbursed for the time it took staff to complete the reports."*
- *"A dashboard to track funds etc and less turnover in staff CBO interface with Trust that we know our communities needs and presumption of competence."*

Funding Worries

While working on the COVID-19 response, 70.5% (n=43) of CBO respondents reported that during one or more stages, they were worried that funding would run out. A breakdown of funding worries across stages is provided in Figure 19.

Figure 19: Percent of respondents who feared that funding would run out during each stage (N=61)

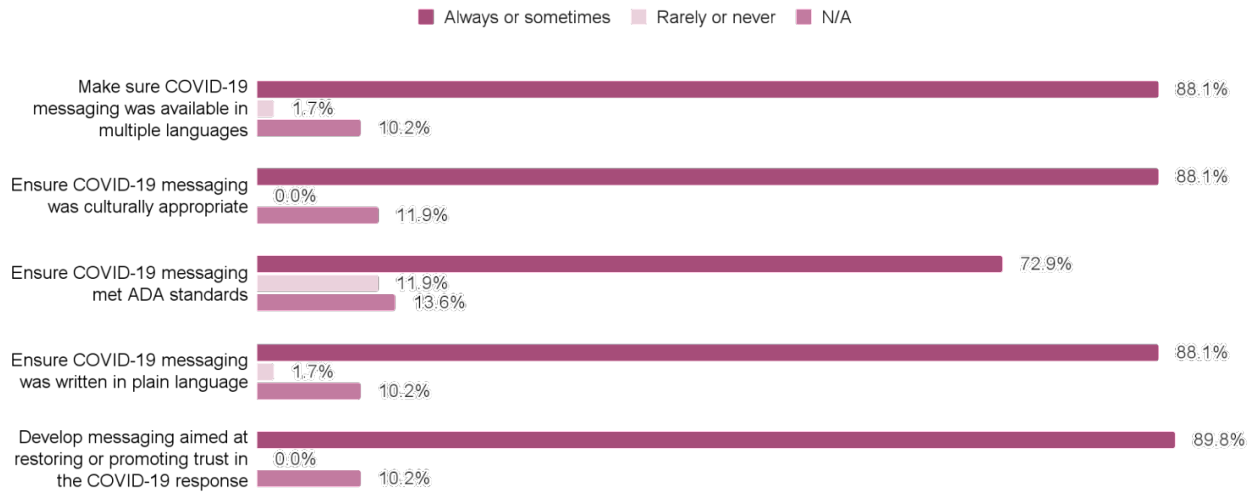


Communications

CBO communications

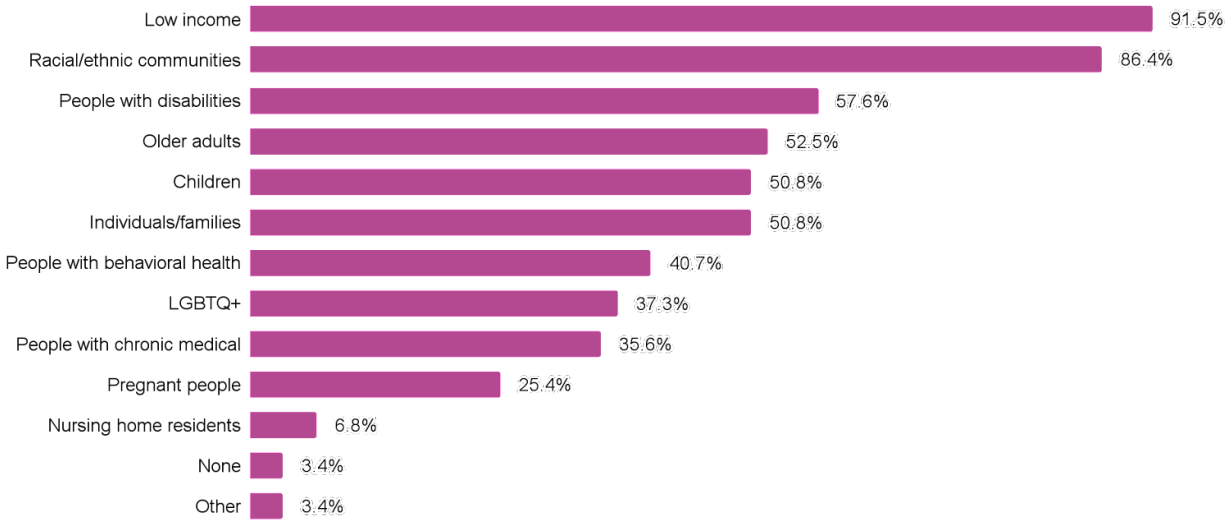
When asked about following messaging best practices, most respondents selected that they always or sometimes follow best practices of making sure COVID-19 messaging was available in multiple languages (88.1%, n=52), was culturally appropriate (88.1%, n=52), met ADA standards (72.9%, n=43), was written in plain language (88.1%, n=52), and was aimed at restoring or promoting trust in the COVID-19 response(89.8%, n=53). he practice that was least commonly followed by CBOs was ensuring that COVID-19 messaging met ADA standards.

Figure 20: When developing targeted public health messaging, CBO respondents did the following: (N=59)



The most frequently mentioned population that CBOs prioritized for community or population specific messaging was the low income population (92%, n=59).

Figure 21: Populations CBOs prioritized for community or population specific messaging (N=59)

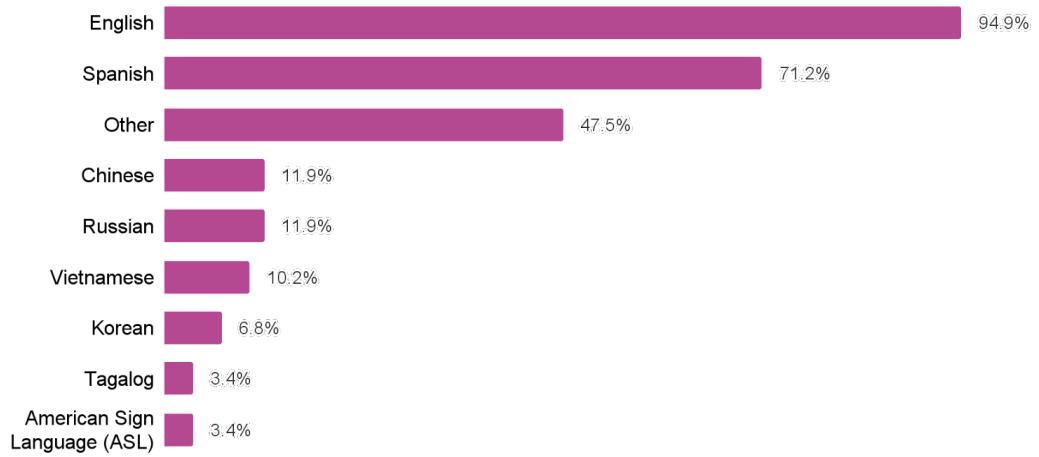


Others included:

- Refugees and immigrants (3)
- “Everyone was always welcome, besides our target population”
- Displaced wildfire survivors
- Entire congregation
- Individuals with criminal background
- Support workers and systems
- Rural-dwelling community members

The most common language that CBOs made COVID-19 messaging available was in English (95%, n=59), followed by Spanish, Korean and American Sign Language.

Figure 22: Languages in which CBOs made COVID-19 messaging available (N=59)



Other languages respondents reported their CBO providing COVID-19 messaging in included:

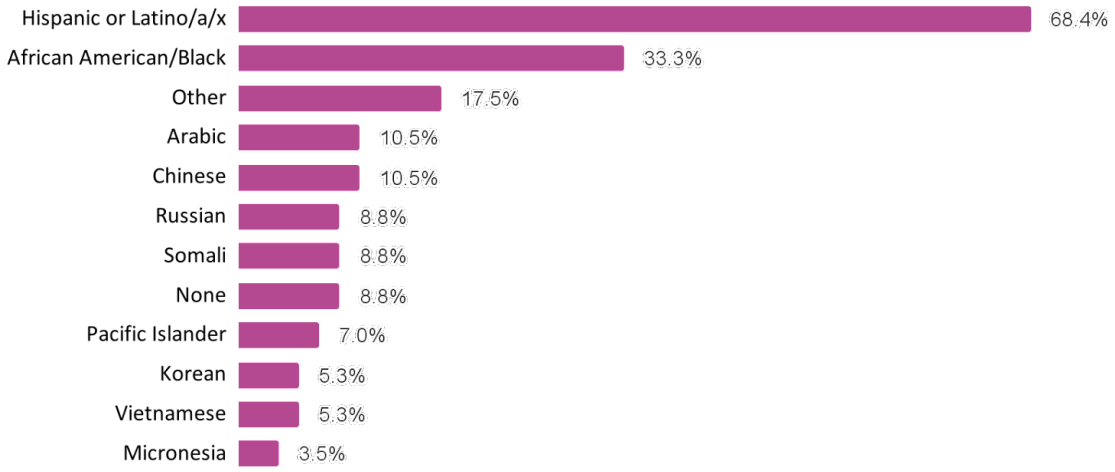
- Somali
- Arabic
- Bosnian
- Urdu
- Broken African language
- Swahili
- French
- Farsi
- Ukrainian
- Thai
- Mam
- Ewe
- Mina
- Mai Mai
- Bengali
- Somoan

- Tongan
- Hawaiian
- Chuukese
- Marshallese
- Pingelapese
- Palauan
- Chamorro
- Turkish
- Oromo
- Visual
- Burmese
- Rohingya

Hispanic or Latino/a/x communities were the racial/ethnic community most commonly prioritized for culturally-specific COVID-19 messaging (66%, n=59).
Others included:

- White
- African immigrants
- Benagli
- Ukrainian
- PWD [Persons with Disabilities]
- Refugee community
- Burmese community
- ‘Rohingya community

Figure 23: Racial/ethnic communities CBOs prioritized for culturally-specific COVID-19 messaging (N=61)



OHA Communications with Public:

CBO survey respondents were asked to rank how well OHA communicated to the public about various public health mandates that were implemented during each stage of the pandemic. Throughout stages, survey respondents rated OHA as good or excellent for most of their communications. During Stage 1, two-thirds or more of respondents felt OHA did good or excellent across all mandates. During Stage 2, respondents were less favorable about how well OHA communicated on vaccine availability and lifting restrictions, but these still had over half of respondents rating OHA as good or excellent. By Stage 4, approximately one-third of respondents rated OHA as poor or fair in their communications.

Figure 24: Rating of OHA Communication with Public, Stage 1 (March - Nov 2020) (N=58)

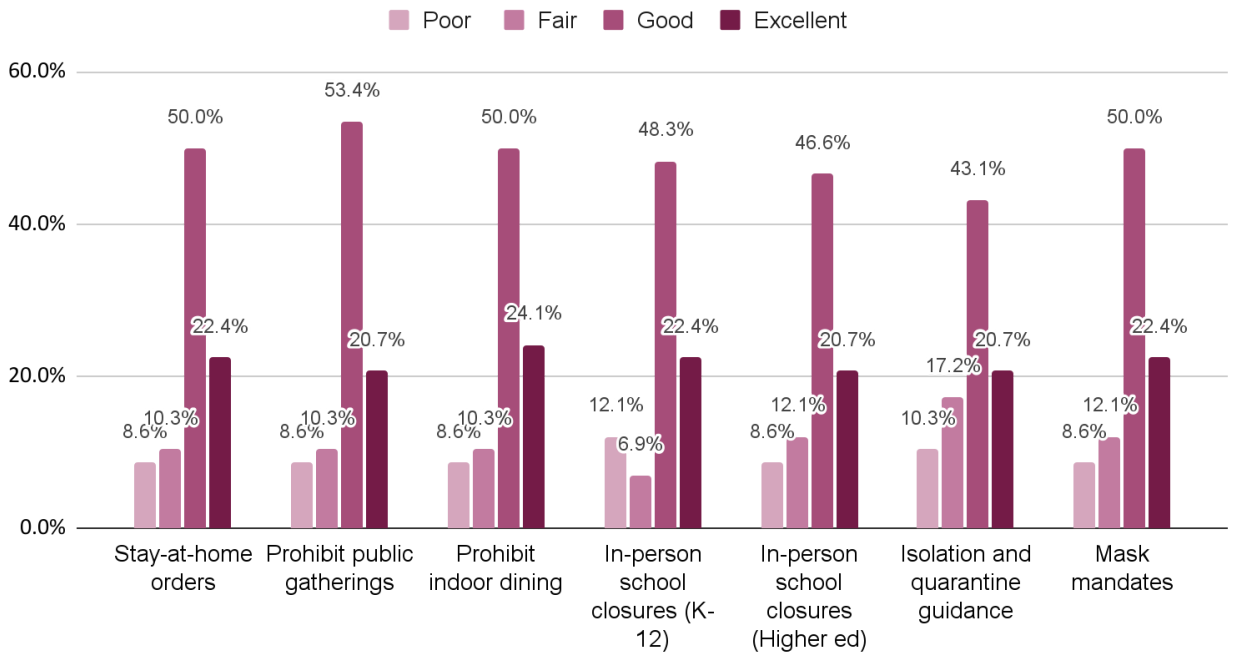


Figure 25: Rating of OHA Communication with Public, Stage 2 (Dec 2020 - Aug 2021) (N=58)

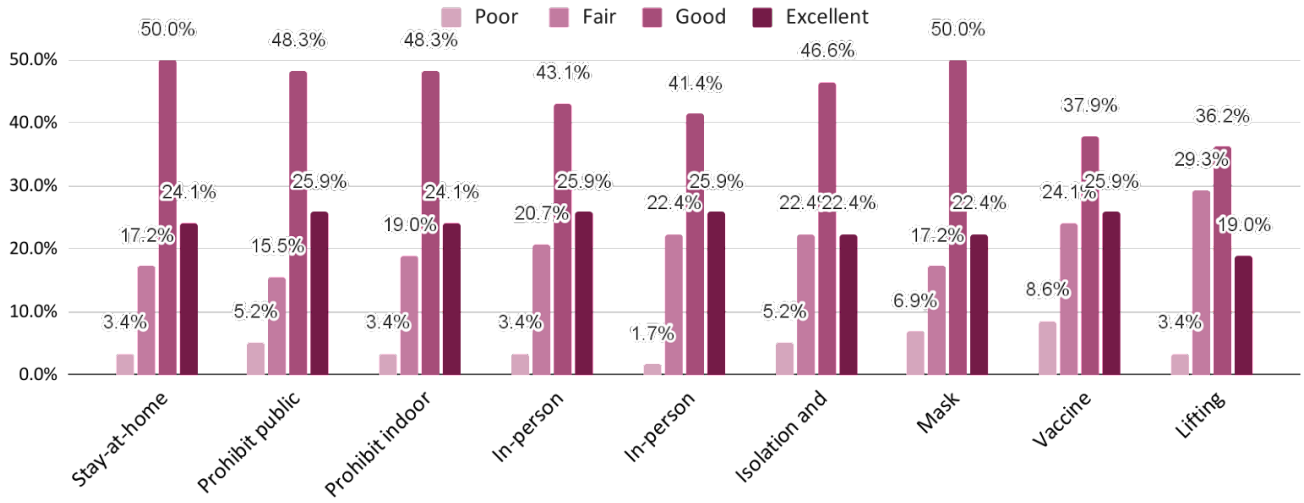


Figure 26: Rating of OHA Communication with Public, Stage 3 (Sept 2021 - Feb 2022) (N=58)

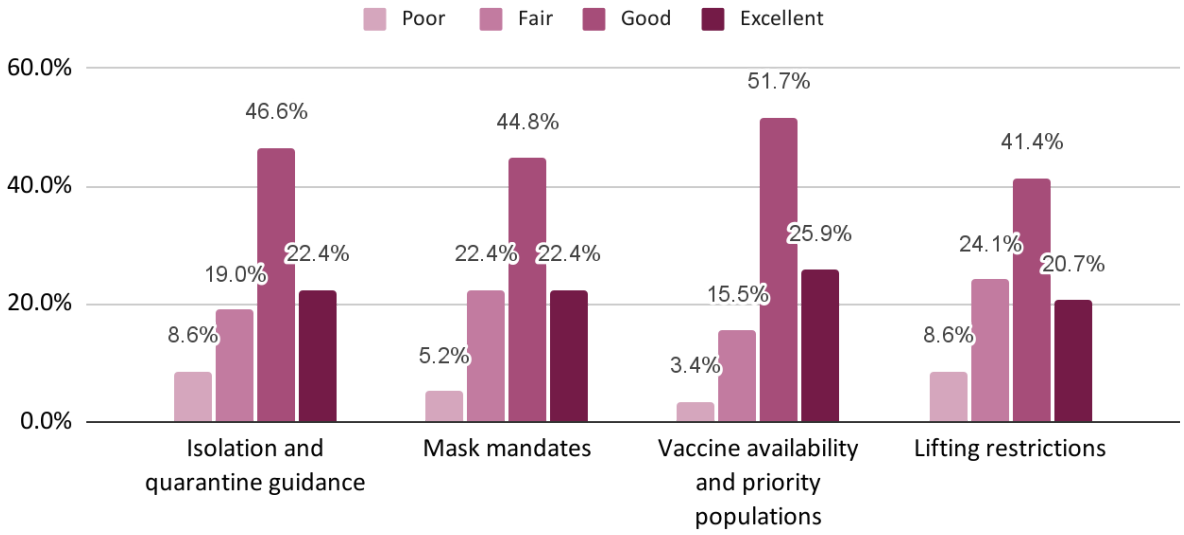
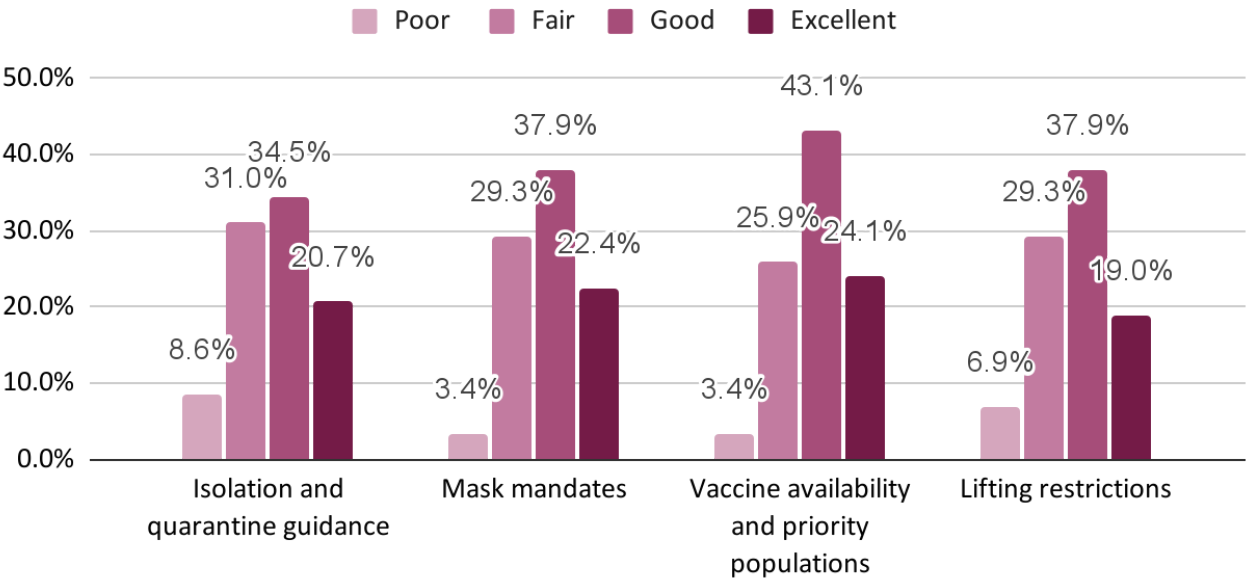


Figure 27: Rating of OHA Communication with Public, Stage 4 (March - July 2022) (N=58)

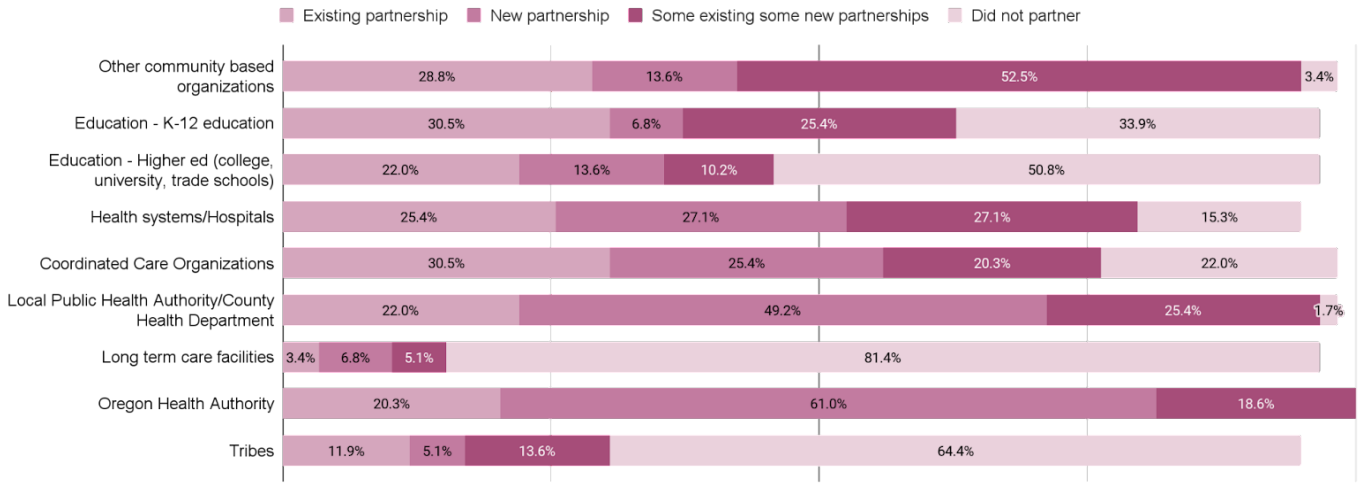


Partnerships

Types of Partnerships

Whether or not CBOs tapped into existing partnerships or created new partnerships was pretty different depending on what sector they were reporting on. The two sectors that the most respondents reported building new partnerships with were OHA (61%, n= 36) and LPHA/County Health Departments (49.2%, n=29). Very few respondents reported working with long term care facilities (15.3%, n=9) or Tribes (30.5%, n=18).

