AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

November 15, 2016
2:00-4:00 pm

Conference line: (888) 251-2909
Access code: 8975738
Webinar link: https://attendee.gotowebinar.com/register/7642805758114922498

Meeting Objectives

- Review process and timeline for the PHAB Accountability Metrics subcommittee's work through the end of the year
- Review and make initial recommendations for health equity and system change measures
- Prepare for November 17 presentation to PHAB on this subcommittee's work-to-date

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

2:00-2:05 pm	**Welcome and introductions** • Review and approve October 27 minutes	All
2:05-2:25	**Review process and timeline through the end of the year** • Review steps for developing accountability metrics through the end of the year.	Sara Beaudrault, Oregon Health Authority
2:25-3:15 pm	**Review accountability measure matrix** • Focus on measures for health equity and system change • Identify whether measures meet selection criteria • Make initial recommendations for health equity and system change measures	All
3:15-3:45 pm	**Prepare for November 17 PHAB meeting** • How will the subcommittee's work-to-date be shared with the Board? • What information and materials will be provided? • Who will lead discussion?	All

3:45-3:50 pm	**Next steps** • Discuss joint meeting with Incentives and Funding subcommittee • Set date and agenda for December meeting	All
3:50-4:00 pm	**Public comment**	
4:00 pm	**Adjourn**	

PHAB Accountability Metrics subcommittee

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

November 15, 2016

Process and timeline for developing accountability metrics through the end of 2016

The PHAB Accountability Metrics subcommittee is responsible for developing a set of metrics that will be used to measure Oregon's progress toward public health modernization. This PHAB subcommittee will make recommendations to the full PHAB, which will adopt a set of metrics for public health modernization.

Public health modernization accountability metrics are intended to demonstrate improved health outcomes and efficiencies across the public health system. A subset of the metrics will be used to award incentive payments to local public health authorities that meet a benchmark or improvement target.

The PHAB Accountability Metrics subcommittee will focus for the remainder of 2016 on developing measures for the areas of work that have been prioritized for 2017-19. These areas include communicable disease, environmental health, emergency preparedness and response and health equity.

The Coalition of Local Health Officials (CLHO) has committees that meet monthly, some of which focus on communicable disease, environmental health and emergency preparedness. As such, local public health administrators who are members of PHAB have recommended using the CLHO committees as subject matter experts for these areas. Recommended measures from the CLHO committees can be used to inform the recommendations put forward by this subcommittee.

Proposed outline for work to be completed in 2016:

Date	Activity
Nov 2-10	PHAB subcommittee homework
Nov 15	**PHAB Accountability Metrics subcommittee meeting.** Focus on measures for health equity and system change
Nov 17	**PHAB meeting.** Present work-to-date and solicit feedback from Board members
Nov 14-Dec 2	CLHO committees make recommendations for communicable disease, environmental health and emergency preparedness measures. Recommendations to PHAB Accountability Metrics subcommittee by Dec 2
Between Dec 2-8 (Meeting currently scheduled for Dec 19 needs to be held before the December PHAB meeting)	**PHAB Accountability Metrics subcommittee meeting.** Review recommendations from CLHO committees on CD, environmental health and emergency preparedness measures. Finalize initial set of recommended measures
Dec 15	**PHAB meeting.** Present initial set of recommended measures
Dec 16-31	Set of accountability metrics included in statewide modernization plan
Jan 1, forward	Continue to develop set of accountability metrics

PHAB Accountability Metrics Subcommittee
Subcommittee members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines
November, 2016

Instructions

This matrix contains existing measures from many data sources for three public health modernization priority areasfor 2017-19: communicable disease, environmental health and emergency preparedness and response. **Please complete your review of potential measures and submit it back to PHD staff on November 10, 2016. (Late is okay , too- please send it when you can). PHD will compile responses, and this will be the basis for the discussion at the November 15, 2016 subcommittee meeting.** Complete the following steps:

Step 1: Look at each measurement area (in green cells) and determine whether this measurement area should be included in an accountabilty metrics set for the public health system. **Mark "yes" in Column N if you think the measurement area should be included.**
Step 2: If you noted that a measurement area should be included, review the existing measures and note which you think should be included to demonstrate modernization of Oregon's public health system. Select up to three measures for each measurement area. You can use the criteria agreed upon by this subcommittee (Columns C-M) to determine whether a measure is a good fit for public health modernization, but you do not need to fill out all these cells.
Step 3: If you know of other measures that should be considered by the subcommittee, please add them to this matrix.
Step 4: Review the next tab, "PHMM Deliverables". Note which deliverables you think should be turned into a metric to demonstrate progress toward a modernized public health system.
Step 5: Submit this back to PHD on November 10 (or soon thereafter). Come prepared to the November 15, 2016 subcomittee meeting, ready to come to agreement on which measurement areas and which measures to put forward as recommendations to PHAB.

Health areas and measures	Measure source	PHAB subcommittee core principles (columns do not have to be filled out)					PHAB subcommittee additional considerations (columns do not have to be filled out)						**Complete this column:** Recommend to include? **(Mark "yes" for up to three measures for each measurement area)**
		Promotes health equity	Respectful of local priorities	Transformative potential	Consistent w/. State/national quality measures	Feasibility of measurement	Consumer engagement	Relevance	Attainability	Accuracy	Reasonable accountability	Range/diversity of meaures	
2017-19 public health modernization priority: Communicable disease													
Measurement area: Immunization													
M152 Childhood immunization completeness (community) Percentage of children 19-35 months who are up-to-date on immunizations per Advisory Committee on Immunization Practices (ACIP).	PHAST												
M154 Childhood immunizations administered by agency (agency) Number of immunizations, including those for influenza, administered by the LHD to children 0-5 years, and children 6-18 years, during the past 12 months.	PHAST												
M201 Confirmed vaccine-preventable disease cases (community) Number of confirmed vaccine-preventable disease cases in the past 12 months (cases of rubella, measles, congenital rubella, mumps, tetanus), by vaccination status if possible.	PHAST												
Childhood immunization status	CCO incentive measure												
Immunization for adolescents	State performance "test" measure												
Childhood Immunization Status: The percentage of children 2 years of age who have received specific immunizations.	Child and family well-being measure												
Rate of Non-medical Exemptions for Immunizations	Child and family well-being measure												
Rate of 2-year-olds who are fully vaccinated	State Health Improvement Plan												
HPV vaccination series rate among 13- to 17-year-olds	State Health Improvement Plan												
Seasonal flu vaccination rate in people ≥6 months of age	State Health Improvement Plan												
Nonmedical exemption rate for kindergartners	State Health Improvement Plan												
Number of vaccines administered by SBHCs	State Health Improvement Plan												
Percentage of flu vaccinations administered by pharmacists	State Health Improvement Plan												
Percentage of HPV vaccines administered by pharmacists to 11- to 17-year-olds	State Health Improvement Plan												
Number of HPV vaccines administered by SBHCs	State Health Improvement Plan												
Number of independent labs reporting HPV-related dysplasias	State Health Improvement Plan												
Seasonal influenza vaccinations in southern rural and frontier counties	State Health Improvement Plan												
Seasonal influenza vaccination among adult men > 19 years of age	State Health Improvement Plan												
Tdap vaccination among pregnant women.	State Health Improvement Plan												
Flu vaccination rate among pregnant women.	State Health Improvement Plan												