Figure 28: Types of CBO partnerships for COVID-19 response (N=59)

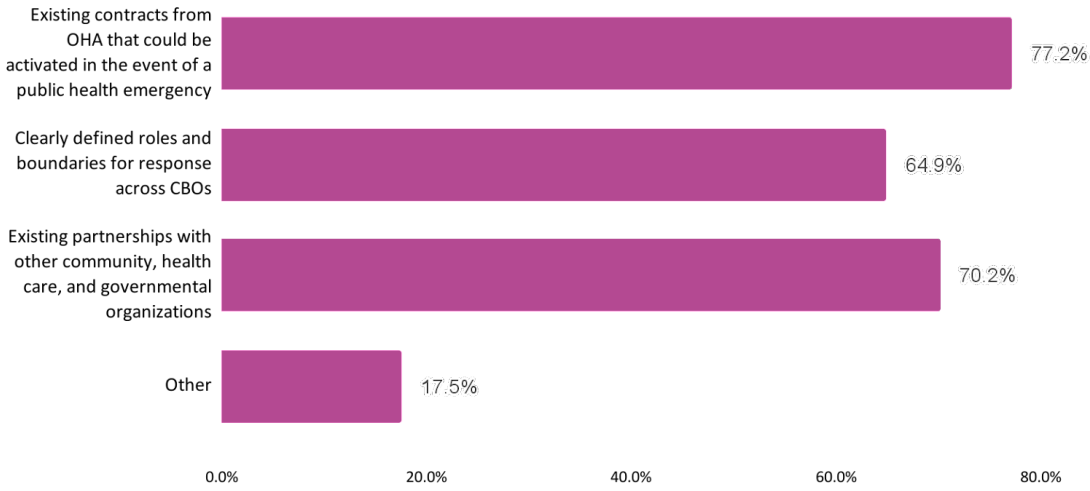


Lessons Learned

Supports to Improve CBO Response

Respondents were asked what might have helped their CBO in a more effective response to the COVID-19 pandemic in their community. Over three quarters of respondents reported that existing contracts from OHA would have helped (n=44), nearly three quarters of respondents reported that existing partnerships with other organizations would have helped (n=40), and two-thirds reported that clearly defined roles would have helped (n=37).

Figure 29: What would have helped CBOs in a more effective response to the COVID-19 pandemic in their communities (N=57)



Ten respondents added "other" responses:

- *"Clearer information about finding opportunities"*
- *"Other thing that would help is making grants available from other sources to keep up with helping clients. We provided many supports due to the pandemic and now, we can not due to the changes and reduced in cases, but people are still struggling and reaching to us for those same resources, thought we cannot provide them now. We should not be in the business of turning clients down because funding is no longer available. I believe that there should have been other sources of fundings to continue to help."*
- *"Ensuring that prohibited activities were treated the same."*
- *"Having local leadership support a response moving forward would be very helpful. Having a qualified LPHA would be excellent."*
- *"The wishy-washiness of the government! Because of that, it affected every other aspect of trying to get funds to CBOs.*
- *flexible funding"*
- *"None of the above; I think we had the resources we needed to mount an effective response for our community"*
- *"More willing partners from county health departments."*
- *"we already had all of the above"*
- *"trust and resourcing front line groups"*

Lessons Learned by CBOs

Lessons learned by respondents included the following:

- *"Working intimately with my community during the Covid-19 process made me realize how much it takes to get resources to those in need. Any delay during the process can make it difficult to provide for them. It just gave me a new appreciation for everyone involved in the effort."*

- *“Public health systems need to be strengthened, at the state and federal levels. The "messaging" has been muddled or confusing from the beginning. This nation should be ashamed of the numbers who have died--and are continuing to die daily--and of our failure to address the largely 'hidden' effects of long Covid, and the many adverse effects of the pandemic across all of the social determinants of health, presently and in the future. Communities of color and the poor and vulnerable will continue to suffer disproportionately from this and future pandemics--nothing systemic has changed to prevent that. A robust system of public health must work constantly with local communities to counter the malign effects of the mis/disinformation permeating social media and political discourse. Instead, we are allowing Covid-19 (as with so many other diseases and inequities) to become "normalized" and largely ignored, as somehow the "price" that some will have to pay so that "most" people can "get on with their lives." The "final lesson" is that few clear lessons seem to have been learned, or at least "the public" seems all over the map in what they think and how they behave.”*
- *“The community engagement team (team Dolly) we're magnificent and great to work with. I wish I knew more about finding for wraparound services as we could have greatly used it.*
- *Local communities should have more authority to how a public health emergency should be handled in their own jurisdiction. Not all communities are the same and policies should not be directed only from the Metropolitan areas like Portland and Salem. Local counties should have the flexibility to set their own guidance based on local rates of infection or death.*
- *Great job overall for OHA.*
- *“I think you all did amazing. You were navigating a completely new situation and you did so with dedication.”*
- *“We have a wonderful lesson learned: Partnership with OHA/PHD, A community of CBOs, and over all the trust that was put in each community to handle large sum of money in response to this Covid-19 pandemic, and the support that is provided to manage such money. Many communities were seen, involved and serve in a way never seen before. Oregon public health have stepped it up and we looking for other governmental organizations to follow. We look forward for a lasting relationship and partnership because it would make it easy to circle back with CBOs in a case of any other outbreak to help community to be reach faster them ever because of this partnership that has being established. We always wanted this type of partnership for our communities and for every community to have representation, and it is happening now, though it has to take this devastating outbreak. Thank you!”*
- *“As an organization not usually engaged in this type of work, OHA made the process very easy. Both on a professional and personal basis I believe OHA did an exceptional job of quickly educating our state on what we were facing, where help was available, and providing CBO's amazing resources. So much of the work OHA did with the CBO program is unknown outside of the CBO's that were involved. Which is a shame, because OHA kicked ass on this and they haven't been recognized for that by many people in the general population. To be able to pay rent, utilities, food, etc. for the families of our historically underserved community while also being financially supported by OHA to provide educational enrichment activities for youth during the lockdown was amazing. We were able to provide far more than just resource guidance and directions to vaccine clinics.”*
- *Overall, Oregon had one of the lowest death rates in the nation because of guidance was believed, followed and well communicated.*

- *“The recruit for CBOs were good, however, the expectation for funds to carry out the response was delayed. Also, th*
- *e initial response from the Public Health contact person was almost non-existent, and we needed more direct interaction from OHA. The position was finally eliminated, and OHA finally took over.”*
- *“1 - If we as a state, and as a public health network including county public health departments, don't pause to build internal cultural/linguistic/plain language capacity and trust with communities now, the next crisis will not go much better. Trust is the real threat to public health in Oregon and must be addressed by the systems who hold power and control resources (OHA, public health). CBOs can be good partners, but cannot stand in the huge gaps between current public health infrastructure and communities most impacted. Finally, don't invest in CBOs only in a crisis, build CBO capacity (including flexible general fund support to build staff and do responsive community-determined work) consistently so that we can be ready to respond and play our role in an emergency.”*
- *“There's no such thing as over communication or over collaboration”*
- *“The importance of maintaining the infrastructure CBOs built so we can activate and respond faster in the future”*
- *“It was great to work with OHA and other community partners- it was a learning experience for all of us!”*
- *“All in all, great job during an uncertain time in history.”*
- *“Having to form a partnership with OHA, during the crisis provided a learning curve. Having a pre established relationship would have been beneficial.”*
- *“Having access to public health emergency information in other languages for vulnerable communities is something that we think is important and something we learned that would need further investment”*
- *“It was critical for our culturally specific organization to be able to work with OHA and our county public health department. The focus on underserved communities was a significant reason we felt comfortable working with OHA and our local public health department.*
- *Public health response must be based purely on science which means that if an activity is prohibited for one group, it needs to be prohibited for all groups no matter how just the cause. Not doing so caused significant distrust in the public health response from members of rural communities which may have far reaching implications in future public health emergencies.”*
- *“The gape between communities and OHA”*
- *“The last couple of years have been unprecedented. We have had some truly wonderful CBO coordinators that have stepped up and asked all the questions to help make sure our work was done well, and we appreciate that. When contact tracing ended, we were kind of left in the lurch with referalls and more could have been done to make sure that local CBOs did not lose their stream of referrals. Local public health kind of dropped away as contact tracing was centralized up north and we needed better systems to get our local community members the help that they needed.”*
- *“Collaboration and communication are paramount and require proactive leadership”*
- *“Politics and division are our worst enemy in a response to a public health crisis.”*
- *“A lesson learned is that collaborating with other organizations our community get information and resources from people who can trust.*

- *“Have systems/forms in place to address the next pandemic.”*
- *“Many consumers were referred for wrap around supports who were not financially impacted (receiving SSI, SSDI, TANF, etc), requested services while their companies offered benefits (sick time, public health leave, etc), or had spousal support without personal income (thereby negating the need for financial assistance). The presentation of resources needed inclusion of restrictions to applicable parties and some sort of impact to income verification.”*
- *“thanks for all you did to support CBOS”*
- *“I think overall they did an excellent job of responding to the Covid 19 pandemic and working with the CBO's. There was a lot of time devoted to communicating with us via Zoom calls and in some cases meeting in person, especially at the beginning of the pandemic.*
- *“The initial lack of access to family members and other support people for patients with disabilities who were hospitalized was a serious issue that should have not taken so long and should not have required legislative action to rectify. It is still a problem in that some hospitals are not following the intent of the Senate Bill 1606 mandate as passed by the State Legislature.”*
- *“Maintain constant and frequent communication to the public and partners. Do not hold back on information or making the difficult calls.”*
- *“The collaboration with CBOs started poorly and increased overtime, particularly when OHA put people from diverse communities in the frontline. CBOs that have never done business with OHA had the chance to build trust and confidence. Oregon's public health response to the Covid-19 pandemic has been an opportunity to build and improve relationships with communities, which can help to respond very quickly and more effectively any other emergency situations.”*
- *LPHAs are ill-equipped to handle community-wide crises alone. With trust in government at an all-time low in the U.S., adopting a more decentralized and grass-roots approach to response and recovery is crucial.*
- *“I would like to have seen more hands on training with our organization.”*
- *“Proud of Oregon's public health response and partnership with CBO's to connect with underserved community members. CBO's played a critical role in communication, outreach and impact. As we move forward hopeful to continue to partner with CBO's but also seek to find ways to streamline reporting requirements to reduce the burden on smaller CBO's”.*
- *“Pre recorded videos to share about new/changes to guidance- consistent messages for all communities.*
- *OHA did a great job adjusting to a volatile situation. The pandemic was addressed and now there's a baseline from which to work for the next pandemic. OHA was very responsive to our organization's needs and reached out to us.”*
- *“Equity was so obviously ignored early on . Medical systems have a medical model this was a social and medical issue There were responsive individuals but also presumptions about all POC and PWD and orgs that represent them being the same without thinking about values. Also it was like grafting a very fluid community driven response onto stodgy beaurocracy that over time built more and more rules”*
- *“In the beginning of the pandemic OHA seemed to struggle with coordination issues, but having worked with them from the start, I think they are doing a fantastic job.”*
- *“Dolly England’s team at the OHA was really fantastic. Very responsive, flexible, and supportive. I think OHA communications could do better at making social media posts more accessible*

(adding image descriptions) and leveraging multiple social platforms integrating more videos and stories. The OHA YouTube page should really be better organized, it's hard to find information on there."

- *"Overall It was something new for many of us as CBOs, I think partnering with us was a good decision in order to best serve and reach those populations that otherwise may have and still struggle accessing resources and services."*

OR Public Health Response to COVID-19: CCO Survey Preliminary Analysis

Introduction

For this study, a survey was administered to 15 CCO directors between August 24 and September 23, 2022. CCO directors were emailed a survey link directly from Survey Monkey so we could track and monitor who responded. There were a total of 7 responses, for a response rate of 44%.

Demographics of survey respondents

All survey respondents (N=7) had been in their position for a minimum of 6 months, and had been involved in COViD-19 response for the entire study period (all four stages).

	n (%)
Region	
Region 1	1 (14%)
Region 2	1 (14%)
Region 3	3 (43%)
Region 4	2 (29%)
Region 5	1 (14%)

	n (%)
Role	
President/Chief Executive Officer	3 (43%)
Chief Medical Director	2 (29%)
Other	2 (29%)

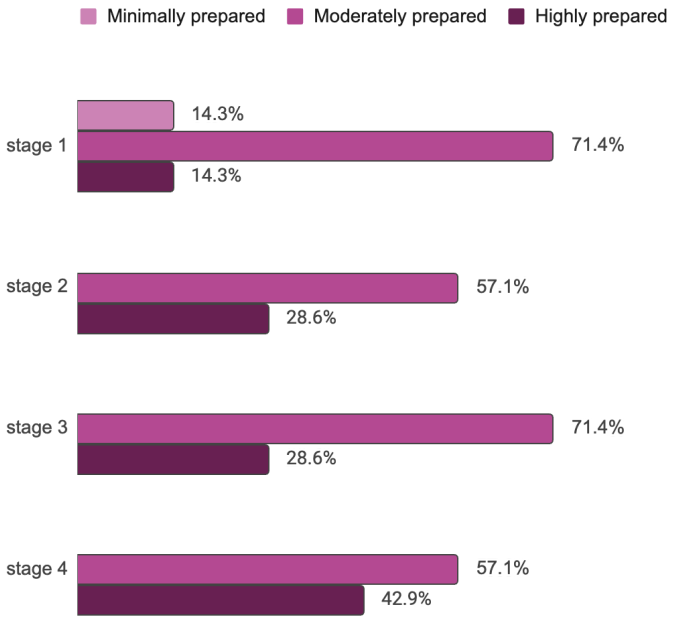
*Regions equal more than 100% since one CCO covers two regions

Emergency Management preparedness

Most respondents felt that their CCO was either highly or moderately prepared for the COVID-19 pandemic in every stage (Figure XX). The respondent who felt minimally prepared during stage 1 reported “We had infrastructure to discuss emergency response, and act. We figured out quickly how to partner with public health, and also how to reach out to remembers in need. It took a little time to

develop processes, but we did it quickly."

Figure 1: CCO's overall level of preparedness to respond to the COVID-19 pandemic at each stage



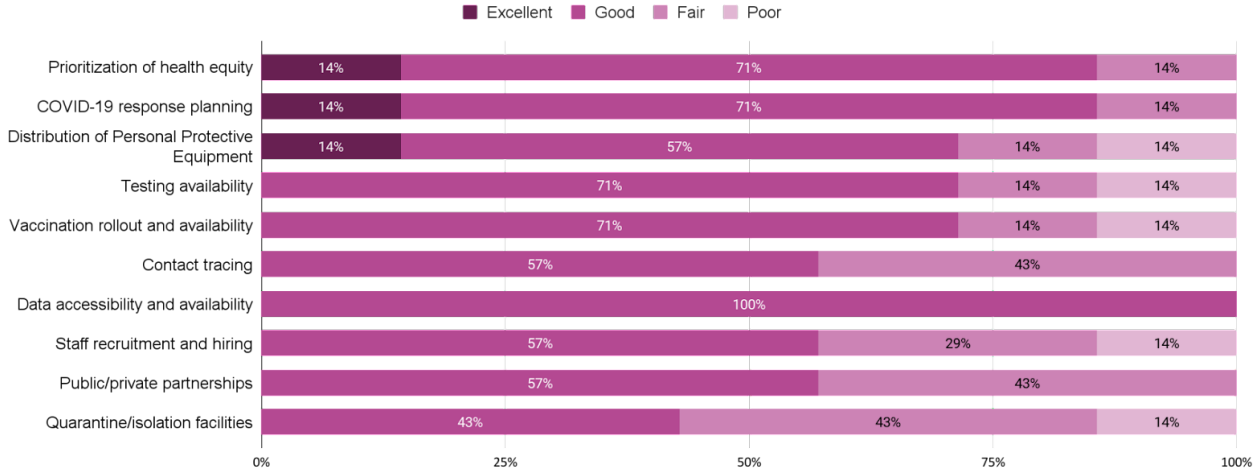
Seventy-one percent of respondents (n=5) reported that prior to the COVID-19 pandemic, their CCO had ever partnered with the Oregon Health Authority or a Local Public Health Authority/County Health Department to assist in emergency response. The remaining respondents (n=2) reported that they did not know.

COVID-19 Response Activities

Public health system response

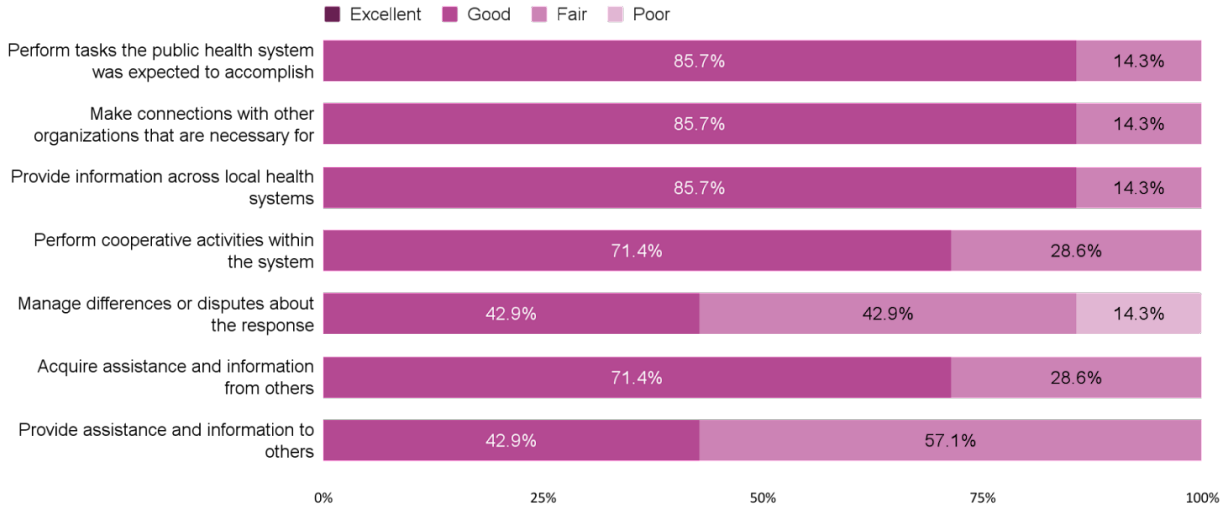
Survey respondents were asked to rate Oregon's public health response to COVID-19 across a range of activities. Overall, response was rated good or excellent, with the exception of the majority of respondents rating "quarantine and isolation facilities" as fair or poor (57%, n=4). All CCOs who responded to the survey rated "data accessibility and availability" as good. See Figure 2.

Figure 2: Rating of Oregon's public health response to COVID-19 (N=7)



When considering OHAs role in COVID-19 response, a little over half of respondents rated OHA low in "manage differences or disputes about the response" and "Provide assistance and information to others" with slightly over half of respondents rating these as poor or fair (57%, n = 4).

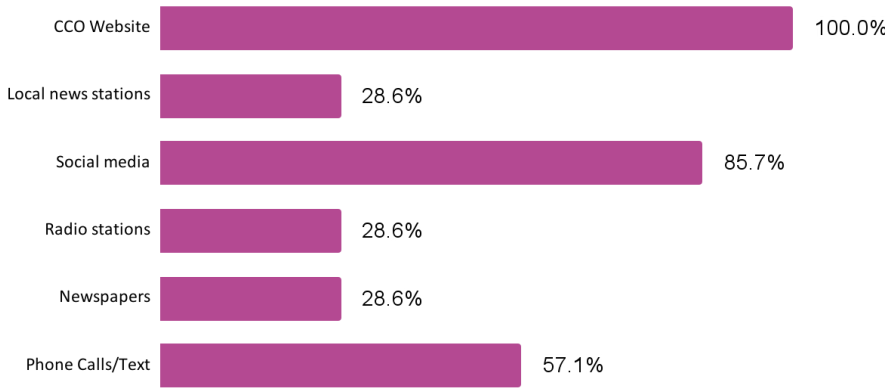
Figure 3: CCO Respondents Rating How Well OHA was Able to Engage in the Following Activities During COVID-19 response (N=7)



Communications

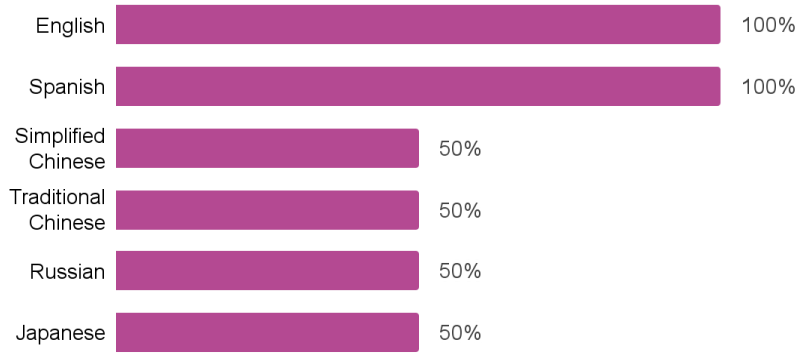
All CCO respondents reported providing public health messaging through mass media communication methods. All respondents provided information on their websites, over three quarters provided information on social media, and over half reported making phone calls/texting all of their members.

Figure 4: Mass communication methods utilized by CCOs (N=7)



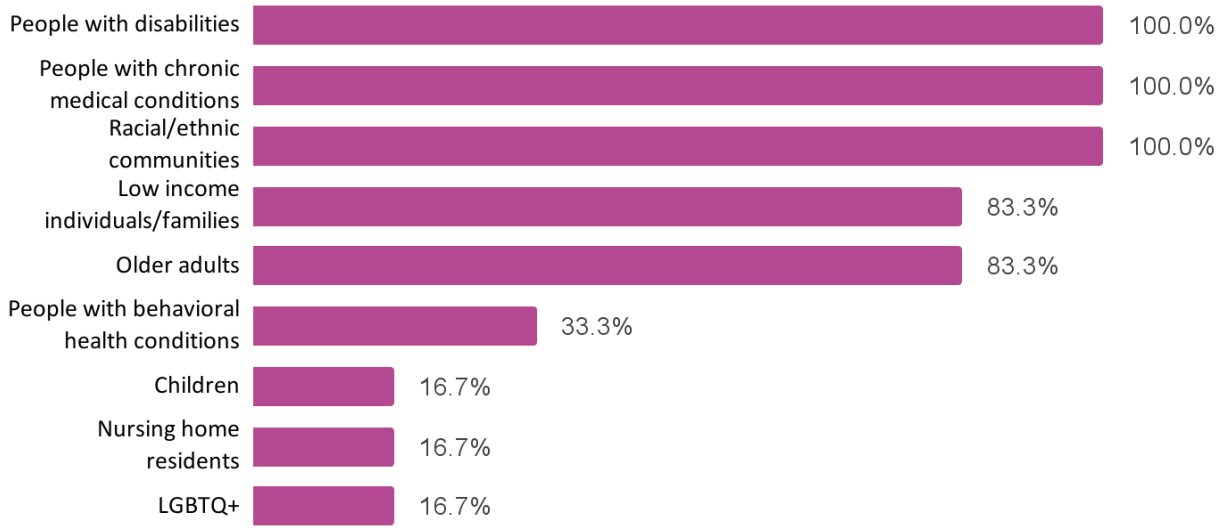
Six of the seven CCO survey respondents reported developing their own public health messages. Of these six CCOs, all provided materials in multiple languages, ensured messaging complied with ADA standards, and utilized plan language. Languages provided included English, Spanish, Simplified and Traditional Chinese, Russian, and Japanese. Additionally, three respondents noted that materials could be requested in any other language or format.