Percentage of enrolled and eligible Vaccines for Children (VFC) providers receiving CDC-defined AFIX quality improvement services	State Health Improvement Plan												
Seasonal flu vaccination rate for health care workers in long-term care facilities	State Health Improvement Plan												
Seasonal flu vaccination rate for health care workers in hospital settings	State Health Improvement Plan												
Seasonal flu vaccination rate for health care workers in ambulatory surgical centers	State Health Improvement Plan												
IID-1 Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases	Healthy People 2020												
IID-7 Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children	Healthy People 2020												
IID-8 Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib,	Healthy People 2020												
IID-9 Decrease the percentage of children in the United States who receive 0 doses of recommended vaccines by age 19 to 35 months	Healthy People 2020												
IID-10 Maintain vaccination coverage levels for children in kindergarten	Healthy People 2020												
IID-11 Increase routine vaccination coverage levels for adolescents	Healthy People 2020												
IID-12 Increase the percentage of children and adults who are vaccinated annually against seasonal influenza	Healthy People 2020												
IID-13 Increase the percentage of adults who are vaccinated against pneumococcal disease	Healthy People 2020												
IID-14 Increase the percentage of adults who are vaccinated against zoster (shingles)	Healthy People 2020												
IID-17Increase the percentage of providers who have had vaccination coverage levels among children in their practice	Healthy People 2020												
Percent of adults age 18 or older who report receiving a flu shot during the past 12 months	Washington Public Health Improvement Partnership												
Percent of children ages 19-35 months with complete vaccination records on file in IIS for the 4:3:1:3:3:1:4 series	Washington Public Health Improvement Partnership												
Adolescent Tdap vaccine	State Health Profile indicator												
Add additional measures here													
Measurement area: Enteric disease													
M167 Foodborne/Waterborne reported case volume (community) Number of reported cases of enteric disease in the past 12 months. Foodborne/Waterborne Diseases = separate totals of all reported cases for each of the following: E. coli, shiga toxin producing strains only; Salmonellosis; Campylobacteriosis; Shigellosis; Ciguatera; Paralytic shellfish poisoning; Scombroid poisoning; Mushroom poisoning; Botulism.	PHAST												
M165 Foodborne/Waterborne confirmed case volume (community) Number of confirmed cases of enteric disease in the past 12 months. Foodborne/Waterborne Diseases = separate totals of all confirmed cases for each of the following: E. coli, shiga toxin producing strains only; Salmonellosis; Campylobacteriosis; Shigellosis; Ciguatera; Paralytic shellfish poisoning; Scombroid poisoning; Mushroom poisoning; Botulism based on CDC case classification guidelines for each disease.	PHAST												
M162x Foodborne enteric disease investigation (responsibility) Who is responsible for foodborne enteric disease investigation in your jurisdiction? (select all that apply) LHD, Regional health agency, State heealth agency, Other governmental local or state agency, Other	PHAST												
M162 Foodborne enteric disease investigation volume (agency) Number of investigations of reported foodborne/enteric disease cases conducted by LHD during the past 12 months.	PHAST												

M164 Foodborne enteric disease investigation completion time (agency) Average time from receipt of reported case of enteric disease to completion or closure of case investigation (including cases lost to follow-up), for all cases received in past 12 months.	PHAST												
Infections caused by Shiga toxin-producing Escherichia O157	State Health Improvement Plan												
Infections caused by Salmonella species commonly transmitted through food	State Health Improvement Plan												
Infections caused by Campylobacter commonly transmitted through food	State Health Improvement Plan												
Implement whole genome sequencing (WGS) for Salmonella isolates submitted to OSPHL*	State Health Improvement Plan												
Percent of identified carbapenemase producers with evidence of transmission*	State Health Improvement Plan												
Percentage of cases of invasive pneumococcal disease that are resistant to at least one antibiotic*	State Health Improvement Plan												
Number of tests for Zika using CDC approved methods*	State Health Improvement Plan												
Rate of non-judicious prescriptions	State Health Improvement Plan												
Number of norovirus outbreaks reported by long-term care facilities within the previous 12 months	State Health Improvement Plan												
Reduce infections caused by key pathogens transmitted commonly through food	Healthy People 2020												
Reduce the number of outbreak-associated infections due to Shiga toxin-producing E. coli O157, or Campylobacter, Listeria, or	Healthy People 2020												
Reduce foodborne illness caused by Salmonella by 14.5%	CDC Winnable Battle												
Reduce foodborne illness caused by Shiga toxin-producing Escherichia coli (STEC) O157:H7 by 29%	CDC Winnable Battle												
Add additional measures here													
Measurement area: Sexually transmitted infections													
M184 STI cases confirmed (community) Number of confirmed sexually transmitted disease cases, by type (gonorrhea, chlamydia, syphilis, HIV).	PHAST												
M181x STI contact tracing (responsibility) Who is responsible for STI contact tracing in your jurisdiction? (select all that apply) LHD, Regional health agency, State health agency, Other governmental local or state agency, Other	PHAST												
M181 STI contact tracing (agency) Number of STI contacts followed by the LHD in the past 12 months, by type (gonorrhea, chlamydia, syphilis, HIV). If data by type are not available, report total number of cases and specify diseases included in the totals.	PHAST												
M204 STI staffing level (agency) Current FTE staffing level for disease intervention specialists (DIS) at the LHD: individuals employed by a local public health authority who are trained to provide components of STI case management and control services, including client interviewing, partner notification and referral, untreated patient referral, education activities, and consultation for individuals diagnosed with an STI.	PHAST												
Chlamydia screening in women ages 16-24	State performance "test" measure												
Rate of Gonorrhea infections in Oregon residents*	State Health Improvement Plan												
Proportion of people living with HIV in Oregon that have a suppressed viral load within the previous 12 months	State Health Improvement Plan												
HIV infections in Oregon residents	State Health Improvement Plan												
Rate of early syphillis infections in Oregon residents (primary, secondary and early latent infections)*	State Health Improvement Plan												
Active Oregon Reminders users receiving regular reminders to test for sexually transmitted infections	State Health Improvement Plan												
Proportion of men with HIV who have sex with other men and participate in the Oregon Medical Monitoring Project with evidence	State Health Improvement Plan												
Proportion of women aged 15–24 years screened annually for chlamydia/gonorrhea	State Health Improvement Plan												

Proportion of women aged 15–44 years diagnosed with chlamydia or gonorrhea that received partner-delivered expedited therapy	State Health Improvement Plan												
HIV-2 Reduce the number of new HIV infections among adolescents and adults	Healthy People 2020												
HIV-8 Reduce perinatally acquired HIV and AIDS cases	Healthy People 2020												
HIV-14 Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months	Healthy People 2020												
Reduce the number of new HIV infections by 25%	CDC Winnable Battle												
Increase the percent of people living with HIV who know their status by 11%	CDC Winnable Battle												
Rate of reported chlamydia infections per 100,000 women ages 15-24	Washington Public Health Improvement Partnership												
Percent of reported Chlamydia infections that received treatment in women ages 15-24	Washington Public Health Improvement Partnership												
Add additional measures here													
Measurement area: Tuberculosis													
M195 Tuberculosis (TB) case volume (community) Number of reported newly diagnosed tuberculosis (TB) cases in the past 12 months.	PHAST												
M196x TB contact investigations (responsibility) Who is responsible for TB contact investigations in your jurisdiction? (select all that apply) LHD, Regional health agency, State health agency, Other governmental local or state agency, Other	PHAST												
M196 Investigations of contacts of persons with infectious (active) TB (agency) Number of unduplicated individuals (contacts) that were (1) elicited and (2) evaluated for TB infection by the LHD during the past 12 months.	PHAST												
M193 TB therapy (agency) Number of TB cases that were placed on directly observed therapy in the past 12 months.	PHAST												
M199 TB contacts who completed treatment for latent TB infection (LTBI) (agency) Percentage of contacts with newly-diagnosed latent TB infection who (1) started and (2) completed treatment in the past 12 months.	PHAST												
Incidence of TB disease among U.S born persons*	State Health Improvement Plan												
Proportion of contacts to sputum AFB smear-positive TB cases diagnosed with latent TB infection who start treatment.*	State Health Improvement Plan												
Proportion of contacts to sputum AFB smear-positive TB cases diagnosed with latent TB infection who complete treatment.*	State Health Improvement Plan												
Proportion of immigrants and refugees (B waivers) with abnormal chest X-rays read overseas as consistent with TB that were	State Health Improvement Plan												
Add additional measures here													
Measurement area: Healthcare-aquired infections													
Hospital-onset Clostridium difficile infections	State Health Improvement Plan												
Reduce central line-associated blood stream infections (CLABSI) in hospitals by 60%	CDC Winnable Battle												
Reduce healthcare-associated invasive methicillin-resistant Staphylococcus aureus (MRSA) by 60%	CDC Winnable Battle												
Reduce surgical site infections (SSI) in hospitals by 30%	CDC Winnable Battle												
Reduce catheter-associated urinary tract infections (CAUTI) in hospitals by 30%	CDC Winnable Battle												
Add additional measures here													
Measurement area: Hepatitis C													
New asymptomatic hepatitis C cases per 100,000 reported annually	State Health Improvement Plan												
Add additional measures here													
Measurement area: Other													
PHI-11 Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services	Healthy People 2020												
Add additional measures here													

2017-19 public health modernization priority: Environmental health													
Measurement area: Lead protection													
M219 Elevated blood lead level rate (community) Number of cases of elevated blood lead in children ages 0-6 years identified in the past 12 months, per 1000 children age 0-6 years. Specify blood lead level threshold used to define elevated blood lead level.	PHAST												
M220x Blood lead investigation (responsibility) Who is responsible for blood lead level investigation in your jurisdiction? (select all that apply) LHD, Regional health agency, State Health agency, Other governmental state or local health agency, Other	PHAST												
M220 Elevated blood lead level investigation (agency) Number of cases of elevated blood lead (EBL) in children age 0-6 years investigated by the LHD in the past 12 months.	PHAST												
EH-8 Reduce blood lead levels in children	Healthy People 2020												
Add additional measures here													
Measurement area: Food protection													
M236x Food safety inspection (responsibility) Who is responsible for food safety inspection in your jurisdiction? (select all that apply) LHD, Regional Health agency, State health agency, Other governmental state or local health agency, Other	PHAST												
M236a Food safety inspection reach (community) Total number of (1) food service establishments inspected for food safety during the past 12 months, as a percentage of (2) the total number of food service establishments required to be inspected under state and/or local law.	PHAST												
M236b Food safety inspection volume (community) Total number of inspections of food service establishments conducted during the past 12 months (includes repeat inspections).	PHAST												
M233 Food safety field staffing ratio (community) Number of FTE personnel devoted to retail food safety inspection, protection and control activities per 100 retail food services establishments during the past 12 months.	PHAST												
Percent of inspected permanent food establishments with 35 or more critical violations	Washington Public Health Improvement Partnership												
Add additional measures here													
Measurement area: Water protection													
M272x Water system inspection (responsibility) Who is responsible for water system inspection in your jurisdiction? (select all that apply) LHD, Regional health agency, State health agency, Other governmental health agency, Other	PHAST												
M272a Public water system reach (community) Percentage of the population served by public water systems during the past 12 months.	PHAST												
M272b Exposure to public water system contamination (community) Percentage of population being served by public water systems with no maximum contamination level violations during the past 12 months.	PHAST												
M273 Public water system inspection volume (community) Number of drinking water samples from public water systems submitted and evaluated for public health protection in the past 12 months.	PHAST												
Percent of identified on-site sewage failures with corrective action initiated within 2 weeks	Washington Public Health Improvement Partnership												
Add additional measures here													