Figure 5: Percent of CCO respondents that provided COVID-19 health messaging (N=6) Provided materials in the following languages:



Respondents also noted that they prioritized community or population-specific COVID-19 messaging. All respondents who reported developing their own public health messages (N=6) reported prioritizing people with disabilities, people with chronic medical conditions, and racial/ethnic communities, and the majority reported prioritizing low income families and older adults. All six respondents who prioritized racial/ethnic communities prioritized Hispanic/Latinx populations, half prioritized African American/Black populations, half prioritized Pacific Islander populations, and one prioritized Russian populations.

Figure 6: Populations prioritized by CCOs for community- or population-specific COVID-19 messaging (N=6)



CCOs were asked to rate OHA on their communication with the public about a variety of public health requirements that were implemented by stage.

Figure 7: Rating of OHA Communication with Public, Stage 1

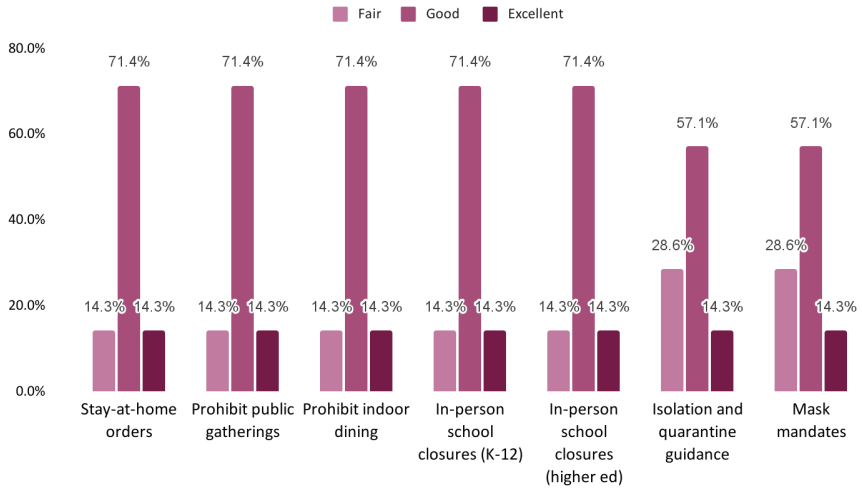


Figure 8: Rating of OHA Communication with Public, Stage 2

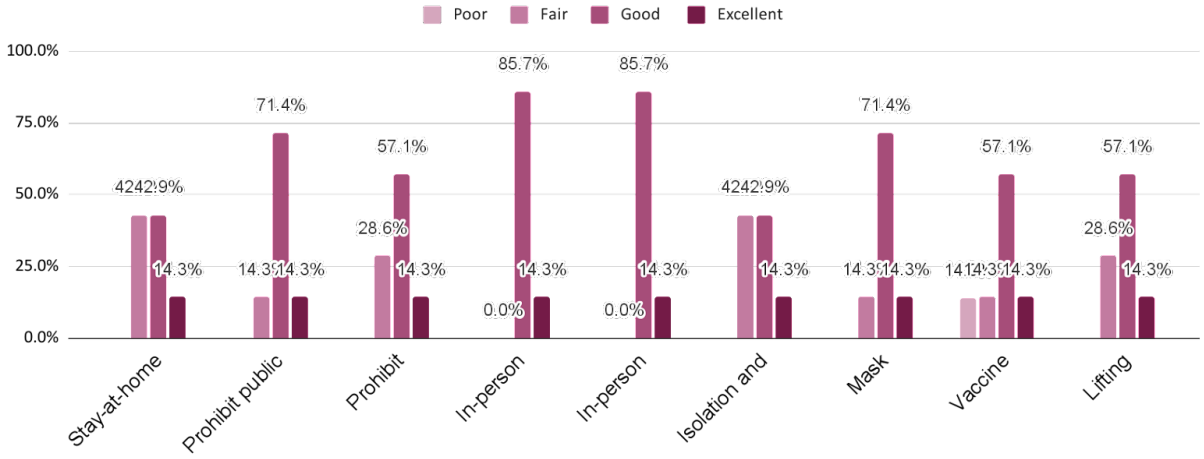


Figure 9: Rating of OHA Communication with Public, Stage 3

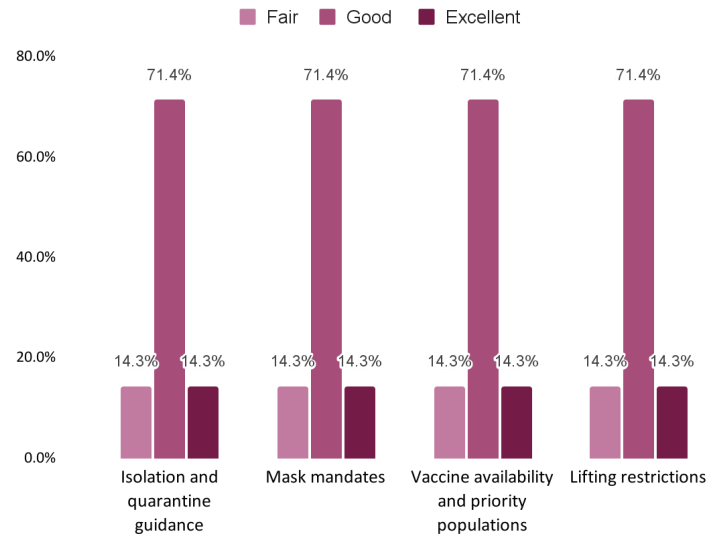
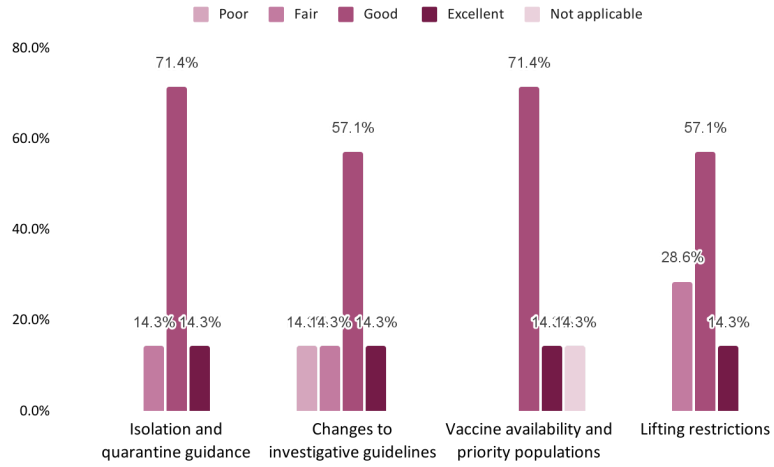


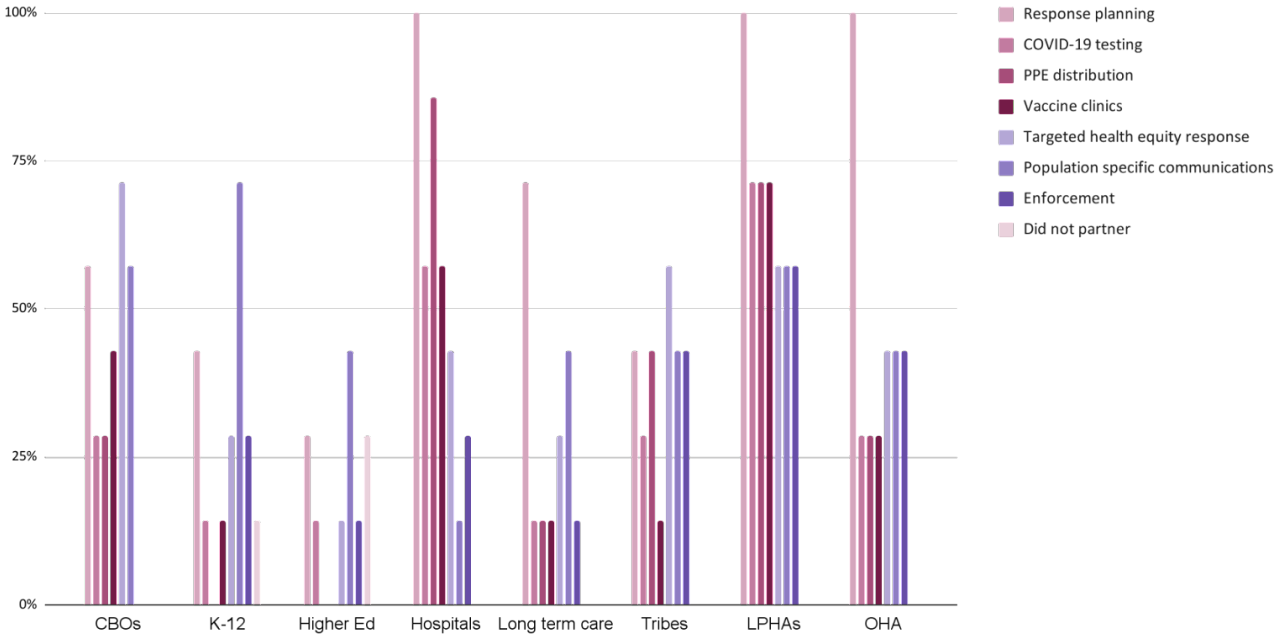
Figure 10: Rating of OHA Communication with Public, Stage 4



Partnerships

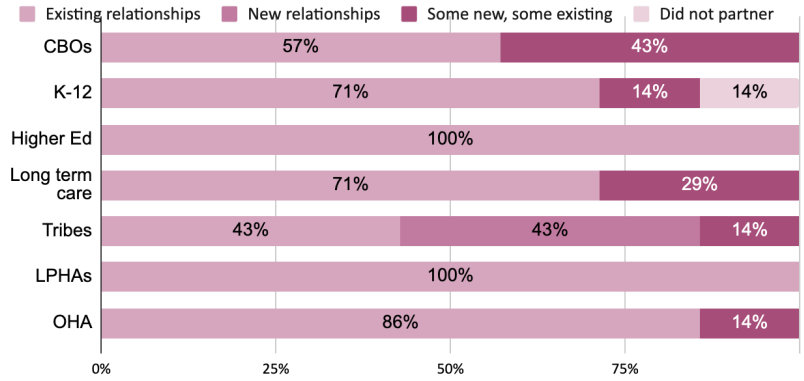
CCOs engaged in many COVID-19 public health response activities with partners. All CCOs who responded to the survey (N=7) partnered with Hospitals, LPHAs, and OHA for pandemic response planning. No respondent partnered with K-12 or higher education on PPE distribution, and no respondent partnered with higher education for vaccine clinics.

Figure 11: Types of activities CCOs partnered on, by organization type



CCOs developed many new relationships with partners during COVID-19 response. All CCO survey respondents reported having existing relationships with LPHAs and Higher education. One respondent reported not partnering with K-12 schools, and three respondents reported new relationships with Tribes.

Figure 12: CCO respondents with new, existing, or some new and some existing relationships with COVID-19 partners (N=7)



OR Public Health Response to COVID-19: Emergency Management Survey Preliminary Analysis

Introduction

For this study, a survey was administered to staff at city and county emergency management offices across Oregon between September 14 and September 28. Emergency management staff were emailed a survey link directly from Survey Monkey so we could track and monitor who responded. The survey was sent to a variety of positions within each agency, including Managers, Operations, Training, Community Planning, and Resilience, for a total of 128 recipients. There were a total of 23 survey responses. One respondent did not complete the survey beyond the demographic information and was excluded from analysis. In order to preserve data, we did not exclude any respondent who partially completed the survey beyond the demographic information; therefore, the denominator changes across questions. We analyzed 22 surveys, including two incomplete ones, for a response rate of 16%.

All survey respondents (n=22) had been in their position for a minimum of 6 months.

Characteristics	**n (%)**
Region	
Region 1	6 (27.3%)
Region 2	5 (22.7%)
Region 3	5 (22.7%)
Region 4	4 (18.2%)
Region 5	2 (9.0%)
Jurisdiction Type	
City	4 (18.2%)
County	14 (63.6%)
Tribe	3 (13.6%)
Other*	2 (9.1%)
Stage Involvement	
Stage 1 only	1 (4.5%)
Stage 1 and 2	2 (9.1%)
Stage 1, 2, and 3	4 (18.2%)
Stage 3 and 4 only	1 (4.5%)
All Stages	14 (63.6%)

*Other jurisdictional types included *Sheriff's Office* and *Region*

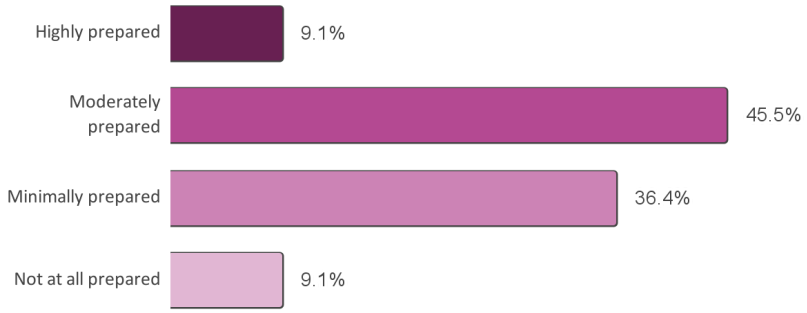
Emergency Management preparedness

City, County, and Tribal Emergency Management Office

Most respondents (54.6%, n=12) felt that their Emergency Management office/program was either highly or moderately prepared for the COVID-19 pandemic (Figure XX). Of the respondents who felt minimally or not at all prepared, respondents reported that:
"staff was not familiar with existing emergency plans or convening/coordinating an EOC"

"we were not in a position to support telework and had to quickly pivot"

Figure 1: City, county, and tribal emergency management preparedness for COVID-19 pandemic (N=22)



We can barely focus on the hazards that affect our area regularly, let alone be resourced to plan for a pandemic."

"I would say moderately prepared because there hadn't been any focus on responding to a global public health emergency that would impact supply chains, every single individual, and last as long as it did - that just hadn't been a conceivable concept for us. From an EM side, I would say out Public Health Team/ESF #8 were very prepared and experienced to manage this response - but again, the scope was just overwhelming."

One respondent reported *"We never activated an EOC before and were trying to do the work entirely virtually.*

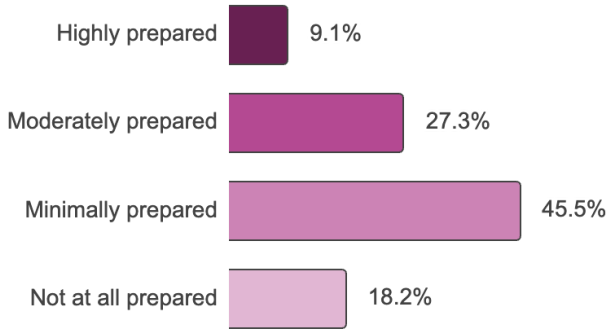
"Public Health Staff didn't have robust ICS Training - they adapted to a very complex model that others couldn't easily integrate into which provided challenges."

Self-preparedness

When asked about their individual level of emergency preparedness to respond to the pandemic (e.g., knowledge, training, experience, expertise), most respondents felt that they were not at all prepared or

minimally prepared (63.7%, n=14).

Figure 2: Emergency management survey respondents self-preparedness for COVID-19 pandemic (N=22)

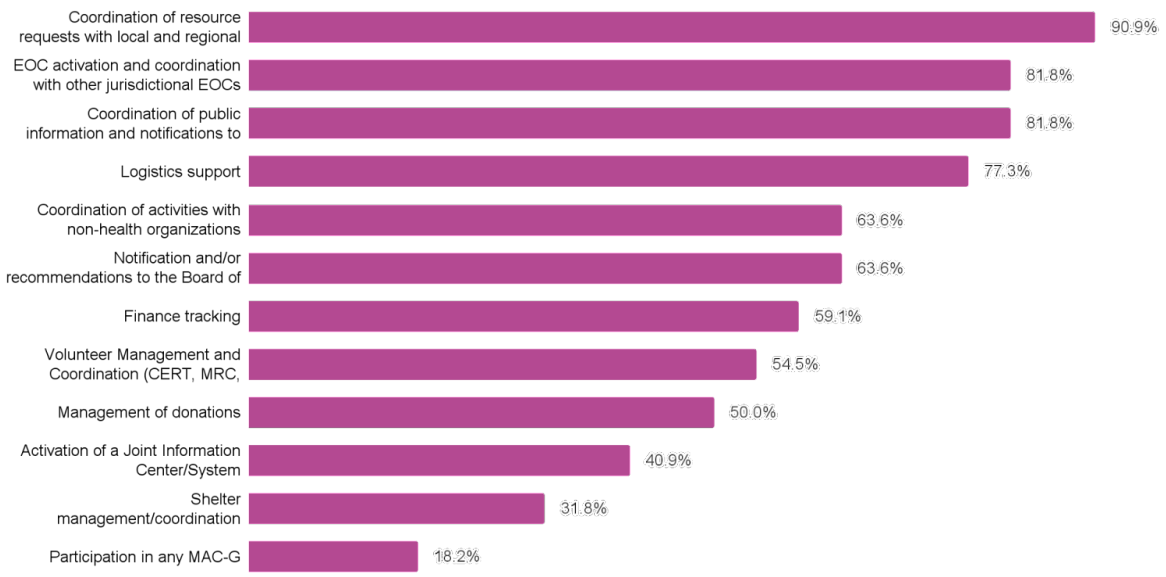


Respondents reported the following as reasons for their rating:
"I'm highly trained and experienced but nobody was 100% ready for Covid"
"I had never formally worked in emergency management
"One of the biggest problems was access to accurate information"
"I had taken training courses but never responded to an actual emergency."
"While I have never worked through a pandemic, we had plans in place for all hazards (to which there was some crossover) and also had open communications between partners involved.
"Some self education and network with nurses and Emergency service employees"
"I had expectations that our Health Department had functional plans.... They did not"
"Many years of experience, higher education in Emergency and Disaster Management, disaster logistic training and experience in all-hazard response.
"No prior knowledge of a pandemic, I believed that Public Health would have taken a more active role in the beginning.
"We don't do much pandemic planning; it's Health Dept duties"
"I had served on a couple of disasters previously, had attended and facilitated trainings, was confident operating in a remote environment"
"It was always the example of the low probability, high consequence event."
"I had only been in my position about 5 months before COVID hit."
"As an emergency manager I would say I was prepared to establish an Incident Command System Structure that provided [my county] and our peers the structure to be successful - but with the specific topic, I was not prepared at all… this event was at a whole new scale."
"No training/experience in pandemics. Unfamiliar w/ supply chain details.

COVID-19 Response Activities

Types of Response Activities

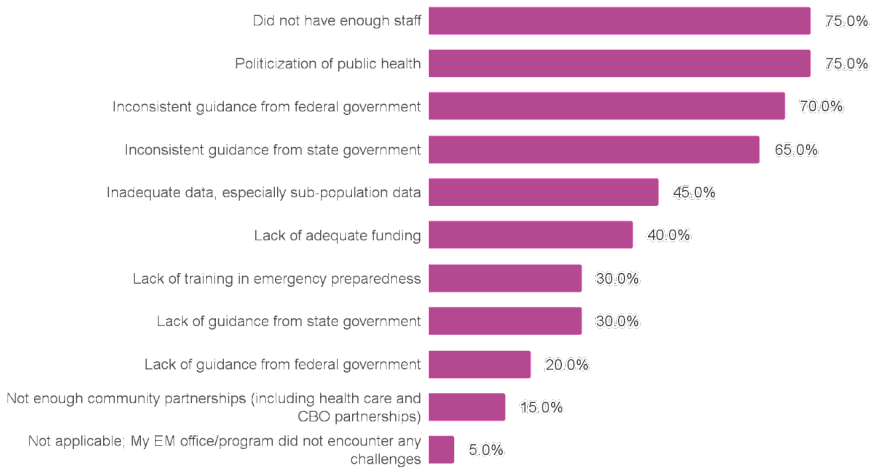
Figure 3: City, county, and tribal emergency management COVID-19 response activities (N=22)



Challenges to Reponse

Almost all respondents (95.1%, n=20) reported there were challenges that hindered the effectiveness, scale, or quality of their EM Office's response to the COVID-19 pandemic. Frequency of reported challenges are reported in Fiugre 4. The top 5 most frequently reported challenges were lack of enough staff (71.4%), politicization of public health (71.4%), inconsistent guidance from federal government (66.7%), and inconsistent guidance from state government (62.0%), and inadequate data, especially at the sub-population level (42.9%).

Figure 4: Challenges that hindered effectiveness, scale, or quality of city, county, and tribal emergency manangement's response (n=20)



A few respondents reported other challenges, which included the following:

"Mandates. You lose Eastern Oregonians when you mandate anything - the communication for metro cannot be the same for rural."

"Lack of understanding from Leadership, particularly around how EOC/EM is supposed to go. No organizational buy-in at the top for how much extra work all of this took from staff in addition to every day work and trying to do it all remotely."

Some respondents opted to elaborate on their challenges:

> *"Public Health and Emergency Management Programs in most areas are different and are not connected as well as they should be. Emergency Managers at the County level are sometimes also their PHEP Coordinators or Search & Rescue Coordinators, or the PHEP is someone entirely different and they don't' integrate well or at all together to coordinate response efforts. OEM provided guidance and OHA Provided guidance but they didn't align which made it hard for us the local level to align and move forward to some degree. "*
>
> *"Mandates don't work. Once it's mandated, people dig their heals in. They stop listening. They stop complying. They stop learning."*

Thoughts on Oregon's public health response to COVID-19 pandemic:

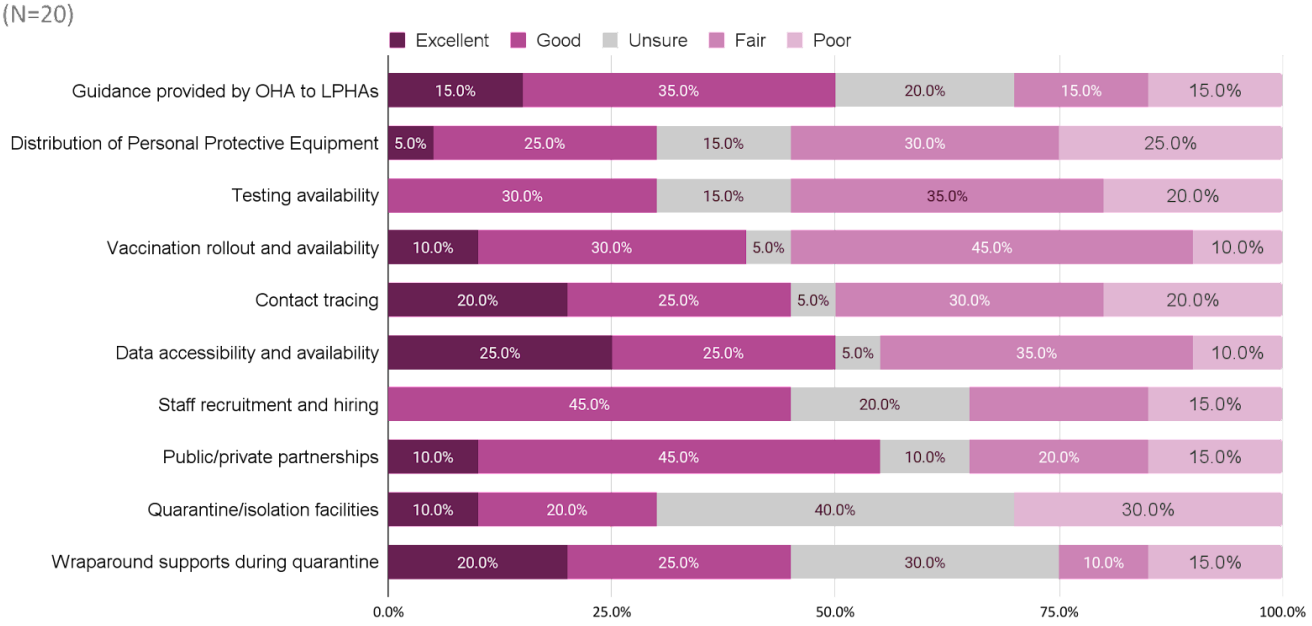
> *"OHA had a lot of rules and rude things to say to counties w/o any proof or understanding of what was going on in counties with smaller populations. They pointed fingers, placed blame on everyone but themselves, and were nasty to some of the nurses/doctors on the front lines dealing with the blow back from all of their rules. They should have provided every county with a team to do testing and vaccinating to take some of the heavy lift off of public health. This would have provided them with MUCH better expertise and understanding of what was truly going on in each county. Instead, that wasn't provided until just a few months ago when it was no longer needed. And they sent these teams anyway and they also came unprepared! We had to provide them with vaccine and supplies! Outrageous. Even a liaison for each county would have been nice. Someone to buffer Public Health employees killing themselves to do their job from being attacked by folks who were ultimately clueless and rude. Some of our best people QUIT because of OHA."*

"State, county and locals need to be better intersected in these events. Inconsistent supplies, information, networks made efforts less effective."

"OHA regularly changed not only guidance but resource request processes. This created a lot of additional frustration and work."

The state (OHA, OEMD) was not good, many things were not done at a satisfactory level. Whether it was the "Push" model for PPE, lack of staff, poor data, etc. It was not a positive response."

Figure 5: Emergency management survey respondent's rating of Oregon's public health system response to COVID-19 (N=20)



Supporting PPE Distribution

Almost all respondents (95%, n=19) reported their EM office provided support to LPHAs for PPE distribution.

Biggest Challenges in Supporting PPE Distribution of PPE:

"We did not know when, or how much, or what kind of PPE was coming to our county."
"Resource ordering and tracking."
"Definitely the supply chain/access to materials was the biggest challenge. Those initial weeks and months of the pandemic we stressful times for everyone, but even more so for work locations that required the appropriate PPE to perform their work -and unfortunately, we weren't able to supply that adequately for some time. The blame should be shared collectively as we did not prepare well enough for this type of supply distribution needs, and we need to collectively identify solutions for future situations that would require similar response efforts (that are not always public health-related). This of course was an unusual event that saw the entire globe competing for supplies - but can the United States, Oregon, and the our jurisdiction adjust our preparations enough to be more resilient locally?"

“Sites note pre arranged. Supplies slow in coming. no inventory information known in advance. Had to make phone calls and even private purchases from stores. Same with Vaccination - no prearranged sites, offered several city buildings but county was not ready to distribute any resources outside of county seat city”
“Finding volunteers and sites willing to distribute”
“The use of the "PUSH" Method was awful! It created a logistical nightmare! Communications at the start of it were awful, and they barley got any better. "Pushing" supplies, not requested, is not OK, it caused us to have our limited warehouse space to be so full, it became a serious fire danger. DONT USE THE PUSH METHOD AGAIN!”
“Staffing. Our EM office distributed all of the PPE and we have a very limited staff.”
“Where do I start? FEMA pushing PPE to jurisdictions. Storage. We had no clear instructions how Health would be giving out the PPE; 20% of the PPE was "held" for a rainy day by Health, then we ended up with way too much PPE and couldn't get rid of it. Most of it expired.”
“Finding out where to get them from”
“The diversity in the PPE we received, inventory and making sure the right type of PPE was distributed back to the people who needed.”
“Finding PPE. There was a lot of issues with finding recommended N-95's and kn-95's for both local needs as well as first responder.”
“Acquiring quality PPE. Also the continued changes in OHA requirements was a challenge”.
“OSFM went direct to Fire Defense Boards, but OEM went straight to EM's and were given different directions for stockpile.”
“Managing the inventory and distribution by myself. I could have used a part time person to take over PPE Distribution.”
“Supply: Too much hand sanitizer, and not enough N95 masks”
“Lack of PPE.”
“Getting PPE to the teeny communities who were hours and hours away in our huge county. We have a huge county mileage wise but not people wise.”

Biggest Success in Supporting PPE Distribution:

“Still able to support those who needed the PPE”
“the process for resource requests and delivery was always smooth and timely”
“The biggest success was the implementation of our EOC Logistics Section. This section had been minimally staffed for real-world and exercise events in the past - however, this extended activation provided the Logistics Section the opportunity to develop specific processes and plans, build staff experience in their roles (and other roles), and emphasized the importance of this section to response operation.”
“Volunteers and private purchases allowed city to distribute widely without waiting for county resources. Post event solid relationships build then continue now.”
“We were able to coordinate numerous events that were very well received.”
“There is no big success, we barley survived it! We had way to much PPE "PUSHED" on to it based on inaccurate data!! The State, “OHA, and OEMD Must never use the PUSH method again, they need to

remain in the standard disaster response logistical ordering process, where items are "Pulled" in the form of requests to the State."
"We made the distribution work for us, even with our limited Medical knowledge and staffing levels, I believe we served our community in a very effective way."
"Giving the PPE to those agencies that needed it. Long Term Care Facilities, etc. They were very grateful."
"The level of participation of people wearing PPE"
"We distributed a lot of PPE"
"Being able to source through the State enough PPE to be able to give it out to the struggling local businesses
"Coordination with local users...clinics, EMS, fire, LE, etc."
We had more than enough to distribute to business early on-they were all thankful and appreciative for the support. ORNG provided staff to unload and stack as well as transport so we didn't have to pick up."
"With the State's help, I was able to keep stocked up, for the most part, of what our medical community wanted/needed. "
"No one ran out, we were able to share resources and make it all work."
"We worked with what we had."
"Because we ordered early and COVID hit us later, we were VERY well stocked and ready to go when it did arrive. We had enough PPE to give out where ever it was needed and we did. We drove all over our huge county to get to those teeny communities so they had PPE as well."

Supporting isolation and quarantine

Few respondents (28.6%, n=6) reported their EM office provided support to LPHAs for isolation and quarantine. Some of the challenges in supporting isolation and quarantine experienced by EM included logistical challenges, particularly for specific populations (e.g., unhoused), and community mistrust in isolation and quarantine guidance.

Biggest Challenges in Supporting Isolation and Quarantine:

"Getting people to trust that they were necessary"
"Dept. of corrections releasing exposed inmates in our County without consideration or coordination."
"Setup a camp/shelter for the unhoused at Fairgrounds and it was difficult to manage."
"N/A My role didn't extend beyond getting the phones."
"We have a county full of anti-government people. They did NOT want to do what was requested of them and didn't. In a small community, everyone knows who has covid and we'd see them in the grocery stores or out and about. They didn't believe the state so they didn't believe public health when they told them the rules for isolation and quarantine. Our small hospital could not handle more than one covid patient so they were sent to other hospitals to be cared for. Not allowing individuals visitors was a HUGE challenge and really, really wrong for those who ended up dying alone and without proper goodbyes. Those families will NEVER recover from the damage done by the state and feds rules. Very sick and cruel - especially when those family members had already been exposed! Husbands and wives share the same bed, yet they were not allowed to share a room while sick with covid? Makes absolutely NO sense. Such absolute cruelty and violates every doctor's code of conduct to do no harm."

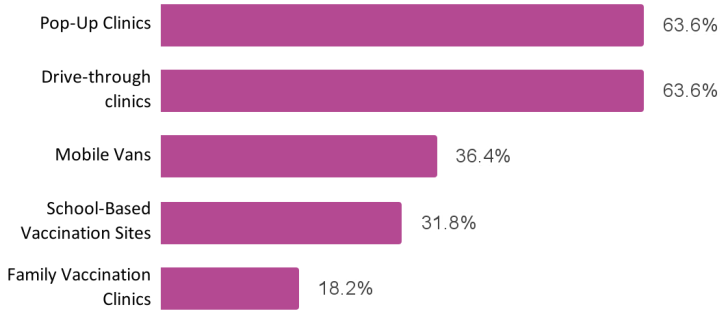
Biggest Success in Supporting Isolation and Quarantine:

"The level of voluntary quarantine"
"Our local health agency took the lead on I&Q. Good coordination with local health."
"We are able to secure an ACF and use a building that was mothballed and resources on hand to make it work"
"My office coordinated with Verizon to provide mobile phones for Contact Tracers."
"We were able to somewhat handle our population without having to open medical shelters."

Supporting vaccine distribution

Almost all respondents (90.1%, n=20) reported their EM office provided support to LPHAs for vaccine distribution. Figure X reports on types of vaccine distribution methods supported by EMs.

Figure 6: Vaccine distribution methods supported by City, County, and Tribal Emergency Management (N=22)



We also looked at vaccine distribution methods by region to see if there was any variability across the state, see Figure 7. Region 3 supported more drive-through clinics (n=5) than other regions.

Vaccine distribution methods supported by city, county, and tribal emergency management, by region (N=22)

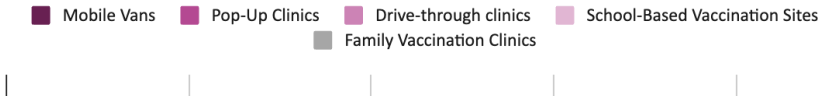
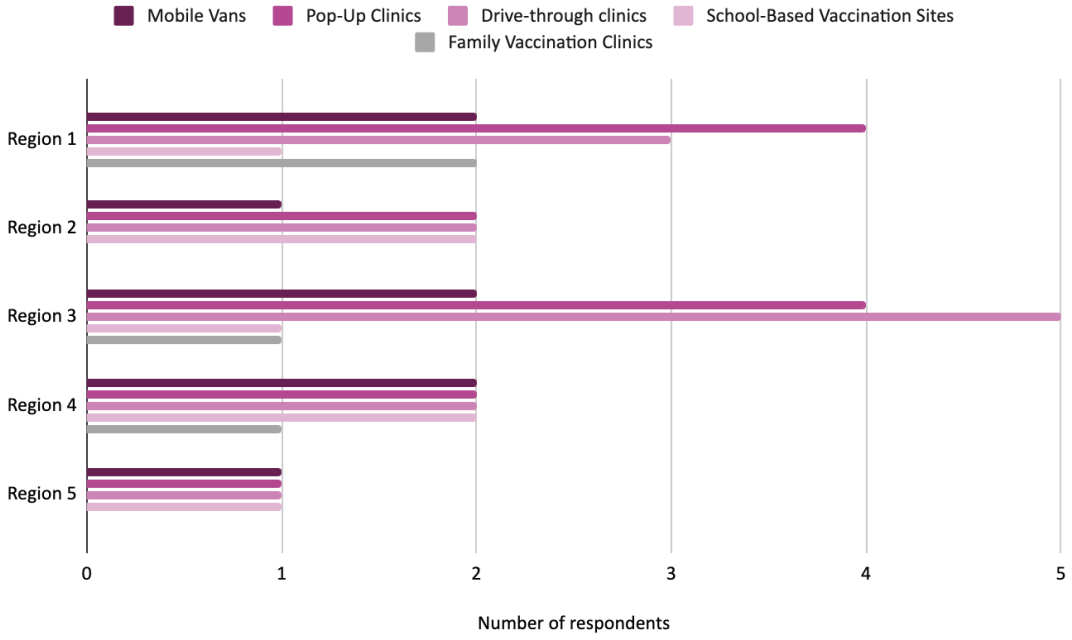


Figure 7: Vaccine distribution methods supported by city, county, and tribal emergency management, by region (N=22)



Biggest Challenges in Supporting Vaccine Distribution:

"logistics"
"volunteers"
"Rural area"
"*the documentation needed between all parties, unclear expectations and communication for logistics coordination in the early planning stages, not knowing how many people to plan to serve (made it hard to designate space to support existing services and allow for vaccinations, and to justify support for additional clinics with workplace management)*"
"*Scheduling appointments, ensuring cancelations and rescheduling was covered*"
"*Communication and coordination with our Public Health nurse and with our community partner who provided vaccinators"*
"Public Health not willing to operate within a county wide "Unified Command" structure within the County EOC. Instead they made the decision to go at it alone and did not include many county departments as I would expect."
"Getting people to trust that the vaccine was safe"
"Weather and getting the information out to certain population groups."
"This was run through the Public Health division of the Tribe and excluded the EM Office. But they still used logistics and operational personnel from the EOC"
"Coordination of all the needed workers, and ensuring we had enough supplies on hand to support them."
"Poor equipment and / or facilities. We purchased tents but they were not adequate. Some best practices would be welcome."

"Coordination and resource support."
"Getting participation from the community. We were prepared to vaccinate thousands of people (once we started getting the vaccine), but we didn't get the participation from those that wanted shots, despite all of our Public Service Announcements and public education attempts."

Biggest Success in Supporting Vaccine Distribution:

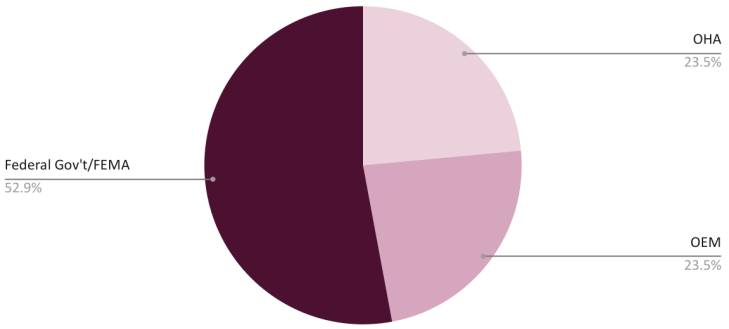
"overcoming the logistics problems"
"We were able to provide staffing assistance for the clinics and two large venues for mass vaccination sites."
"We were able to vaccinate first responders and frontline workers successfully."
"We lead the number and percent of vaccines administered in the state for months!"
"Not giving up, even when we had low turn out."
"The number of people that got the vaccine"
"Many people were vaccinated"
"The smoothness of how they all operated once they were stood up. I was really encouraged to see also the community being so responsive and orderly within the vaccination sites. "
"Good County support and funding"
"All of the partners that stepped up to help. Interagency partnerships were what made it successful."
"Our drive thru and walk in clinics all worked well with very few flaws. When a problem came up, our team worked to fix the problem. "By the time we gave our last POD, it was working seamlessly. "
"Dedicated public health director."
"We had clinics at the fairgrounds and because our population is small, we were able to vax and move ahead on the state's timeline quickly. Even though the state tried to shame us for not doing enough, we did. We even vaccinated people out of county and state because we had so much vaccine and it was easy to get into our clinics - we got NO recognition from the state for anyone we vaxed who was from another county/state. That was ridiculous. They got it HERE, they should count as a vax for HERE."

Funding

Over half (54.5%; n=12) of respondents reported their EM office received COVID-19 specific funding. Funding sources among EM Offices receiving funding are shown in Figure 8.
Many respondents reported barriers to efficient use of COVID-19 funding, which included the following:

- Length of time it took to receive funds (33.3%; n=4)
- Model of funding (e.g., reimbursement structure) (33.3%; n=4)
- Reporting requirements (16.7%; n=2)
- Spending requirements of funding source (8.3%; n=1)

Figure 8: City, County, and Tribal emergency management COVID-19-specific funding sources (N=12)



- County-level administrative requirements (8.3%; n=1)
- Other barrier not listed (41.7%; n=5)

Some respondents elaborated on these barriers to efficient use of funds:
"submitting documentation was cumbersome took two employees weeks. Relies on centralized purchasing & inventory model which many locals do not use."

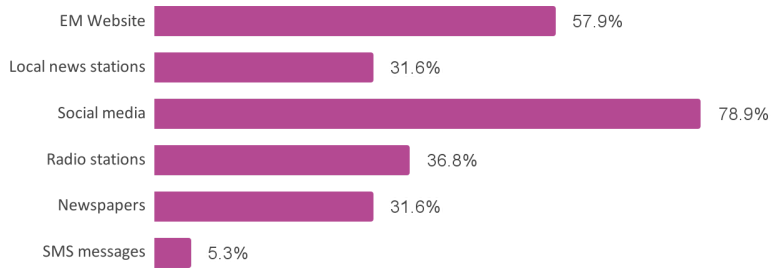
"The funds went to the public health program and then only kind of trickled over to EM. The two were confusingly intersected in some places and separate in others."

Communications

Supporting public information dissemination

Of respondents, 83.3% (n=15/18) reported their EM assisted state or local public health for public information dissemination. One respondent (5.3%) reported their EM did not utilize any mass-reach platforms for public information dissemination. Of the remaining respondents, mass-reach dissemination platforms used are reported in Figure X.

Figure 9: Public Information Dissemination Platforms (N=18)



Biggest Challenges in Supporting Public Information Dissemination:

"Lots of conflicting information from the outside"
"the constantly changing or vague guidelines for risk levels and reopening guidance"
"Reminding county to provide spanish translation, and to include ability, age, and color inclusive materials. Also needed ability access information for clinics so those with disabilities knew what to expect"
"Accurate and timely information from OHA"
"The information available kept changing and was quickly politicized"
"The often times mismatching information. We would hear something from one entity that went against what was being shown on say the federal level. It confused us in the EOC as well as the community at large."
"Call center capability was staffed locally rather than 211. Governor made announcements to the public before we could prepare and act upon them. Made us look dumb at the local level."
"Getting the most up to date information out to our local population."

“The information changed constantly. It was hard to make sure we were all up to date and that we'd reached everyone who needed to know.”

Biggest Success in Supporting Public Information Dissemination:

Worked with PH in supporting public info.
“Bringing awareness to public on where to get information and what local government role was vs county or state.
“Regularly produced original content to support Benton County specific messaging such as target videos and culturally appropriate messaging.”
“Making sure we were able to reach every demographic in our area, and ensuring there were resources available for all individuals.”
“Call center, JIC, and UC/IC with partner agencies in the community.”
“Participation in our drive-thru and walk-in vaccine and testing clinics.”
“Frequent communication and meetings between leadership.”
“We all worked together every day to do the best we could with what we had. Everyone understood the information was confusing, challenging, and changing and we knew we weren't responsible for any of that. lots of grace was given.”

OHA communications with the public

Figure 10: Rating of OHA Communication with Public, Stage 1

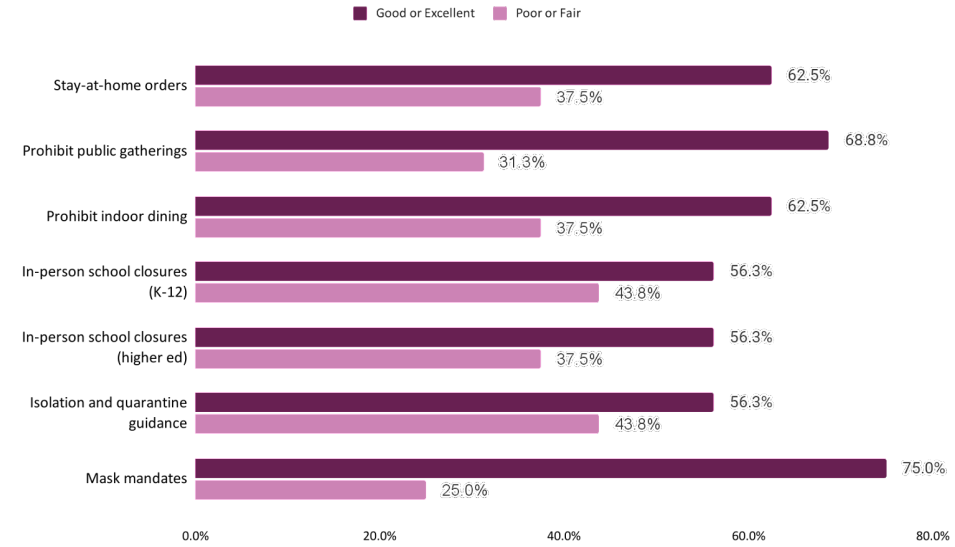


Figure 11:Rating of OHA Communication with Public, Stage 2

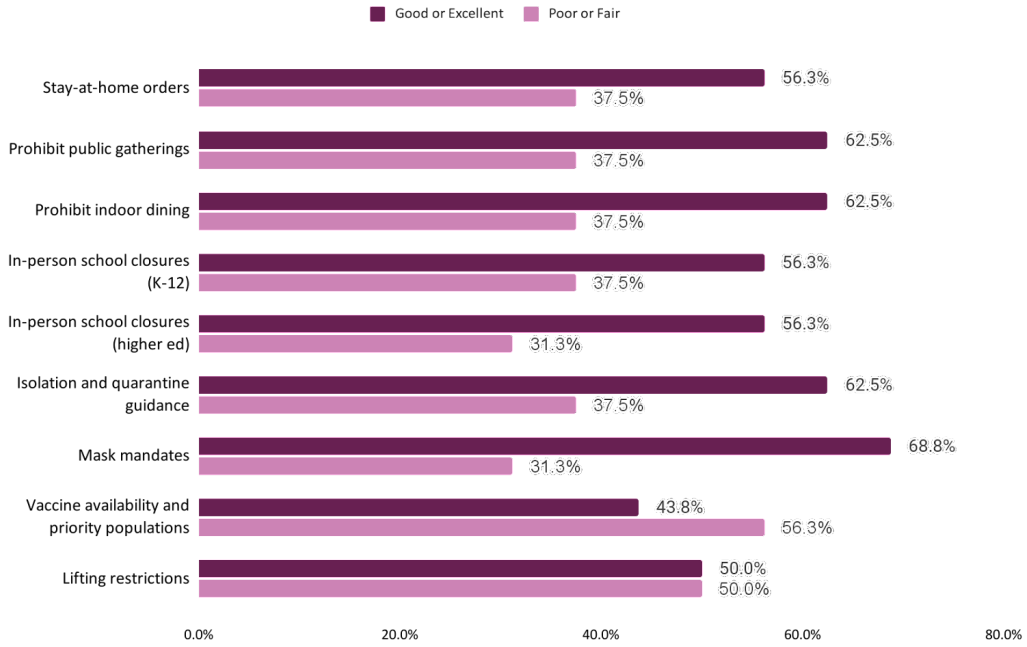


Figure 12: Rating of OHA Communication with Public, Stage 3

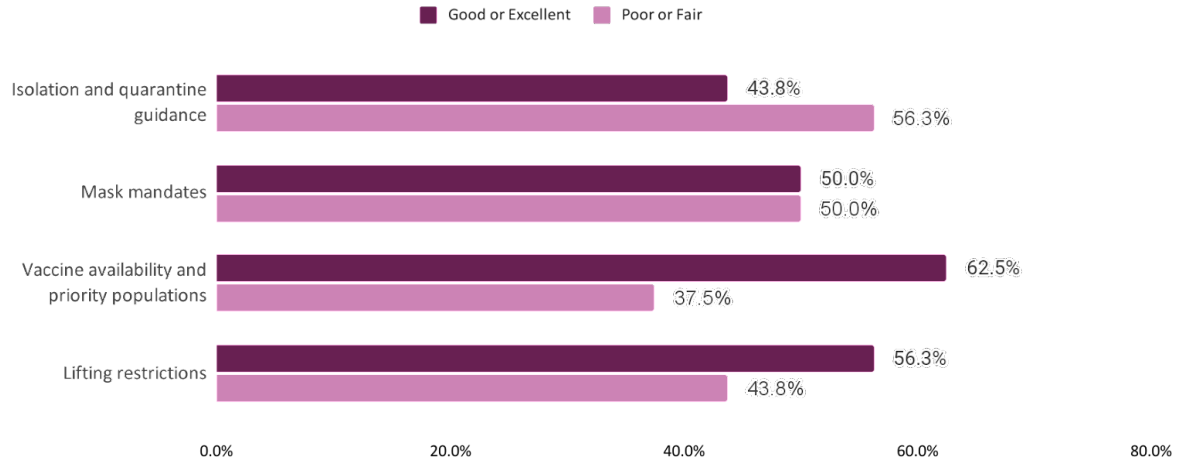
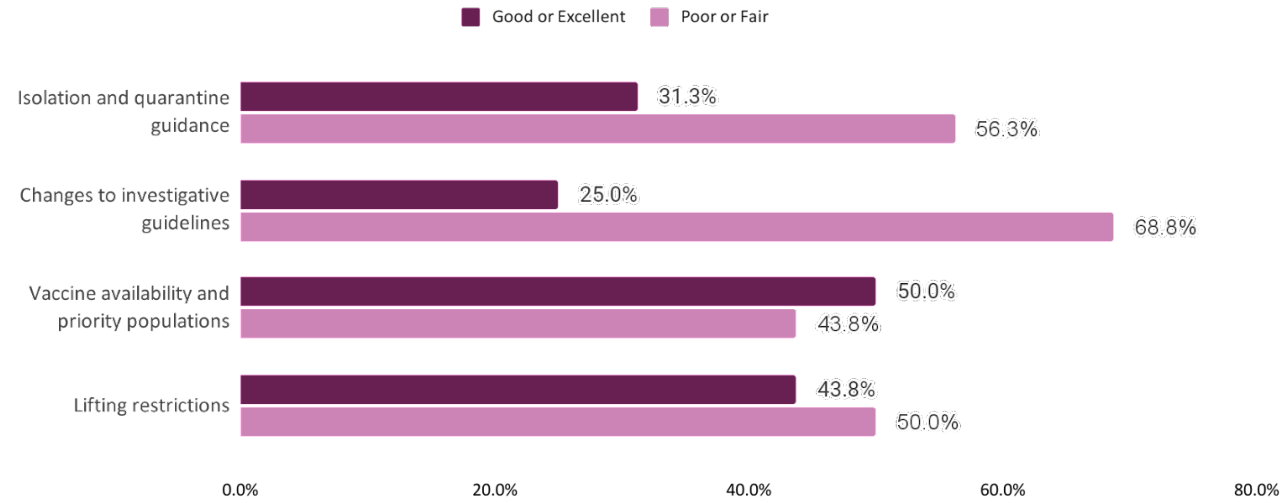