Measurement area: Air quality													
PQI 15: Adult asthma admission rate	State performance "test" measure												
EH-1 Reduce the number of days the Air Quality Index (AQI) exceeds 100, weighted by population and AQI	Healthy People 2020												
Percent of days meeting the Washington State Department of Ecology 24 hour avergae healthy air goal of	Washington Public Health Improvement Partnership												
Air quality: particulate matter concentration	State Health Profile indicator												
Placeholder: diesel	Healthy Places- data demonstrates this is one of the biggest sources of air pollution.												
Placeholder: woodburning stoves	Healthy Places - data demonstrates this is one of the biggest sources of air pollution.												
Placeholder: child asthma rate													
Add additional measures here													
Measurement area: Resiliency													
Neighborhood Amenities: Percent of children that live in neighborhoods with some of the following amenities: sidewalks and walking paths, a park or playground, recreation center, library or bookmobile.	Child and family well-being measure												
Placeholder: built environment	Healthy Places workgroup												
Placeholder: asthma	Healthy Places workgroup- climate change and public												
Placeholder: Health in all Policies	Healthy Places workgroup												
Placeholder: environmental justice	Healthy Places workgroup												
Add additional measures here													
Measurement area: Other													
EH-21 Improve quality, utility, awareness, and use of existing information systems for environmental health	Healthy People 2020												
Add additional measures here													
2017-19 public health modernization priority: Emergency Preparedness and Response													
Measurement area: Emergency preparedness and response													
PREP-4 Reduce the time for State public health agencies to establish after action reports and improvement plans following	Healthy People 2020												
Developed or Updated a Written Emergency Plan	NACCHO												
Provided Emergency Preparedness Training to Staff	NACCHO												
Participated in Tabletop Exercises or Drills	NACCHO												
Assessed Emergency Preparedness Competencies of Staff	NACCHO												
Participated in Functional Exercises or Drills	NACCHO												
Reviewed Relevant Legal Authorities	NACCHO												
Participated in Full-Scale Exercises or Drills	NACCHO												
Add additional measures here													
2017-19 public health modernization priority: Other													
Measurement area: Public health policy													
Communicated with Legislators, Regulatory Officials, or Other Policymakers*	NACCHO												
Participated on a Board or Advisory Panel Responsible for Public Health Policy	NACCHO												
Prepared Issue Briefs for Policymakers	NACCHO												
Gave Public Testimony to Policymakers	NACCHO												
Provided Technical Assistance to Legislative, Regulatory, or Advocacy Group*	NACCHO												
LHD Involvement in Select Policy or Advocacy Areas	NACCHO												
LHD Involvement in Policy or Advocacy Activities Focused on Tobacco, Alcohol, or Other Drugs*	NACCHO												
LHD Involvement in Policy or Advocacy Activities Focused on Obesity or Chronic Disease*	NACCHO												

Technical assistance and/or training provided on performance management to tribal and local health departments (state PHD measure)	Public Health Accreditation Board Standards and Measures (domain 9)												
Staff at all organizational levels engaged in establishing and/or updating a performance management system	Public Health Accreditation Board Standards and Measures (domain 9)												
An adopted perforamnce management system that is updated every five years	Public Health Accreditation Board Standards and Measures (domain 9)												
Placeholder: Public health modernization system change- number of new CJS agreements													
Placeholder: Public health modernization system change- number of collaborations with CCO, early learning, or other local organziations													
Placeholder: Public health modernization system change- documentation of local Heath in all Policies													
Add additional measures here													
Measurement area: Health disparities													
Describing Health Disparities in Jurisdiction Using Data	NACCHO												
Supporting Community Efforts to Change the Causes of Health Disparities	NACCHO												
Training Workforce on Health Disparities and Their Causes	NACCHO												
Offering Staff Training in Cultural/Linguistic Competency	NACCHO												
Educating Elected or Appointed Officials about Health Disparities and Their Causes	NACCHO												
Prioritizing Resources and Programs Specifically for the Reduction in Health Disparities	NACCHO												
Recruiting Workforce from Communities Adversely Impacted by Health Disparities	NACCHO												
Taking Public Policy Positions on Health Disparities	NACCHO												
Conducting Original Research that Links Health Disparities to Differences in Social or Environmental Conditions	NACCHO												
Add additional measures here													

PHAB Accountability Metrics Subcommittee
Subcommittee members: Muriel DeLaVergne-Brown, Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines
November, 2016

Instructions

This matrix contains deliverables included in the Public Health Modernization Manual for three public health modernization priority areas for 2017-19: communicable disease, environmental health and emergency preparedness and response. **Please review the deliverables and note which should be made into a public health modernization metric. Submit your responses to PHD staff by November 10, 2016 (or soon thereafter). PHD will compile responses, and this will be the basis of the discussion at the November 15, 2016 subcommittee meeting.** Complete the following steps:

Step 1: Read each deliverable and determine whether it should be made into a public health modernization metric. Note yes, no or maybe in Column B.
Step 2: Submit to PHD staff by November 10, 2016. Come prepared to the November 15, 2016 subcomittee meeting, ready to come to agreement on which measurement areas and which measures to put forward as recommendations to PHAB.

The Public Health Modernization Manual is available at: www.healthoregon.org/modernization.