Figure 13: Rating of OHA Communication with Public, Stage 4

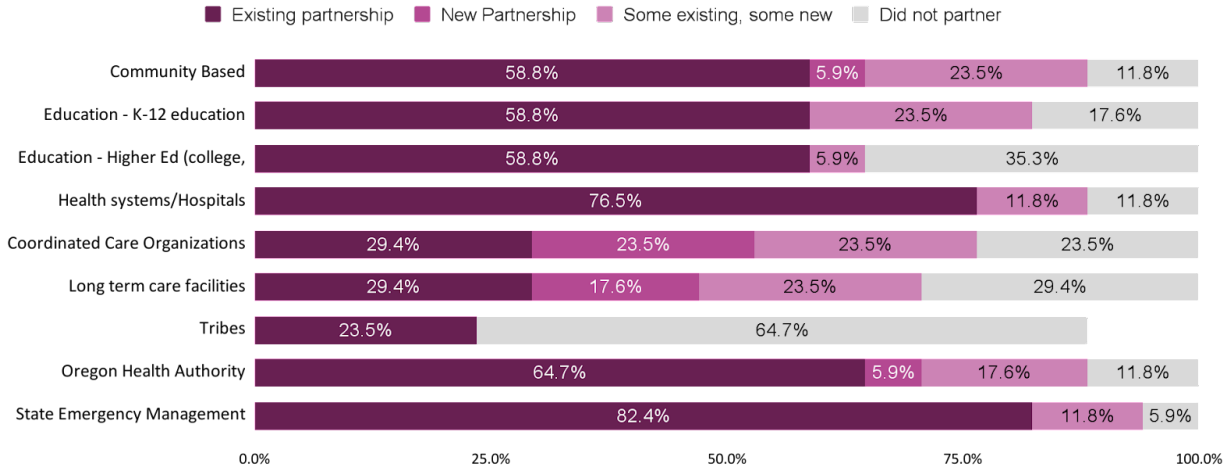


Partnerships

Types of Partnerships

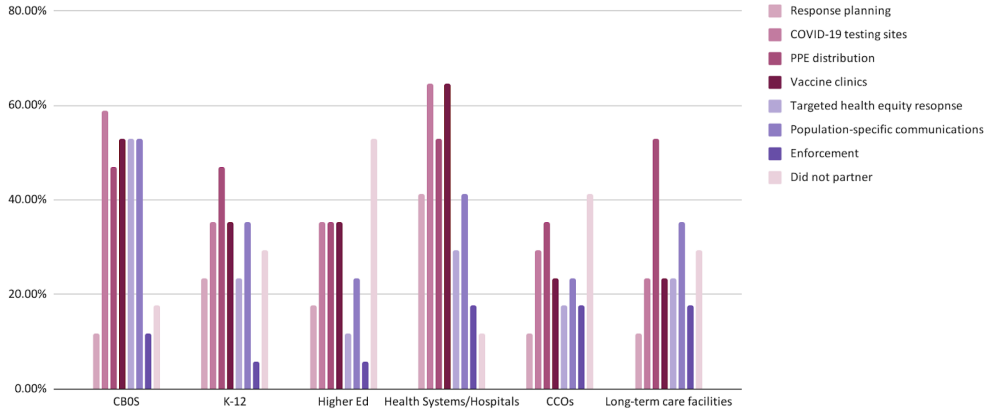
Most respondents reported using existing partnerships for COVID-19 response. There were, however, new partnerships that were made, with CBOs, Education sectors (both K-12 and Higher Education), hospitals, CCOs, Long-term Care Facilities, OHA, and State Emergency Management (See Figure X). The majority of EMs (64.7%, n=11) reported they did not partner with Tribal Organizations for COVID-19 response. Although most respondents reported partnering with long-term care facilities, about 29.4% (n=5) reported not partnering with any long-term care facilities.

Figure 14: Types of Emergency Management partnerships for COVID-19 response (N=17)



Local and Community Partnerships

Figure 15: How EMs partnered with local and community organizations for COVID-19 response



OR Public Health Response to COVID-19: LPHA Survey Preliminary Analysis

Introduction

For this study, a survey was administered to 118 LPHA staff between August 18 and September 23, 2022. It was sent to a variety of positions within each LPHA, including Administrator, Public Health Director, PH Officer, Communicable Disease Lead, Emergency Preparedness Manager or Coordinator, Public information officer, Equity lead or liaison (if applicable), and Epidemiology lead (if applicable). Forty surveys were submitted, with one respondent being removed due to only completing the demographics section. Including one incomplete survey, a total of 39 surveys are included in the sample representing 18 LPHAs, for a response rate of 33%.

Demographics of survey respondents

Eighty-two percent (n=32) of respondents had been in their role for over six months. Of the seven respondents who had been in their role less than six months, previous positions included: Communicable Disease Investigator, Office Manager, LPHA Director, Nursing Supervisor, Public Health Program Manager, and County public health director.
Across roles, 18 LPHAs are represented in the data. Fourteen respondents selected Public Health Administrator for their role, representing 13 LPHAs.

Characteristics	n (%)
Region	
Region 1	11(28%)
Region 2	12 (31%)
Region 3	4 (10%)
Region 4	9 (23%)
Region 5	3 (8%)
Stage Involvement	
Stage 1 Only	0
Stages 2, 3 & 4	3 (8%)
Stage 3	1 (3%)
Stages 3 & 4	1 (3%)
Stage 4	2 (5%)
All 4 Stages	32 (82%)
Current Role (Respondents could select all that apply)	

LPHA Administrator	14 (36%)
Emergency Preparedness Manager or Coordinator	10 (26%)
Communicable Disease Lead	9 (23%)
Epidemiology Lead	6 (15%)
Public Information Officer	4 (10%)
Equity Lead or Liaison	4 (10%)
Public Health Officer	3 (26%)
Other	7 (18%)

Emergency Management preparedness

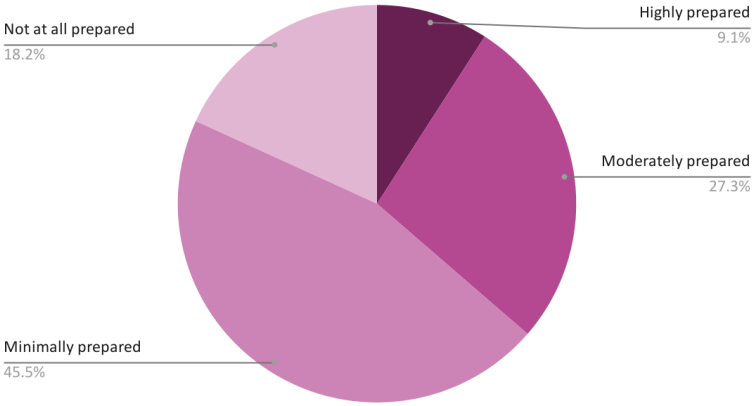
LPHA preparedness

LPHA emergency preparedness increased as stages progressed. At Stage 1, only 41% (n=16) of respondents felt their LPHA was moderately or highly prepared, but by Stage 4 this had increased to 90% (n=35).

Self-preparedness

When asked about their individual level of emergency preparedness to respond to the pandemic (e.g., knowledge, training, experience, expertise), about half of respondents felt that they were not at all prepared or minimally prepared (53.8%, n=21). Respondents reported the following as reasons for their self-assessment:

Figure 1: Self-preparedness for COVID-19 pandemic



Highly prepared:

"I've been trained as a PIO in ICS structure for about 10 years."
"PH Prep Coord since 2010"
"We had plans built for mass vaccinations and outbreaks, which should have been used daily. But we also had a bunch of Health Department Leadership turnover, and the interim leadership, did not understand how to put emergency plans to use, and were prone to panic and exaggerations."

Moderately prepared:

"Worked as PHEP for 3 years, giving me more insight into PH"
"I had completed the required ICS trainings, and had several years of experience with communicable disease and outbreak response. I had not yet been involved in preparedness exercises, live or tabletop, and was not aware of details of public health emergency planning.
had training, and plans, but no real life experience with a pandemic response"
"Have the relevant trainings in ICS but was not in practice during H1N1, which would have been practical preparation"
"I also supervised Emergency Preparedness our county did drills etc"
"I knew it was busy and tried to stay up to date on relevant information prior to working in public health."
"I have training in epidemiology, environmental health, and had participated in various "pandemic" exercises over the years."
"High institutional knowledge but a lack of resources in place to be highly prepared."
"because I came onboard with Public Health in the middle of the response"
"I have communicable disease experience and training for pandemic response, but was not completely prepared for COVID-19"

"I have knowledge, training, experience, and expertise related to communicable disease epidemiology and emergency preparedness. I was able to train all our Covid-19 case investigators and contact tracers to support the early disease interventions during 2020.
EOC was stood up, JIC stood up and partners involved, workforce was surged after first major outbreak"
"several staff worked on H1N1. we had strong emergency management and communicable disease staff in place"
"I came in with experience/expertise of responding to COVID-19 from a different country/continent, but not prepared to respond to COVID-19 in this particular environment/health structure."
"i've been a HO for several years, we have a good response structure, but it had never been really practiced to a point to feel really ready for this"

Minimally prepared:

"First time doing the job"
"I had completed the required ICS trainings and done exercises for points of dispensing, but no further."
"Responding to emergencies - I am moderately prepared. It was the nature of the emergency that was the challenge. Responding to severe outbreak of measles across the state and nation would have likely generated a different answer."
"I had only been hired into the alcohol/drug prevention position 4 months before COVID started."
"Although I have an MPH, its emphasis is in health equity so the epidemiology/communicable disease aspects of COVID were largely new to me"
"New to all of us."
"I had basic I.S. training, I have an MPH in epidemiology and outbreak response experience but obviously no pandemic response experience"
"I was previously a reporter so I was comfortable with putting out press releases, but the verbiage and ways of public health were new to me, and of course COVID was an unmanageable beast in terms of information. I still remember a principal telling me that by the time they had a PSA translated into Spanish and ready to disseminate, the information had already been updated."
"Minimally based on staffing ability to respond. Modertely: We have conducted desktop simulations which helped in being to respond quickly in creating response guidelines, job aids, outreach to partners for collatoration, etc"
"I was new to my job when the epidemic started."
"I had only taken 3 FEMA courses (100, 200, 700). I had only partially been involved in two previous responses (Cyanotoxins and the Solar Eclipse)"
"I was involved at the very beginning - none of us had ever done anything like this before. I had completed FEMA trainings but nothing else."
"Program focus was on preparedness for bioterrorism event and rapid distribution of pill based medical countermeasures. Second area of focus was around Cascadia."
"As COVID is a totally mew thing everyone is minimally prepared for the pandemic."
"I was new to the job and our department didn't emphasize much emergency preparedness aside from ICS courses."
"Our public health department did not have an emergency plan to follow and no leadership to assign roles"

Not at all prepared:

"Started supervising EP program one month before pandemic started"
"Was anyone prepared for this?"
"I started the role 03/2020 right before the shut down. I hadn't finished training yet when shut down occurred."
"We didn't have enough PPE, hand sanitizer, etc and definitely not enough manpower to do the work required"
"I had been out of the PH arena for almost 20 years and re-entered as a temporary Public Health Worker doing Covid-19 CI. I eventually became a Community Health Coordinator and now the PHEP Coordinator."
"I was 6 months into working in Public Health, I had completed the minimal/mandatory ICS online trainings but had not participated in any table top exercises or situational analysis. The PHEP coordinator was actually working in EM, not in PH."

Pandemic response plan

Respondents were asked about the status of their LPHAs jurisdictional pandemic response plan. The majority of respondents (64%, n = 25) reported that their LPHA had an existing plan, with over half of those (36%, n=14) reporting it was updated after the beginning of the pandemic. Five percent of respondents (n=2) reported that their LPHA does not have a plan.

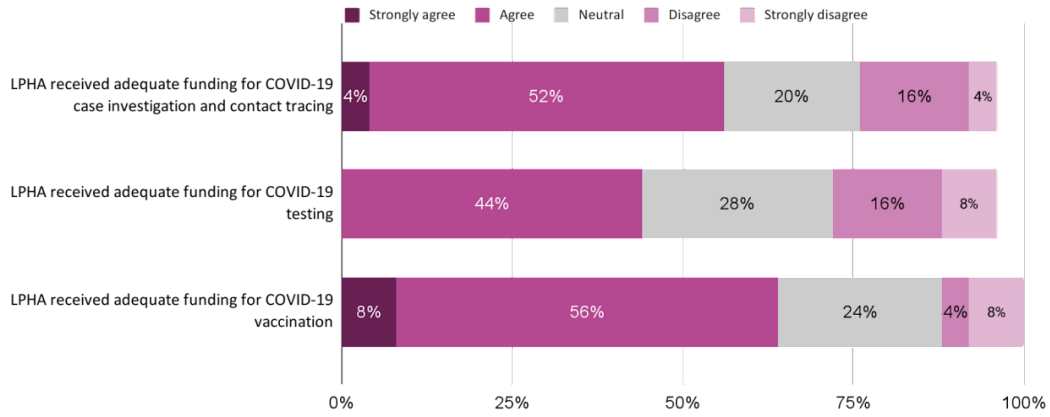
My LPHA had a plan that was developed or updated prior to the start of the COVID-19 pandemic	28%
My LPHA had a plan that was outdated that was updated after the start of the pandemic	36%
My LPHA did not have a plan at the start of the pandemic, but developed one after the start of the COVID-19 pandemic	10%
My LPHA does not have a plan	5%
I don't know	21%

Funding

Many respondents were unable to answer questions about funding, since it was not a part of their role in COVID-19 response. Five respondents reported affirmatively that their LPHA received COVID-19 funding from entities other than OHA, ten reported that they did not, and 24 did not know. Other sources of funding included ARPA, Foundation, CCO, Modernization dollars, General fund, and volunteer labor.

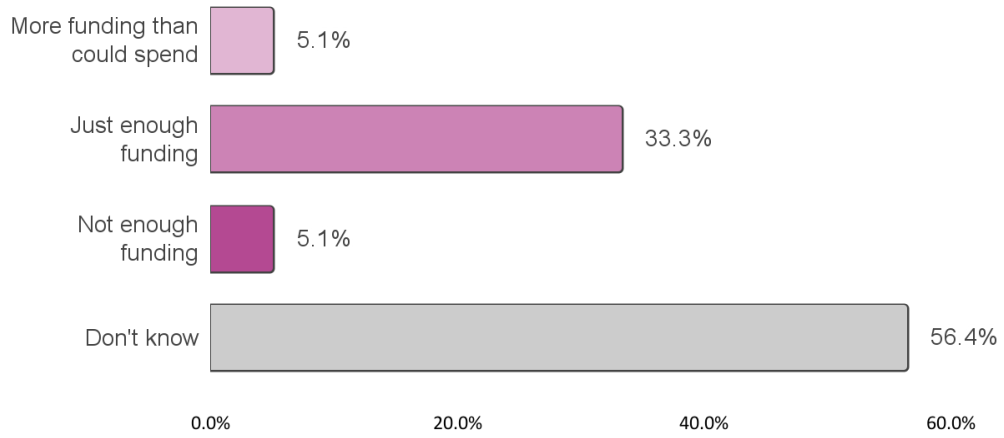
Approximately half of respondents agreed or strongly agreed that their LPHA received adequate funding for case investigation and contact tracing (n=14), testing (n=11), and vaccination (n=16). About a quarter of respondents were neutral, and less than a quarter disagreed or strongly disagreed.

Figure 2: LPHA received adequate COVID-19 funding (N=25)



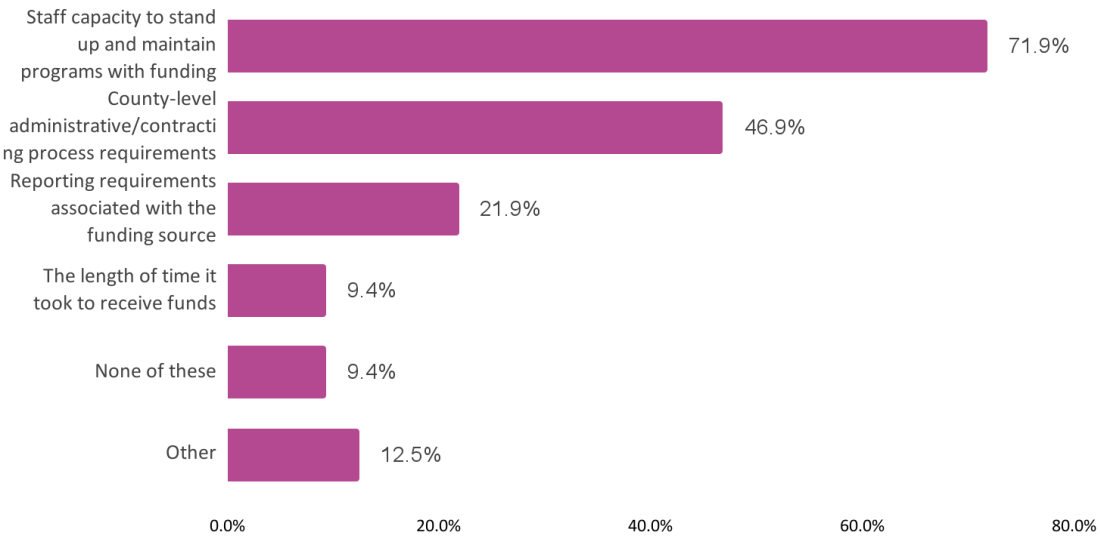
When asked if the existing Public Health Modernization Funding formula for allocation of COVID-19 funds provided enough funding to LPHAs, the majority of respondents indicated that they did not know (n=22). Of those that did provide an answer to this question, thirteen respondents reported that it was just enough funding, two respondents reported it was more funding than their LPHA could spend effectively, and two respondents reported it was not enough funding to respond to COVID-19 effectively.

Figure 3: LPHA's Received Adequate Funding with Public Health Modernization Funding Formula (N=25)



Respondents reported that their LPHA experienced barriers to the efficient use of COVID-19 funds. Nearly three quarters of respondents (n=23) identified staff capacity to stand up and maintain programs and nearly half (n=15) identified county level administrative processes as challenges. “Other” responses included *staff turnover*, *short term limits on funding*, *limitations and changes in allowance of spending*, and *lack of flexibility of certain funding streams*.

Figure 4: Barriers to efficient use of COVID-19 funds from OHA (N=32)



Survey respondents were also asked if anything was needed to assist LPHAs in managing monetary resources during a significant emergency response. The most common thing identified was flexibility within funding streams (n=29), and the second most common thing identified was a rapid timeline for making funds available (n=19).

"Other " responses included:

"Funds that were specifically provided for public health activities (aside from the reallocation of funds from various program elements)"

"We received plenty of funding, but far too late. We couldn't hire when we needed to."

"Open additional FEMA projects; statewide staffing solutions"

"more budget training for newer LPHAS in expanded roles"

"Short term deadlines on funding limits our ability. Until we were provided with a funding mechnism that lasted longer than 3-6 months, we were unable to hire permanent staff."