Public Health Modernization Manual deliverables	Should this deliverable be turned into a metric for public health modernization? Mark yes, no or maybe
Communicable disease control	
Statewide summaries of acute and communicable disease occurrence, causes, distinguishing characteristics and changes over time	
Local reports of notifiable diseases	
Summaries of disease outbreaks	

Maintenance and operation of statewide information systems that are accessible to state and local public health	
Up-to-date investigative guidelines	
Portfolio of strategic partnerships	
Summaries of vaccine-related adverse events	
Summaries of gaps in immunization coverage	
Public-facing communication channels that allow timely access to information about disease trends and outbreak investigation summaries	
Electronic reporting tools	
Policies in place to ensure maintenance of security of personally identifiable data collected through audits, review, update and verification	
Protocols for proper preparation, packaging and shipment of disease and outbreak samples	
Compliance reviews of pharmacies, providers, infection control specialists and others	
Documentation of policies to ensure appropriate screening and treatment for HIV, STD and TB cases	
Health education resources for the general public, health care providers, long-term care facility staff, infection control specialists and others regarding vaccine-preventable diseases, health care-associated infections, antibiotic resistance and related issues	
Electronic transmission of health information between clinical settings	
Protocols or process maps for information-sharing between providers to reduce disease transmission	
Plans to allocate medical countermeasures in a public health emergency	
Plans to allocate scarce resources in an emergency or outbreak	

Reports of gaps in surveillance, investigation and control of communicable diseases in public health agencies	
Standards and documentation of technical support for enforcement of public health laws	
Technical support for enforcement of public health laws	
Environmental public health	
Documented compliance with federal and state standards and regulations	
Documented provision of licensing and certification	
Review and inspection reports of regulated facilities	
Documented investigation of complaints and assessment of fines/penalties	
Documented compliance with standards and processes	
Documented enforcement of regulations	
Information systems that provide current and accurate information to support environmental health functions at the state and local level	
Documented assessments of environmental health hazards and protection recommendations	
Reports of occupational health surveillance	
Trained radiation emergency response teams	
Current community health assessment that includes environmental health	
Documentation of health analyses prepared for other organizations	
Reports using environmental data that other agencies or stakeholders prodice	
Reports of projected changes in health resulting from changes to the built and natural environment	
Assessments of the health impacts of environmental hazards or conditions	

Communications on environmental justice concerns and disparities	
Local ambulance service area plans	
Annual foodborne illness program plan	
Written best practices for vector control	
Policy briefs and other communications or environmental health impacts	
Documented communications on environmental health hazards and protection recommendations to regulated facilities, the public and stakeholder organziations	
Written guidance on mitigating environmental health risks and maximizing health benefits	
Public communications about environmental health risks	
Documented provision of onsite outreach and training for rural emergency medical services providers	
Documented consultations on the assessment and mitigation of environmental health hazards for local public health authority staff, the food service industry and the general public	
Documentation or recommendations made to other organizations on approaches to ensure healthy and sustainable built and natural environments	
Environmental health data reports on the natural and built environment	
Documented integration of standard environmental public health practices into facilities that present high risk for harmful environmental exposures or disease transmission	
Emergency preparedness and response	
Disaster epidemiology report	

Documented participation in emergency response efforts	
Continuity of Operations plan	
Documentation of emergency public health orders	
Documentd maintenance of public health laboratory capacity (LRN-B and LRN-C)	
Documentation demonstrating planning for emergency preparedness exercises	
Documented that planned emergency preparedness exercises have been executed	
Public health emergency preparedness plans according to established guidelines	
Portfolio of community partnerships to support preparedness and recovery efforts	
Plans for the distribution of pharmaceuticals in an emergency	
Documented delivery of health alerts and preparedness communications to partners and the general public	
Situational assessments and resulting operational plans, including objectives, resources needed and how to resume routine operations	

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee Meeting Minutes

October 27 2016
2:00 – 3:00pm

PHAB Subcommittee members in attendance: Eva Rippeteau, Eli Schwarz, Teri Thalhofer, Jennifer Vines

PHAB Subcommittee members absent: Muriel DeLaVergne-Brown

OHA staff: Sara Beaudrault, Myde Boles, Rebecca Pawlak, Angela Rowland

Members of the public: Kelly MacDonald

Welcome and introductions

The September 22 draft meeting minutes were unanimously approved by the subcommittee.

Public Health Activities & Services Tracking (PHAST) measures

Betty Beckmeier and Greg Whitman from the University Of Washington School Of Nursing provided an overview of the PHAST measures.

The beginning measure set started with the Multi-network Practice and Outcome Variation Examination (MPROVE) measures. The purpose is to identify high value public health service measures across jurisdictions and collect the evidence based data. They were sorted in three core public health domains: Communicable Disease Control, Environmental Health Protection, and Chronic Disease Prevention. They are working with states to adopt these measures and use them for public health practice.

Eli asked if there are any national groups working with this criteria and Greg stated that a crosswalk is included in the presentation materials.

In May 2015 the MPROVE measures evolved to correct errors, provide clarity, and add responsibility questions.

Jennifer commented that these are process outcomes and inquired if there are any cause and effect outcomes. Betty stated this is activity data and do have some outcome data with behavior changes. She did work on existing data and did some matching of health department data with health outcomes to demonstrate the local public health contribution of services. She found the data was very limited across the states. Jen cautions the cause and effect of these findings and to be explicit with what is known and unknown.

Betty explained the obesity prevention data findings showing that prevalence of obesity is lower and physical activity is higher in all LHD groups with population-based interventions compared to LHDs with no apparent activities. Also, population-based interventions are more strongly linked to positive outcomes in literature when compared to individual-level interventions.

Eli questioned whether there is currently a standardized instrument to collect data at a county level. Betty stated that PHAST has received funding from the Robert Wood Johnson Foundation to provide a standardized instrument to collect these data at a local level.

Betty also presented the cross-jurisdictional sharing and immunization completeness study. Health departments that were sharing services had higher immunization completeness rates for toddlers.

For more information: http://phastdata.org

Subcommittee business

The next subcommittee meeting will be a two-hour in-person meeting held on November 15th. The materials will be sent out ahead of time to allow for committee members to review and come back with decisions to put forward. The group will work to prioritize environmental health and communicable disease PHAST measures as well as state health profile indicators.

Eli recommended a crosswalk of the measures be provided.

Public comment
No public testimony.

Adjournment

The meeting was adjourned.

Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health

EXECUTIVE SUMMARY

Prepared for the
Robert Wood Johnson Foundation

Original to the Foundation: June 2014
Revised for dissemination: June 2015

Prevention Institute
Prevention and equity | at the center of community well-being
www.preventioninstitute.org

In spring 2014, the Robert Wood Johnson Foundation (RWJF) commissioned Prevention Institute to develop a set of metrics to inform its broader set of metrics for its Culture of Health. In its original form, this document served as a background document for RWJF staff to inform discussion around disparity metrics for the Foundation and the nation. This version has been slightly modified for broader dissemination, including adding an executive summary.