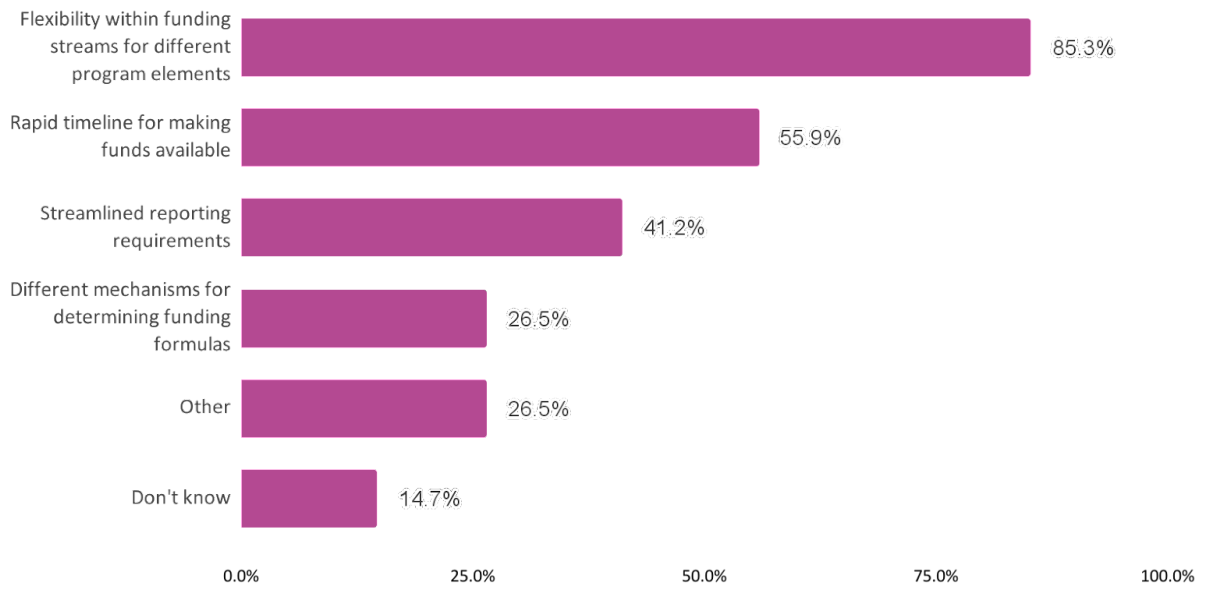
"Need to relax reporting requirements during high level of work"

"Streamlined budgeting tools - so many different budget formats depending on the program element - this can get annoying. There is a streamlined reporting system, let's move to a standardized budget format/tool across PEs"

"there was NOT an adequate infrastructure prior to the pandemic that could have supported something so long-term and of this magnitude. We did not have a system that could rapidly hire, train, retain staff at the local level. We also had to deal with the effects of the pandemic on ourselves (we didn't have remote work set ups before this, we had to move very quickly as a local government entity to figure out how to keep functioning) We have been working with the bare minimums for decades. The local HDs cannot quadruple our workforce in 30 days. Plus then we had a local issue with hiring that only allowed us to keep people for 520 or 1040 hours. We were waiting for the State or the Feds to deploy the PH Workforce but that never came so we had to keep using our same local system for over 2 years, constantly hiring dozens of people, training, re-training. We were

impacted by departures to our already very small workforce (losing 2 supervisors and 2 nurses to retirement, for example, had to recruit for key permanent position while responding to the pandemic)... Testing was something we did really well, the local university and hospital stepped up and had free tests available very fast."
"infrastructure to disperse and spend funds in a meaningful way"

Figure 5: Supports needed for LPHAs to manage monetary resources during public health emergency (N=39)

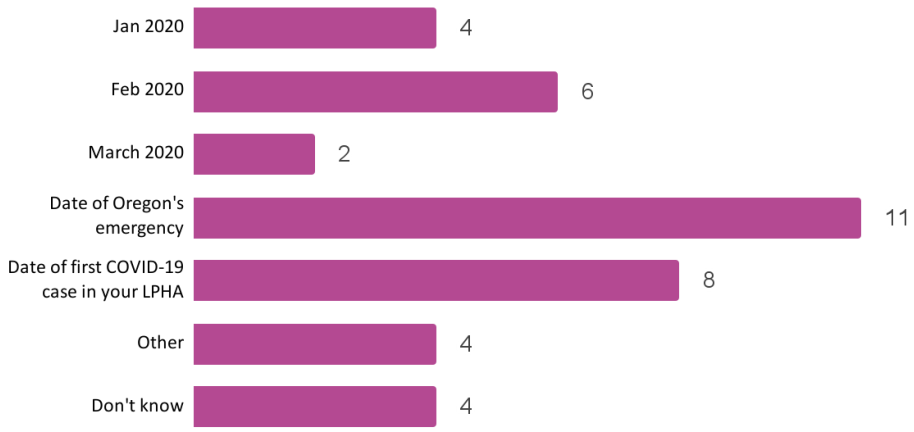


COVID-19 Response Activities

Formal Pandemic Response:

Respondents were asked when their LPHA began their formal COVID-19 response. Most respondents said it was in January or February, prior to Oregon declaring a state of emergency. The two "other" responses were "*Before first case*," and *"When it started to seem like it was going to be "a thing.""*

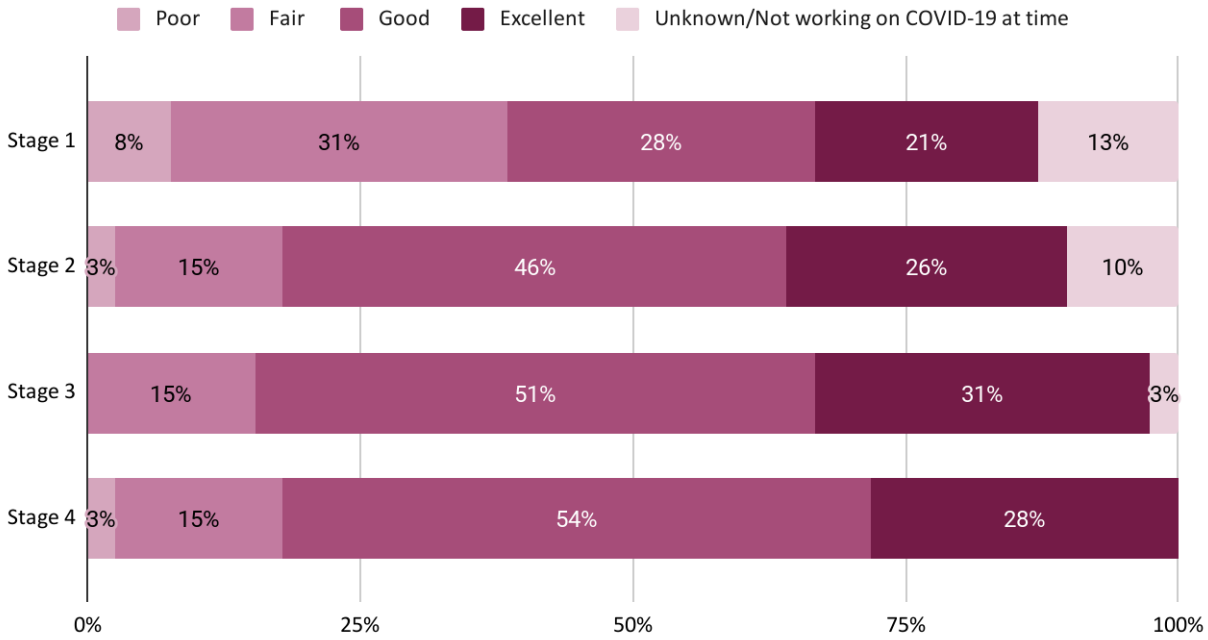
Figure 6: When LPHA began formal COVID-19 response (N=39)



Overall Response:

Respondents rated their LPHA how well they responded to the pandemic overall, by stage. Approximately 50% of respondents reported that they did good or excellent during Stage 1, and over two-thirds of respondents reported that they did good or excellent in Stages 2-4.

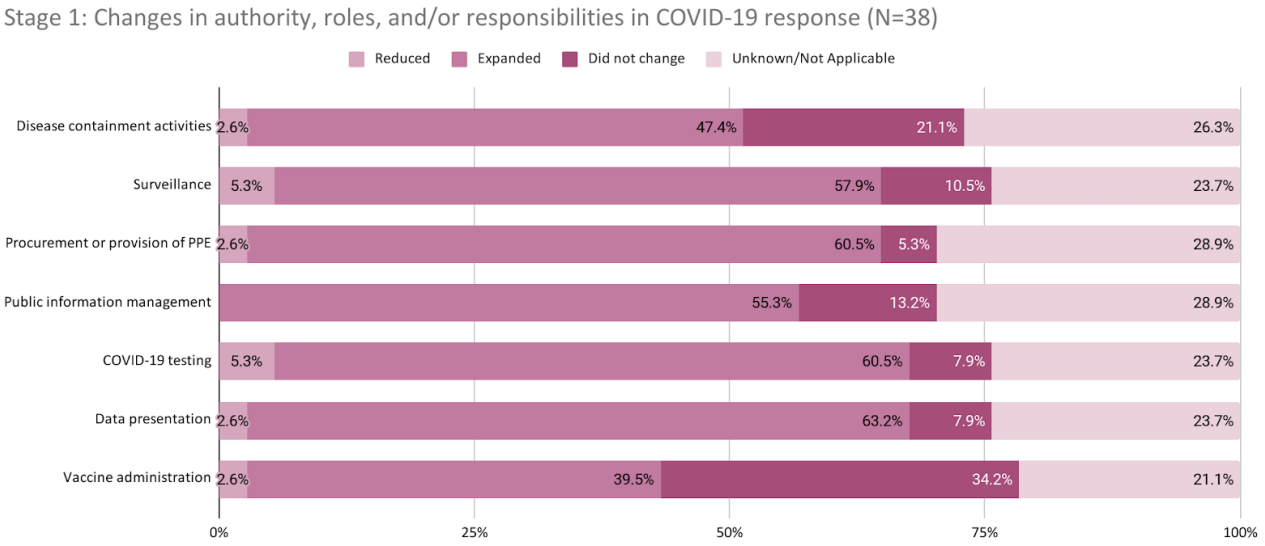
Figure 7: Rating of LPHA's Response to COVID-19 Per Stage (N=39)



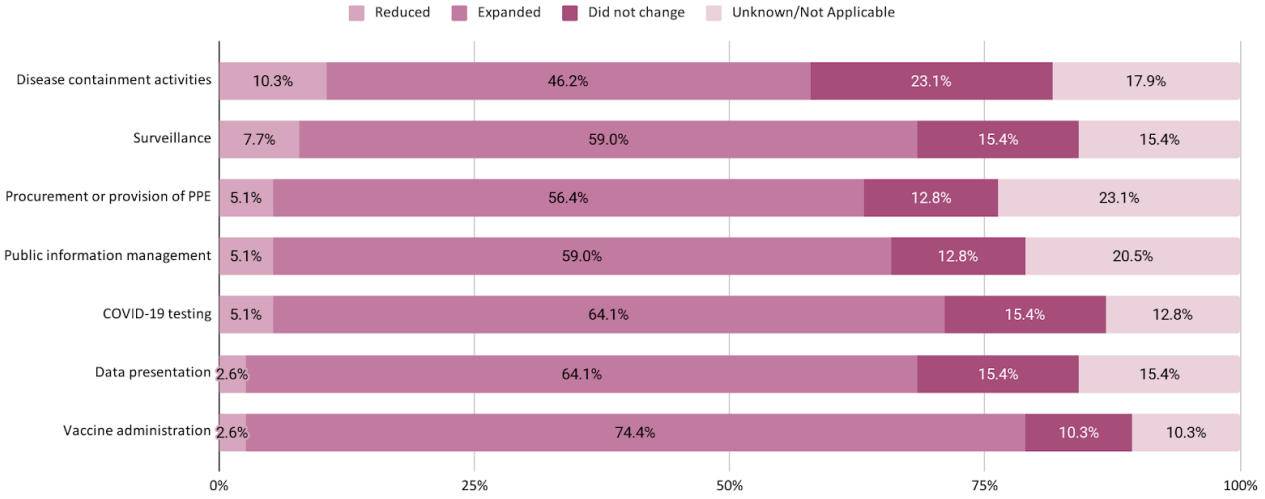
Changes in LPHA Authority or Structure:

Respondents were asked to share changes in their LPHAs authority, roles, or responsibilities in COVID-19 response by Stage. The Unknown/Not Applicable response option includes respondents that

selected either “I was not working on COVID-19 response in my organization at this stage” or “I cannot answer; this was not included in my role in the COVID-19 response.” During the first two Stages of the pandemic (March 2020- August 2021) respondents reported that their LPHA’s disease response activities expanded or did not change, but by Stage 4 (March -July 2022) many activities were reduced.



Stage 2: Changes in authority, roles, and/or responsibilities in COVID-19 response (N=38)



Stage 3: Changes in authority, roles, and/or responsibilities in COVID-19 response (N=38)

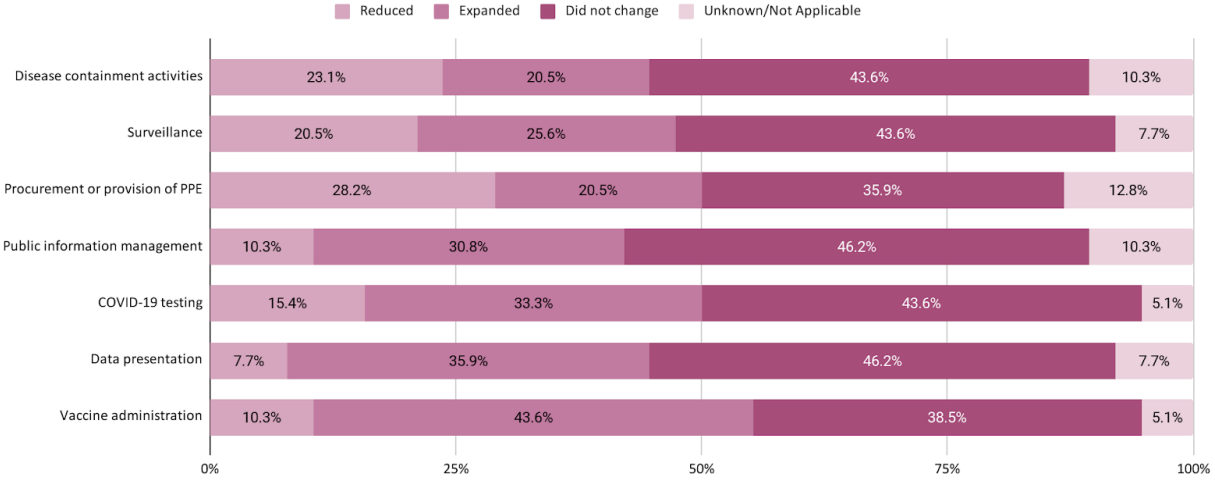
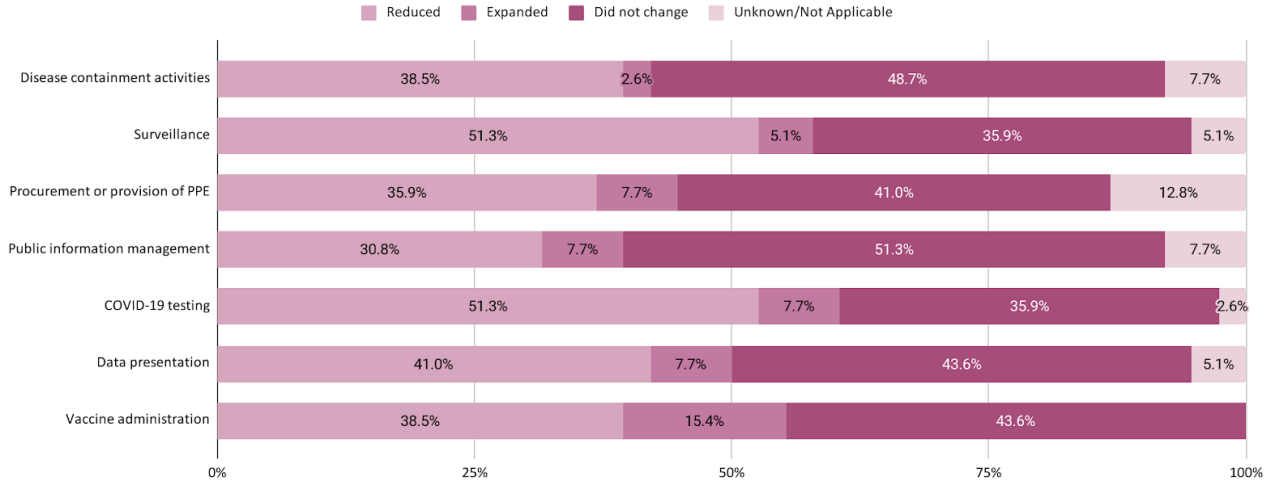


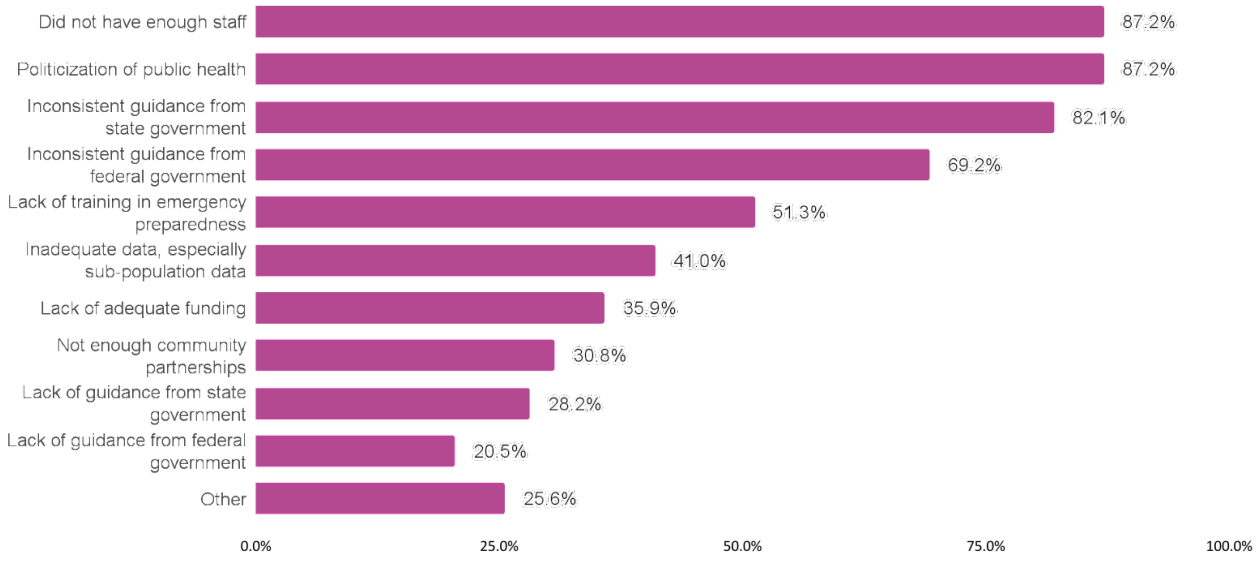
Figure 11: Stage 4: Changes in authority, roles, and/or responsibilities in COVID-19 response (N=38)



Challenges:

Respondents identified many challenges in the effectiveness, scale, or quality of their LPHAs COVID-19 response. Over three quarters of respondents reported not having enough staff (n=34), the politicization of public health (n=34), and inconsistent guidance from the state government (n=32) as challenges. Over half of respondents reported inconsistent guidance from the state government (n=27) and lack of training in emergency preparedness (n=20) as challenges.

Figure 12: Challenges that hindered the effectiveness, scale, or quality of LPHA's COVID-19 response (N=39)

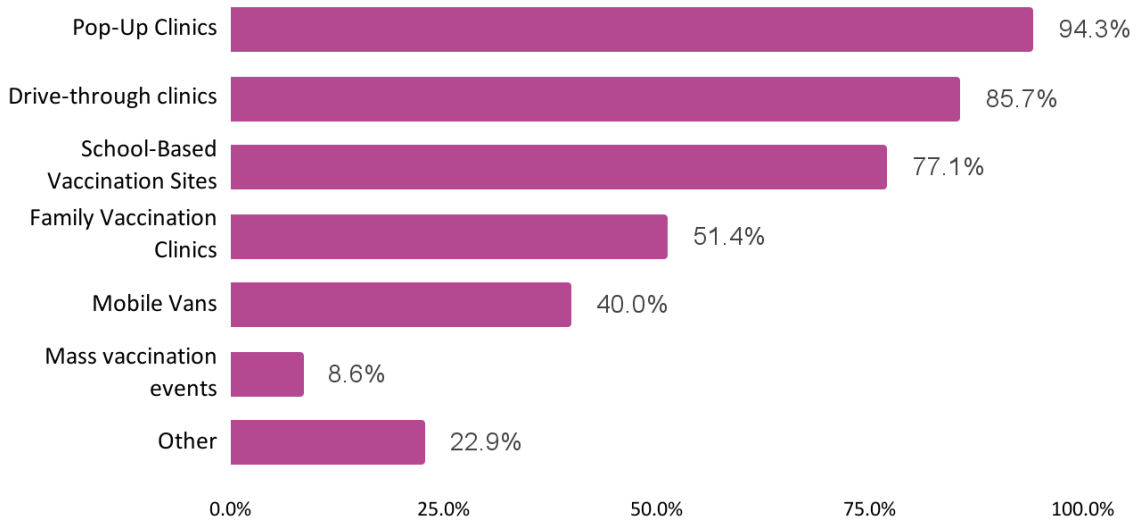


Vaccinations:

Nearly all respondents (97%,n=34) reported that their LPHA coordinated or provided vaccination clinics. The most common types of vaccine distribution methods were pop-up clinics (n=33), drive through clinics(n=30), and school-based vaccination sites (n=2). Methods included in “other” are door-to-door,

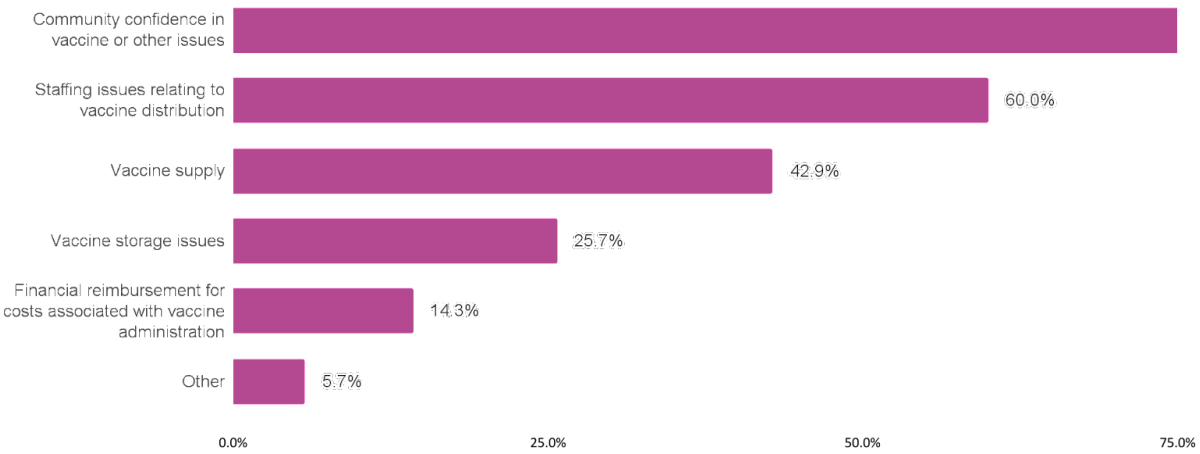
EMS fire, clinics in workplaces, community events, home health visits, drop-in, pcp clinics, and pharmacies.