Prevention Institute is a nonprofit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on community prevention, injury and violence prevention, health equity, healthy eating and active living, positive youth development, health system transformation and mental health and wellbeing.

Principal Author:
Rachel Davis

ACKNOWLEDGEMENTS

Prevention Institute would like to thank the following individuals for providing input via interviews, which helped direct, shape and refine our thinking and approach:

Kelly Brownell, Dean and Professor of Public Policy, Duke University
Natalie Burke, Common Health Action
Nadine Chan, King County Department of Public Health
Mark Cervero, Common Health Action
Mari Egan, Pritzker School of Medicine, University of Chicago
Erima S. Fobbs, Common Health Action
Rejane Frederick, Common Health Action
Tony Iton, The California Endowment
Nicole Kravitz-Wirtz, University of Washington
Neil Maizlish, California Department of Public Health
Dan Perales, San Jose State University
Patrick Remington, County Health Rankings
Kara Ryan, Common Health Action
Brian Smedley, Joint Center for Political and Economic Studies, Health Policy Institute in June 2014; National Collaborative for Health Equity in June 2015
Katy Weeks, Common Health Action
Sandra Witt, The California Endowment
Elva Yanez, Colibri Strategies Inc. in June 2014; Prevention Institute in 2015 and the California State Park and Recreation Commission

INTRODUCTION

The Robert Wood Johnson Foundation (RWJF) has laid out a bold and ambitious agenda of achieving a Culture of Health in the U.S. RWJF's new vision of a Culture of Health requires that the Foundation become more explicit about the need to expand the opportunity for good health for all. As such, RWJF has adopted health disparities[i] as a major priority. RWJF recognizes that persistent health disparities linked with disadvantages experienced by particular populations undercut our nation's founding principle of equal opportunity to life, liberty, and the pursuit of happiness. The Foundation has set an ambitious goal of measurably reducing health disadvantages and disparities.

In spring 2014, RWJF commissioned Prevention Institute to develop a set metrics to inform its broader set of metrics for its Culture of Health. This paper is the outcome of that work. It provides a framework for understanding how disparities in health outcomes are produced and how health equity can be achieved, particularly by addressing the determinants of health. It lays out the determinants of health – structural drivers, community determinants, and healthcare – that must be improved to achieve health equity. It also describes the methods and criteria that Prevention Institute applied to identify health equity metrics. Finally, the paper delineates a set of metrics that could reflect progress toward achieving health equity.

We count what matters. Metrics that measure and track our progress on the determinants of health can help set priorities and inform necessary actions to keep *all* Americans healthy, lower the cost of healthcare, increase productivity, improve quality of life, and ensure that everyone has an equal opportunity to prosper and achieve his or her full potential.

We count what matters. Metrics that measure and track our progress on the determinants of health can help set priorities and inform necessary actions to keep all Americans healthy, lower the cost of healthcare, increase productivity, improve quality of life, and ensure that everyone has an equal opportunity to prosper and achieve his or her full potential.

UNDERSTANDING HEALTH INEQUITY AND HEALTH EQUITY

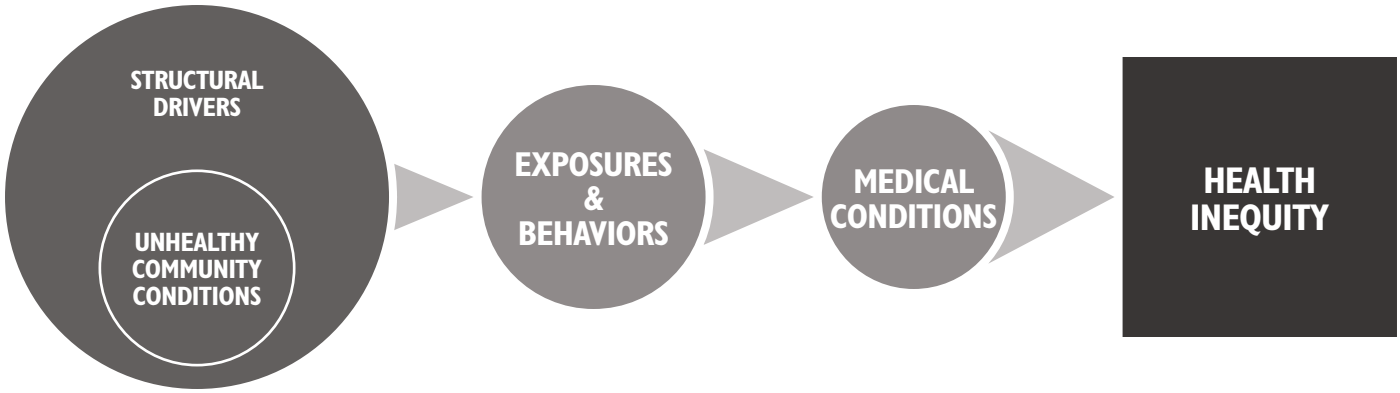
Good health is precious. It enables us to enjoy our lives and focus on what is important to us—our families, friends, and communities. It fosters productivity and learning, and it allows us to capitalize on opportunities. However, good health is not experienced evenly across society. Health inequity is related both to a legacy of overt discriminatory actions on the part of government and the larger society, as well as present day practices and policies of public and private institutions that continue to perpetuate a system of diminished opportunity for certain populations.

The Trajectory of Health Inequity (Diagram A) depicts how inequity in health outcomes are produced. It shows the relationships between structural drivers and unhealthy community conditions (community determinants), exposures and behaviors, medical conditions and health inequity. Structural drivers and community determinants generate inequity, which are exacerbated by exposures and behaviors, and further exacerbated by how medical conditions are addressed in

i At the time of the final production of this paper the RWJF Eliminating Health Disparities team has changed its name to the Achieving Health Equity team. This paper reflects the language in use at the time of the project.

healthcare. The accumulation of inequity across the trajectory is represented by the increasing size of the arrows moving from left to right, indicating that inequity in health outcomes increase at each stage. The diminishing size of the circles from left to right indicates a diminishing contribution to health inequity. The determinants of health have the biggest impact on inequities in health outcomes.