Figure 13: Types of vaccine distribution methods (N=35)



The two most commonly reported challenges in coordination and implementation of LPHA vaccination plans were community confidence in vaccine or other issues (n=27) and staffing issues related to vaccine distribution (n=21).

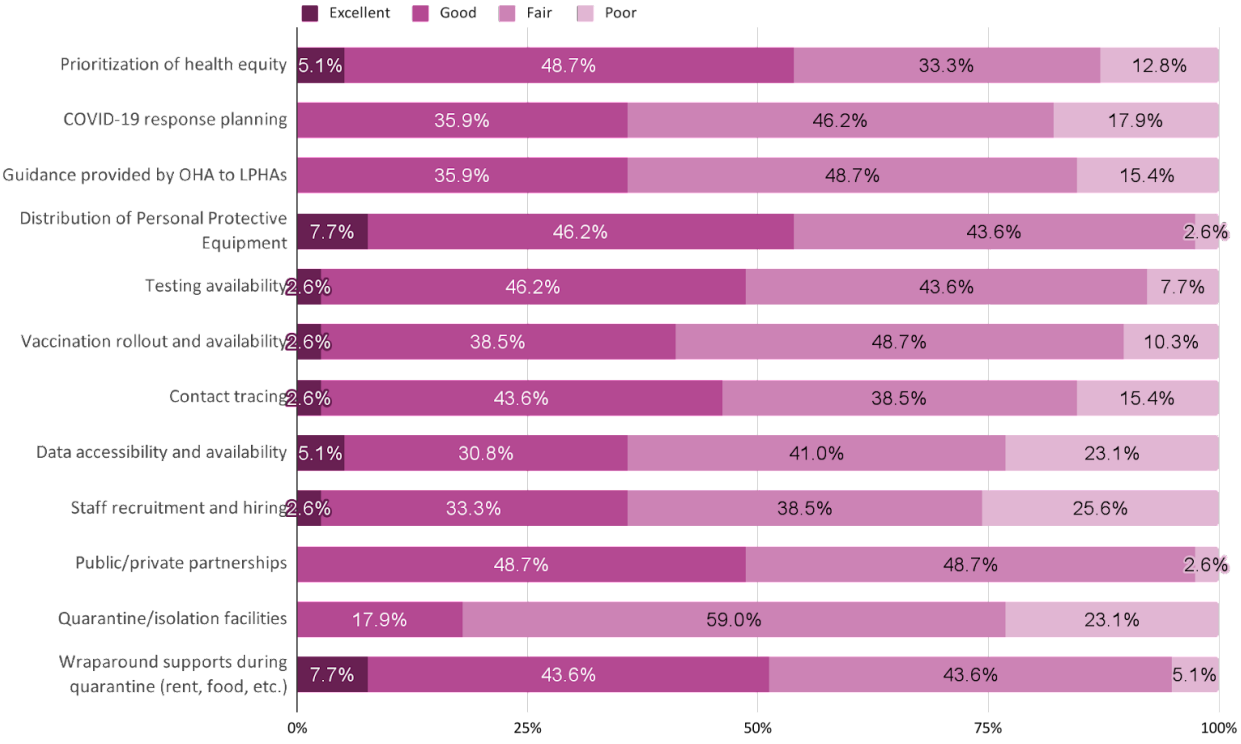
Figure 14: Challenges in coordination and implementation of LPHA vaccination plans (N=35)



Public health system response

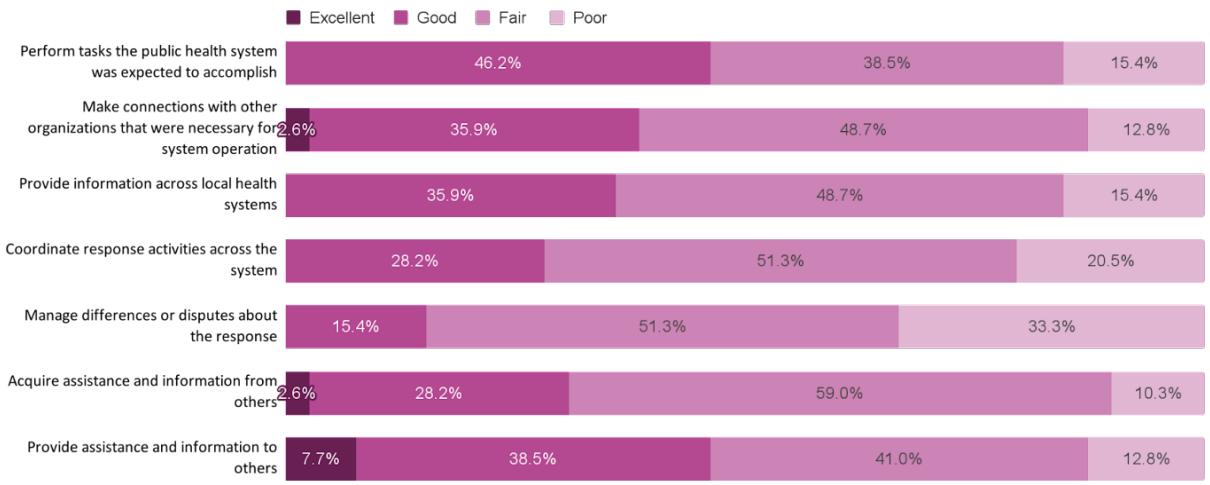
Survey respondents were asked to rate Oregon's public health response to COVID-19 across a range of activities.

Figure 15: LPHA Survey Respondents Rating of Oregon's Public Health System Response to COVID-19 (N=39)



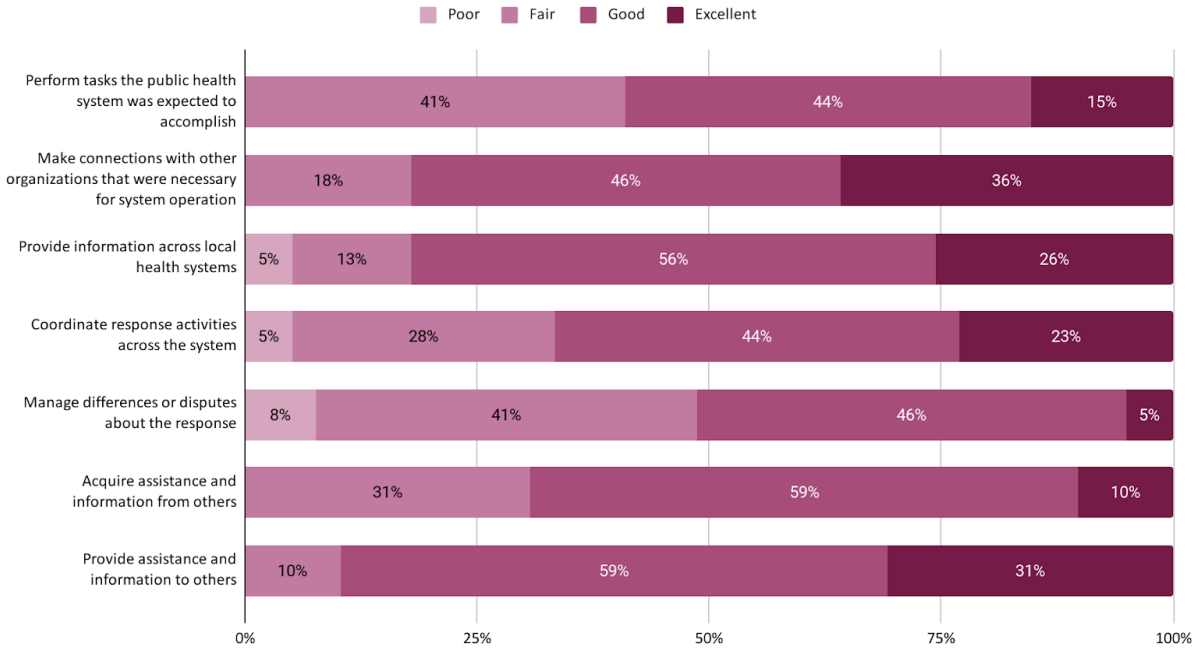
When considering OHAs role in COVID-19 response, respondents rated OHAs ability to perform a variety of public health activities.

Figure 16: LPHA respondents rating how well OHA was able to engage in the following activities during COVID-19 response (N=39)



Respondents also rated their own LPHAs ability to conduct a variety of public health response activities.

Figure 17: Rating of LPHA's ability to conduct public health activities (N=39)



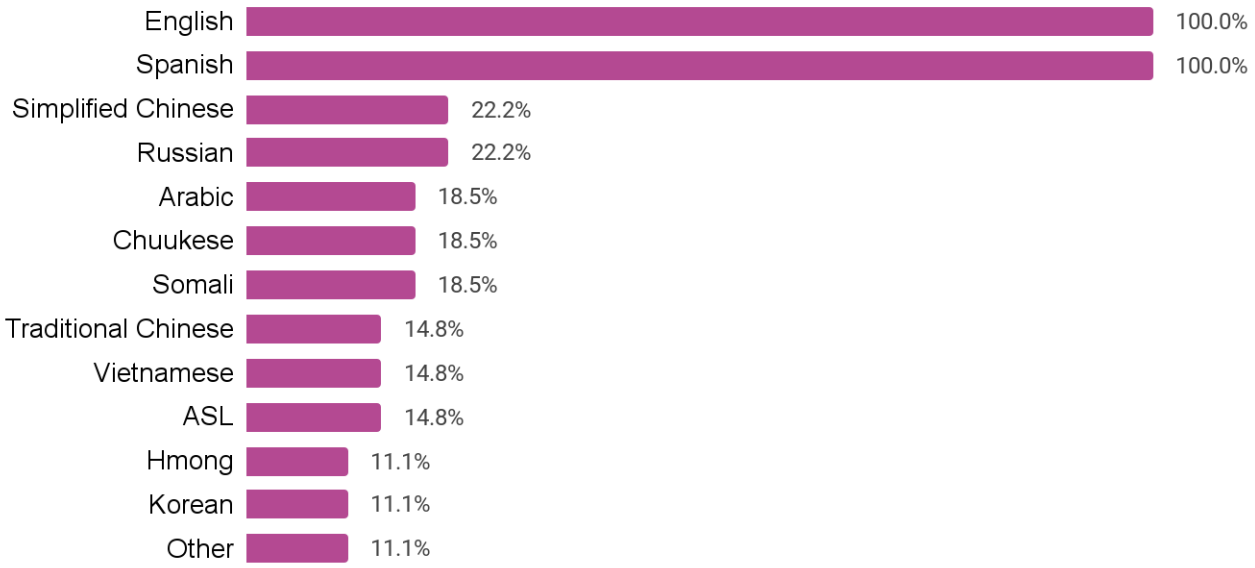
Communications

Figure 18: Types of mass media outlets utilized by LPHA survey respondents (N=34)

All LPHAs reported providing public health messaging through mass media communication methods. Nearly all respondents provided information on their websites and on social media, and over half reported utilizing local news stations, radio stations, and newspapers. “Other” mass media outlets included flyers, internet ads, billboards, and a PSA.

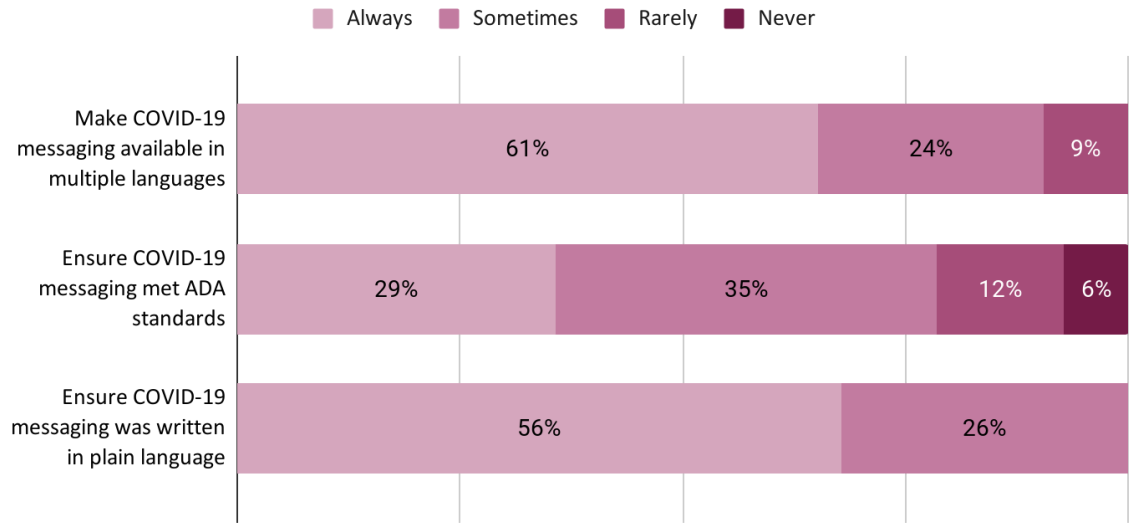
Twenty-seven LPHA survey respondents reported developing their own public health messages. Of these 27 respondents, all provided materials in multiple languages (see Figure 19 for which languages). “Other” languages mentioned were Marshallese (n=2) and Indigenous languages from Guatemala (n=1).

Figure 19: Percent of respondents who provided targeted messaging in the following languages (N=27)



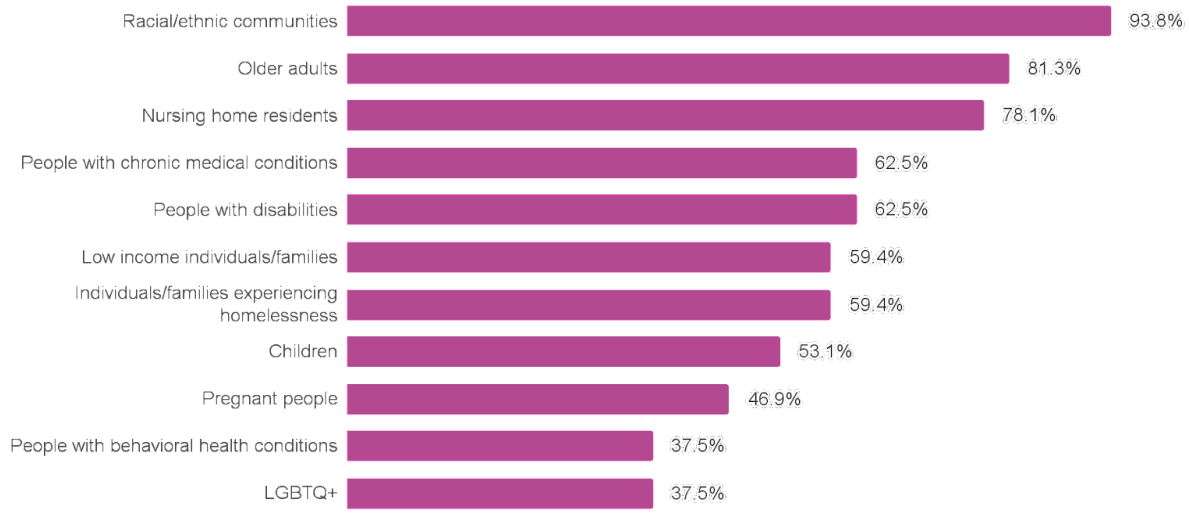
Respondents were also asked to reflect on how their LPHA incorporated accessibility standards into their public health messaging. Of respondents that answered this question (n=28) all reported that COVID-19 messaging was always or sometimes written in plain language, nearly all respondents reported that messaging was always or sometimes available in multiple languages, and 65% (n=22) reported that messaging always or sometimes met ADA standards. Two respondents reported that they never ensure messaging met ADA standards.

Figure 20: When developing targeted public health messaging, respondents did the following (N=27):



Some respondents also noted that they prioritized community or population-specific COVID-19 messaging. Nearly all respondents reported prioritizing Racial/ethnic communities. Most respondents also reported prioritizing older adults and nursing home residents.

Figure 21: Populations prioritized by LPHA respondents for community-specific COVID-19 messaging (N=32)



LPHAs were asked to rate OHA on their communication with the public about a variety of public health requirements that were implemented by stage.

Figure 22: Rating of OHA Communication with Public, Stage 1 (March - Nov 2020) (N=34)

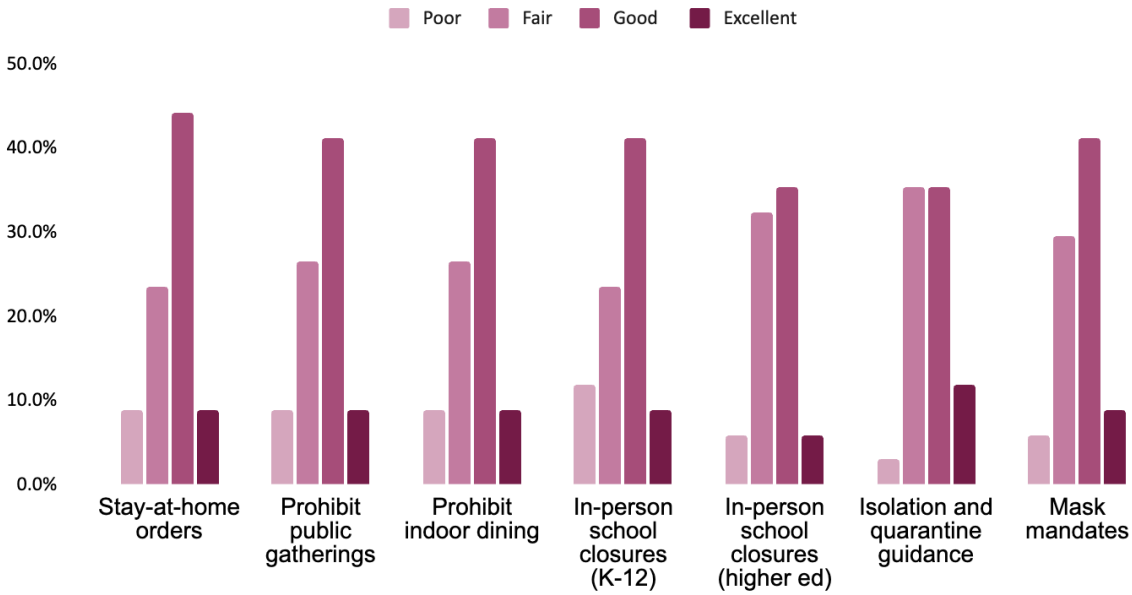


Figure 23: Rating of OHA Communication with Public, Stage 2 (Dec 2020 - Aug 2021)

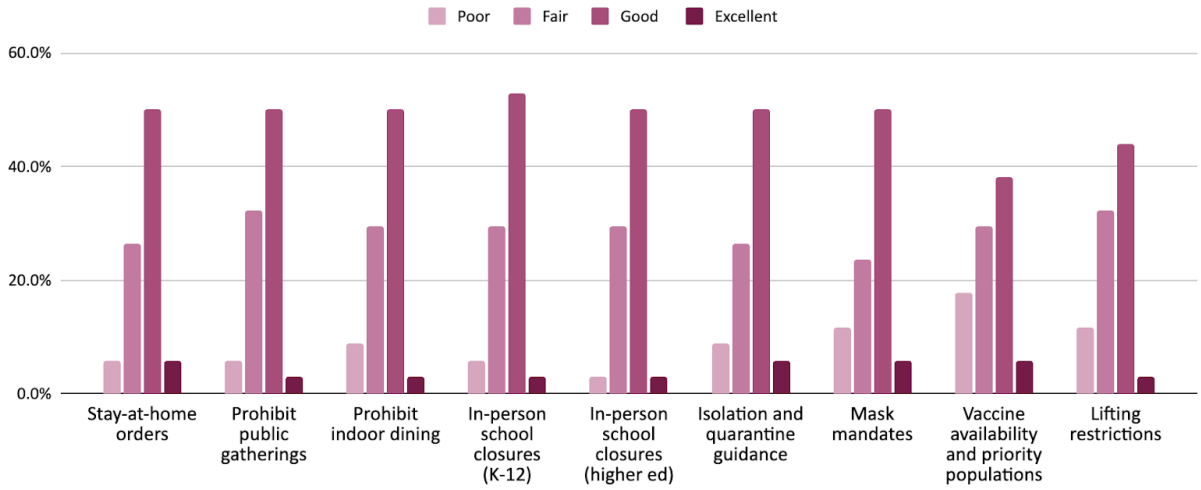


Figure 24: Rating of OHA Communication with Public, Stage 3 (Sept 2021 - Feb 2022)

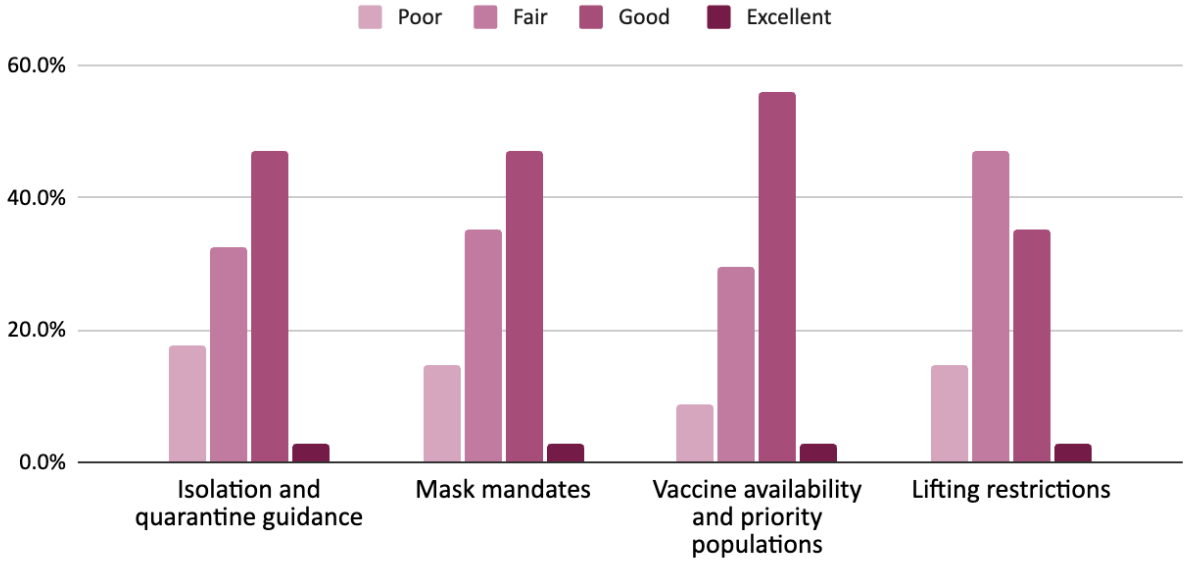
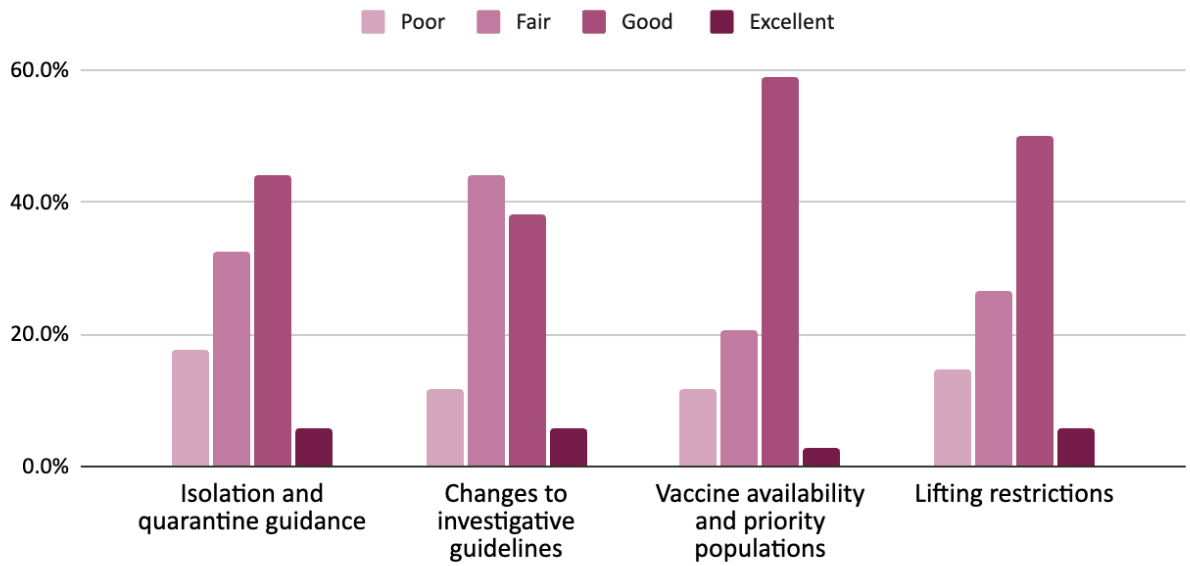


Figure 25: Rating of OHA Communication with Public, Stage 4 (March - July 2022)



Partnerships

Respondents engaged in many COVID-19 public health response activities with partners.

Figure 26: Types of activities LPHAs partnered on with community organizations and education (N=38)

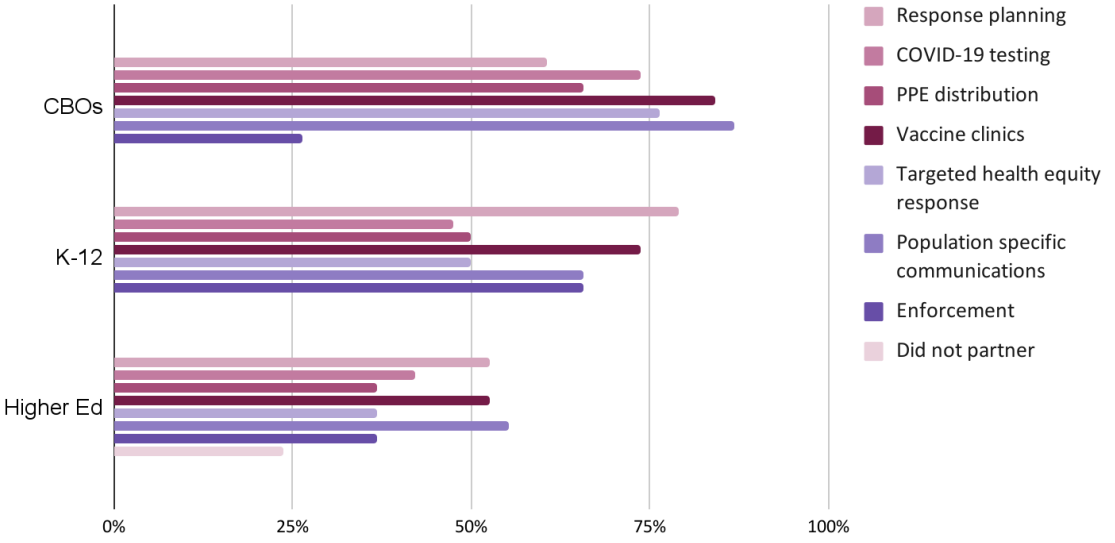
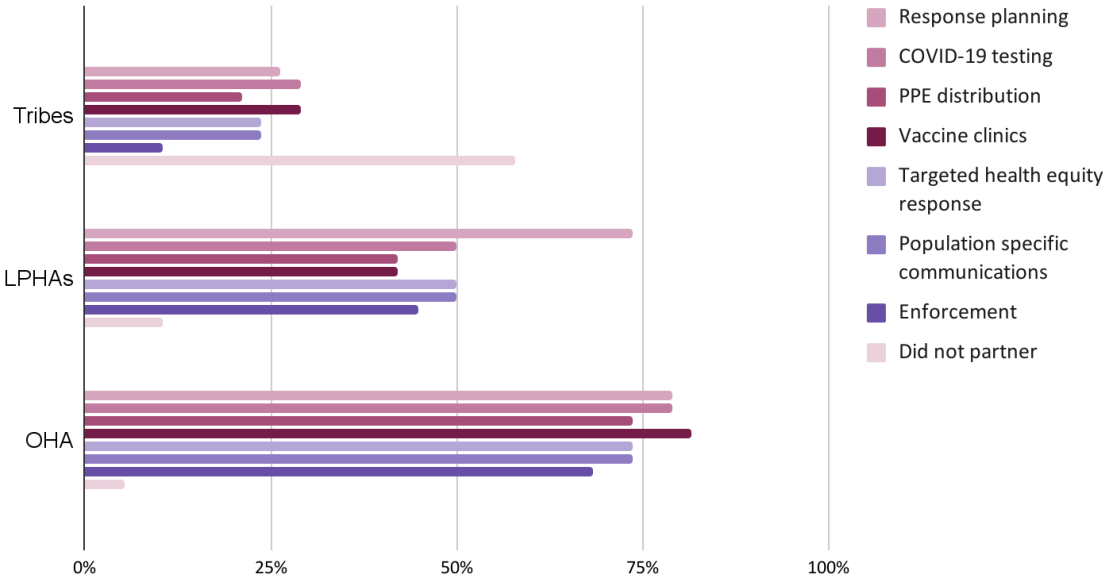


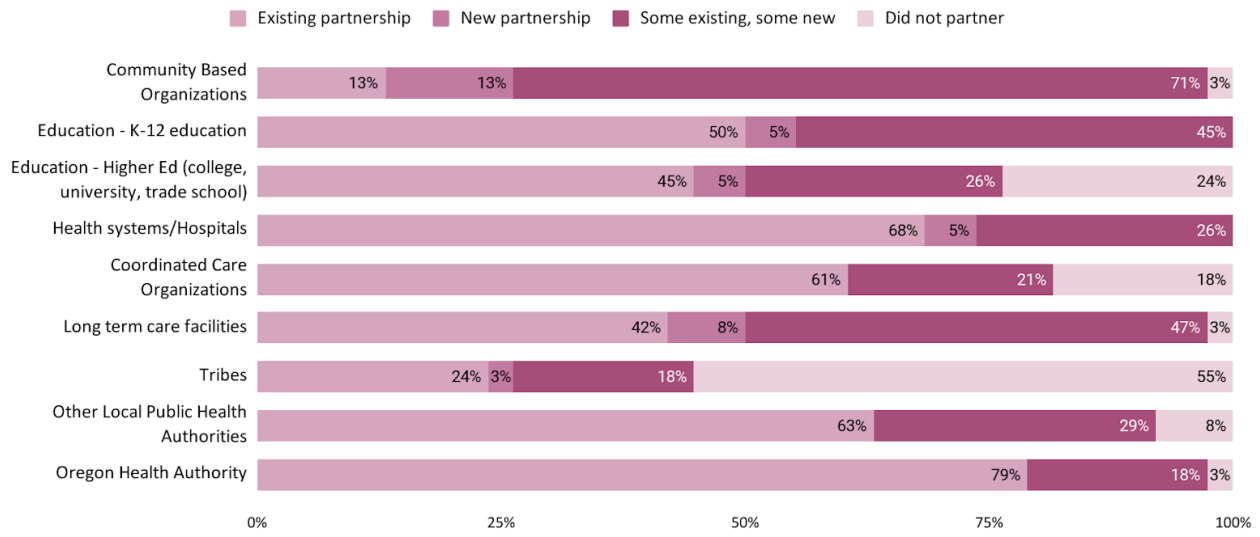
Figure 27: Types of activities LPHAs partnered on with other government entities (N=38)



LPHA survey respondents developed some new relationships with partners during COVID-19 response. Over half of respondents did not partner with Tribes, but many added a note that they do not

have a Tribe in their jurisdiction.

Figure 28: Types of LPHA partnerships for COVID-19 Response (N=38)



Public Health Services

LPHA survey respondents were asked to report on changes in the provision of a variety of public health services during COVID-19 by stage. Answers do not equal 100% because respondents who stated that they did not work on COVID-19 response during the stage were removed. There were potential issues with the response option of “LPHA doesn’t provide” because it was assumed that it would be consistently selected for services across stages but it was not, but since it is not consistent, one explanation is that this was selected if that service wasn’t provided during that stage. Respondents reported reduction in many services during Stage 1 of the pandemic, with the exception of emergency preparedness and epidemiology and surveillance. The two program areas that the most respondents indicated were reduced were environmental health services (n=19) and tobacco, alcohol and other drug prevention (n=19).

Figure 29: Changes in services provided by LPHAs, Stage 1 (N=33)

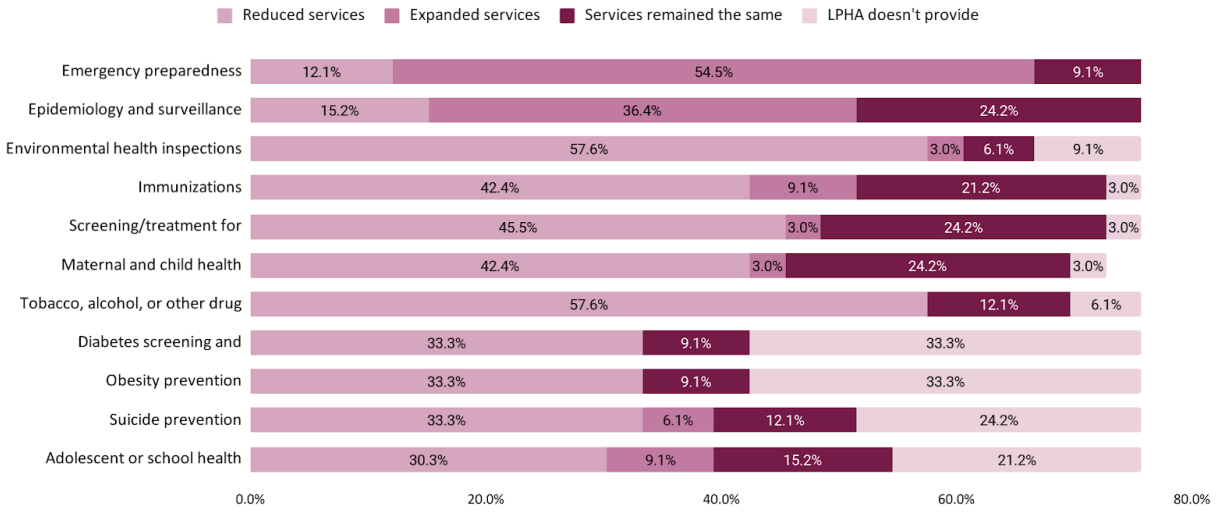


Figure 30: Changes in services provided by LPHAs, Stage 2 (N=33)

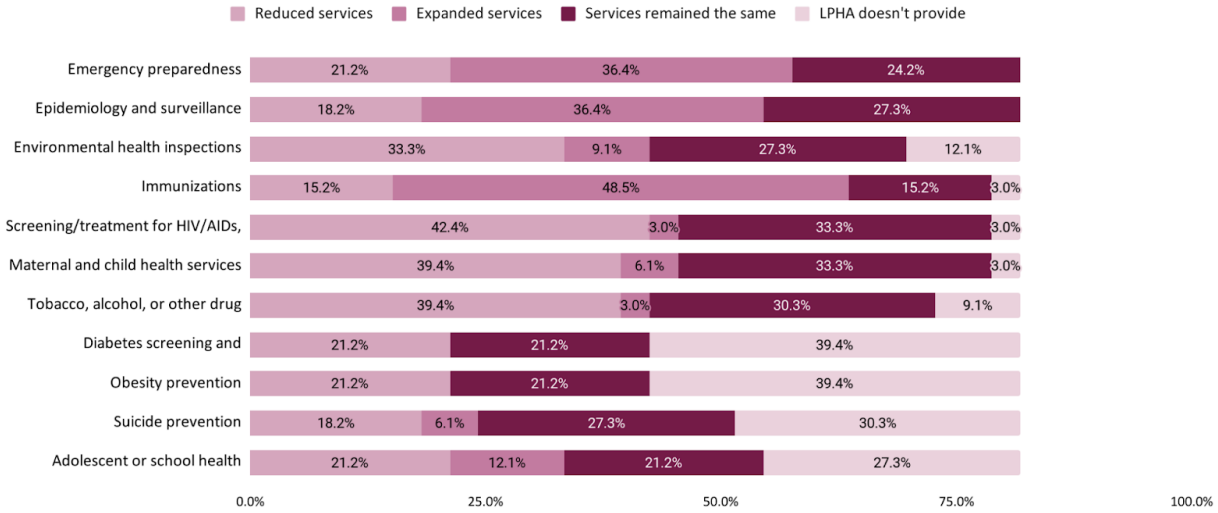


Figure 31: Changes in services provided by LPHAs, Stage 3 (N=33)

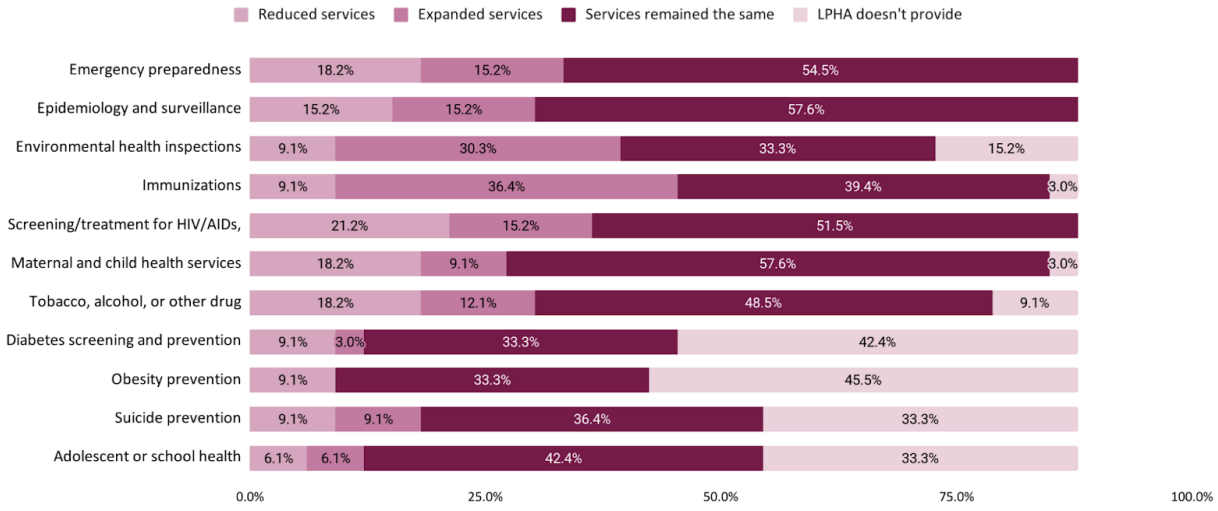
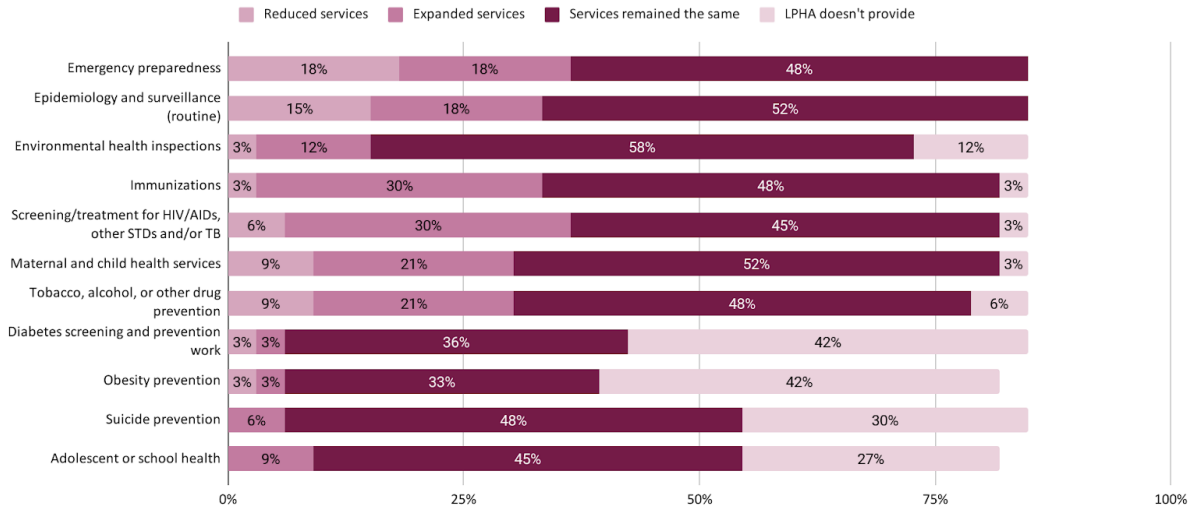
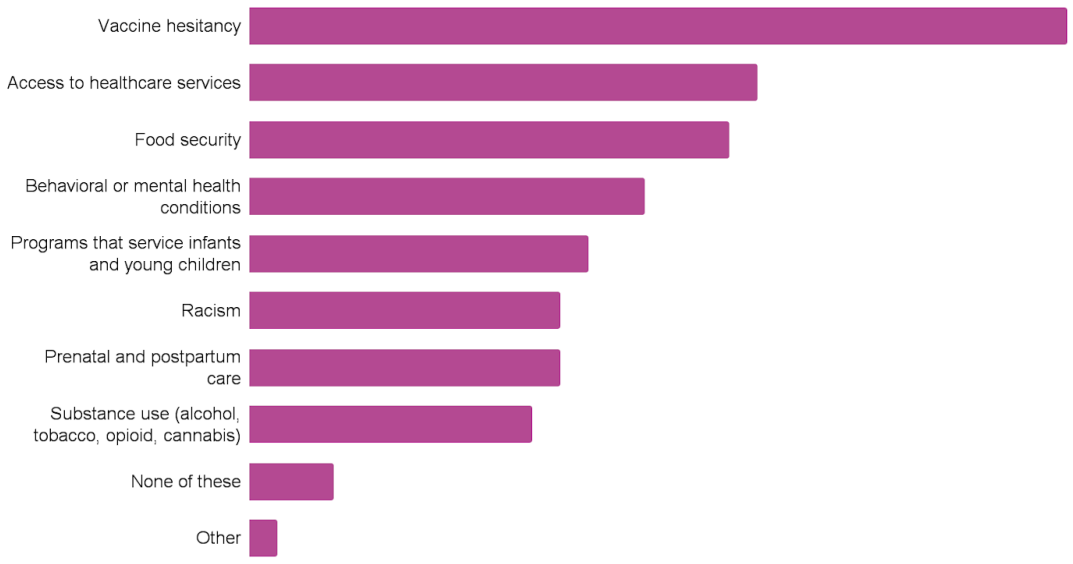


Figure 32: Changes in services provided by LPHAs, Stage 4 (N=33)



Respondents were also asked to identify any additional services that they provided during the pandemic. Figure 33 displays responses. A majority of respondents reported that they addressed vaccine hesitancy (n=29). About half of respondents reported that they worked on access to health care services (n=18), and food security (n=17). The "other" initiative or program mentioned was *"Reduced stigma for COVID, it doesn't infect based on race/ethnicity" (n=1).*

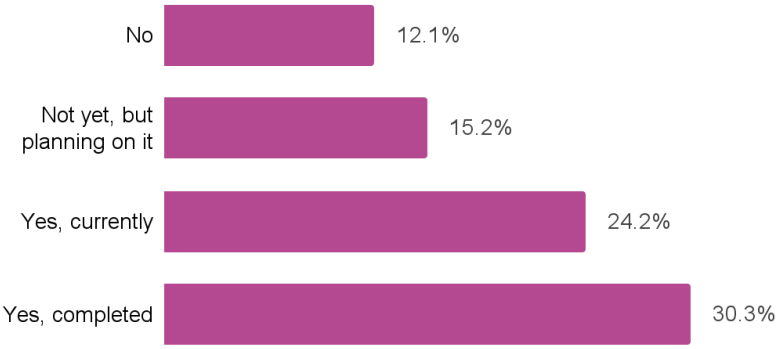
Figure 33: Issues addressed by LPHAs via targeted initiatives or programs during the COVID-19 pandemic (N=33)



After Action Review

Ten respondents said that their LPHA had completed an After Action Review (AAR) and another eight respondents were currently conducting an AAR at the time of the survey.

Figure 34: Has your LPHA conducted an After-Action Review (AAR)? (N=33)



Of the 23 respondents who said they had either completed an AAR, were currently conducting an AAR, or were planning on conducting an AAR, seventeen said that they were going to make changes or adjustments to their program, functional, or business models based on lessons learned during COVID-19 pandemic. The following changes that were adopted or going to be adopted were mentioned:

"update policies, add some IT staff for producing info online"
"We would never reduce our programs and redirect staff with such high expectations for so long again."
"hMPXV planning changes developed and process."
"We've added multiple positions to our team to expand CD/communications capacities"
"Not going to work the staff to utter exhaustion. Take care of employee mental and physical health needs. Prioritize staff needs."
"Addressing by PHEP Coordinator. Also adapting alternative ways for client visits"
"Currently working on an AAR and routinely discuss what lessons have been learned from COVID and integrated into our current and ongoing work."
"We are streamlining our Covid outbreak response. We do not want to focus all our staffing on the Covid response. We have staff supporting non-Covid diseases and staff supporting Covid outbreaks."
"Increased staffing. Created a unit specific to outreach and maintaining relationships with partners we've made over the pandemic"
"Leveraging the PH foundational capabilities in program development and implementation such as epidemiology, communications, outreach and engagement of CBOs and community members, data collection and sharing, community partnerships, equity"
"Developing a comprehensive immunization program. Expanding mobile services (HIV/STI testing, vaccinations), organizational structural changes"
"Training plan updated and implementing now. LCPH is 30% bigger, new org structure, need to re-train all staff to ICS Prep standards. Continuing activations for Monkeypox. Hiring and staff retention prioritized by leadership"
"Each phase of the pandemic was dynamic and we implemented changes to streamline and better serve the public."

“Emergency preparedness”
“Increased Emergency Preparedness Training and protocol.
“Response id being worked into our programs more earnestly”

State Partnerships

Figure 16: How EM partnered with state organizations for COVID-19 response