Diagram A: Trajectory of Health Inequity



The Trajectory of Health Inequity (Diagram A) reflects Prevention Institute's Two Steps to Prevention methodology, which traces a pathway from medical conditions to the behaviors and exposures that led to them, and then to the structural drivers and community determinants that are at the root of the behaviors and exposures. Prevention Institute's analysis started with identifying leading medical conditions that reflect health inequity and are leading causes of death, illness and injury. The first step of the Two Steps approach is from examining these leading medical conditions to identifying exposures and behaviors associated with them. Limiting unhealthy exposures and behaviors enhances health and reduces the likelihood and severity of disease. Through an analysis of the factors contributing to medical conditions that cause people to seek care, researchers have identified a set of nine behaviors and exposures strongly linked to the major causes of death: tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and inappropriate drug use.[1] These behaviors and exposures are linked to multiple medical diagnoses and addressing them can improve health broadly.

The Trajectory of Health Inequity reflects Prevention Institute's Two Steps to Prevention methodology, which traces a pathway from medical conditions to the behaviors and exposures that led to them, and then to the structural drivers and community determinants that are at the root of the behaviors and exposures.

Exposures and behaviors are determined or shaped by the environments in which they are present. The second step is from the exposures and behaviors to the environment, identified here as the determinants of health (structural drivers, community determinants, and healthcare). Taking the second step from exposures and behaviors to the environment presents a tremendous opportunity to reduce health inequities by preventing illness and injury before their onset. In analyzing the social determinants of health and health inequities, the World Health Organization (WHO) has identified structural drivers—the inequitable distribution of power, money, opportunity and resources—as a key determinant of inequity in health and safety outcomes.[2] Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequity, contributing to chronic stress and building upon one another to create a weathering effect, whereby health greatly reflects cumulative experience rather than chronological or developmental age.[3]

Structural drivers deeply shape community conditions – the places where people live, learn, work and play. [4] On the whole, a person's zip code is a better predictor of his/her health status and life expectancy than his/her genetic code.[5] Prevention Institute's THRIVE (Tool for Health and Resilience in Vulnerable Environments) framework delineates community determinants that fall into three interrelated clusters: the social-cultural environment (people cluster), the physical/built environment (place cluster), and the economic environment (equitable opportunity cluster). These community determinants fundamentally impact health and health inequity and represent an important place for action to achieve health equality.

Access to quality healthcare services is also an important determinant of health. People want and need high-quality medical care, including good medical, mental health, and dental services, and access to quality, culturally and linguistically appropriate medical and dental care, and emergency medical responses.

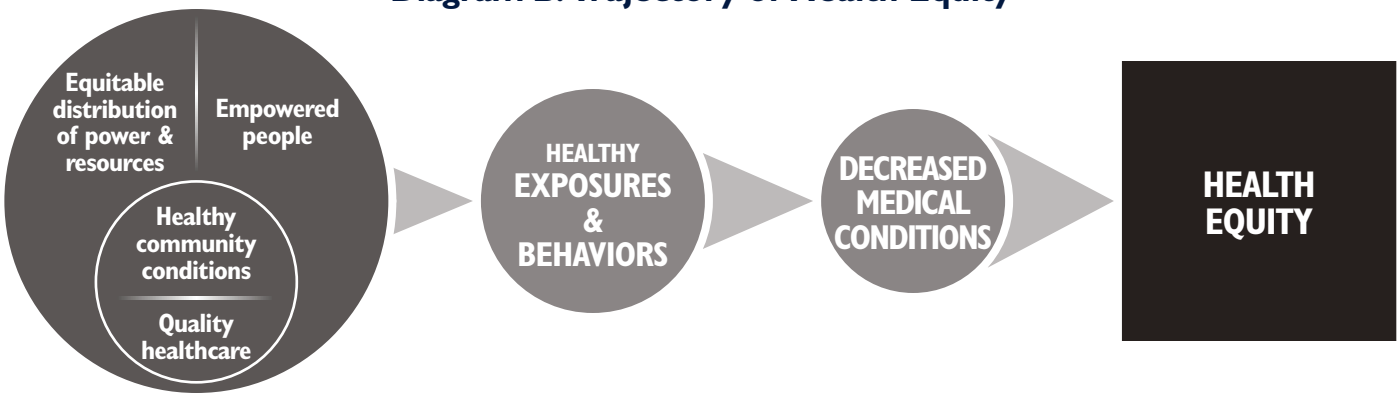
Table A shows the determinants of health, the related sample behaviors and exposures, and the medical conditions. Community determinants are organized into three interrelated clusters: the social-cultural environment (people cluster), the physical/built enviornment (the place cluster), and the economic environment (equitable opportunity cluster).

Table A: Determinants of Health, Related Behaviors and Exposures, and Medical Conditions

Determinants of Health	Behaviors and Exposures	Medical Conditions
STRUCTURAL DRIVERS ■ Inequitable distribution of power, money, opportunity and resources ■ Disempowered people **COMMUNITY DETERMINANTS** **Social-cultural environment (people cluster)** ■ Social networks & trust ■ Participation & willingness to act for the common good ■ Norms & culture **Physical/built environment (place cluster)** ■ What's sold & how it's promoted ■ Look, feel & safety ■ Parks & open space ■ Getting around ■ Housing ■ Air, water & soil ■ Arts & cultural expression **Economic environment (equitable opportunity cluster)** ■ Education ■ Living wages & local wealth **QUALITY HEALTHCARE**	Tobacco/smoking Excessive alcohol Diet/Nutrition Physical activity Chemical exposures and air pollution Sexual behaviors Infections pollens, dust Automobiles Falls Poisoning Weapons Violence Drug use and abuse Trauma and adverse experiences	Heart Disease Cerebrovascular Diabetes Mellitus Malignant Neoplasms Chronic Lower Respiratory Disease Unintentional Injury Suicide Homicide HIV Infant mortality Liver disease Nephritis Mental health conditions and trauma Occupational exposures Drug/substance use and abuse

The Trajectory of Health Equity (Diagram B) shows how improving the determinants of health will generate health equity. Improving structural drivers focuses on equitable distribution of power and resources and empowered people. Improving community determinants leads to healthy community conditions. Healthcare is also determinant of health. Improving this determinant results in quality healthcare. The Trajectory of Health Equity reflects that improving the determinants of health contribute to healthy exposures and behaviors, and decreased medical conditions. The contributions to greater health equity across the trajectory are represented by the increasing size of the arrows moving from left to right.

Diagram B: Trajectory of Health Equity



METRICS FOR HEALTH EQUITY

Altering the determinants of health (structural drivers, community determinants and healthcare) supports health equity. Therefore, the recommended health equality metrics are focused on the determinants of health. Metrics that capture the determinants of health can account for inequity across multiple dimensions including not only race/ethnicity and socio-economics but also geography-, gender-, sexual orientation- and disability-based inequity.

Building on the understanding of health inequity, and the determinants that need to be improved to achieve health equity, Prevention Institute developed a set of metrics. In May and June of 2014, Prevention Institute reviewed existing metrics and measurement projects, particularly for social determinants of health, and interviewed 17 people, including academics, people implementing place-based strategies, researchers who have or are developing metrics and indicator sets, and experts in specific topical areas. Prevention Institute considered health equity principles, terminology used in association with measurements, and criteria to assess individual metrics as well as the composite set of metrics. Numerous considerations were taken into account, including the strengths and limitations of indicators, indexes, and composite measures, the distribution of metrics across the determinants of health, and the need to frame the metrics in a manner that illuminates potential solutions.

Terminology

There are many terms used in association with measurements, including index, measures, metrics, and indicators. For the purpose of this paper, the following terminology is used:

- ***Indicator:*** An indicator is a single measurement.
- ***Index:*** An index is a measurement that includes multiple indicators and is in use by others – particularly for research purposes.
- ***Composite measure:*** A composite measure includes multiple indicators and is not necessarily in use by others but includes specific indicators that correlate strongly with health outcomes.

A set of health equity principles provided guidance and informed the criteria for the selection of the recommended metrics, including, but not limited to, understanding historical forces that have left a legacy of racism and segregation and the acknowledgment of the cumulative impact of stressful experiences and environments. Criteria were developed and applied to evaluate and prioritize potential individual metrics as well as the composite set of metrics. The criteria used to evaluate and prioritize individual metrics consisted of, but was not limited to, such factors as feasibility, measurability, and validity. The criteria used to evaluate and prioritize the set of metrics consisted of, but was not limited to, such factors as whether they align with a Culture of Health metrics and are grounded in health equity principles.

Consideration was given to the strengths and limitations of indicators, indexes, and composite measures. For example, indicators can be straightforward in what they express and can convey direction for policy and action. However, because they are single measures, they don't necessarily reflect complexity. Because indexes include multiple indicators, they are able to account for more complexity than a set of single indicators; yet at face value, they may not appear as actionable as single indicators. Composite measures can account for complexity and fill a gap in the field, but also may not appear as actionable as single indicators. The recommended metrics reflect a mix that maximizes the strengths and minimizes the limitations of indicators, indexes, and composite measures. It is recommended that additional composite measures be developed to fill gaps in the field. For example, a composite measure is recommended to address the strong relationship between community safety and health inequity in a manner that accounts for the complexity of community safety.

Metrics are important both as a tool for measurement of health inequity for the country as well as for clarifying the sources of inequity and fostering understanding of solutions. The recommended metrics also consider the need for effective framing that communicates clear direction and spurs action.

Determining how to distribute the metrics across the determinants (structural drivers, community determinants, and healthcare) is important. The recommended metrics reflect the overall set of determinants while giving balanced consideration to the distribution: about one-third of the set of metrics reflect the structural drivers, about one-half of the set of metrics reflect community determinants, and one-sixth of the set of metrics reflect healthcare. The recommended metrics for structural drivers include attention to: 1) the equitable/inequitable distribution of resources, power, money and opportunity; and, 2) empowered/disempowered people. The recommended metrics for community determinants include: 1) the social-cultural environment (people factors); 2) the physical/built environment (place factors); and, 3) the economic environment (equitable opportunity factors). The recommended metrics for healthcare include attention to access.

Metrics are important both as a tool for measurement of health inequity for the country as well as for clarifying the sources of inequity and fostering understanding of solutions. The recommended metrics also consider the need for effective framing that communicates clear direction and spurs action.

The following recommended health equity metrics reflect the determinants of health (structural drivers, community determinants, and healthcare).

STRUCTURAL DRIVERS

1. Neighborhood Disinvestment Index (index)
2. Gini Index[6] (index)
3. Index of Dissimilarity[7] (indicator)
4. Rates of incarceration by race/ethnicity (indicator)
5. Percent of residents from traditionally marginalized communities in positions of influence (indicator)
6. Geographic distribution of health: life expectancy by zip code (indicator)
7. Community Trauma (composite measure)
8. Community Readiness (composite measure)
9. Number of communities with indicator projects (indicator)

COMMUNITY DETERMINANTS

Social-cultural environment

10. Collective efficacy[8] (index)
11. Civic engagement (composite measure)

Physical/built environment

12. Physical activity environment[9] (index)
13. Retail Food Environment Index (index)
14. Food Marketing to Kids Group (index)
15. Housing Index[10] (index)
16. Affordability of Transportation and Housing[11] (index)
17. Pollution Burden Score[12] (index)
18. Mobility and Transportation[13] (index)
19. Opportunities for engagement with arts, music and culture[14] (index)
20. Per capita dollars spent for park space per city/neighborhood (indicator)
21. Safe place to walk within 10 minutes of home (indicator)
22. Alcohol outlet density (indicator)
23. Number of comprehensive smoke-free policies in places that prohibit smoking in all indoor areas of work-sites and public places (indicator)
24. Community Safety Scorecard[15] (index)
25. Number of cities with a comprehensive, multi-sector violence prevention plan (indicator)

Economic environment

26. Number of living wage policies in place (indicator)
27. Academic achievement (composite measure)
28. Local wealth (composite measure)
29. Complete and livable communities[16] (index)
30. School Environment[17] (index)
31. Percent of families who say it's hard to find the child care they need (indicator)
32. Workplace safety (composite measure)

HEALTHCARE SERVICES

33. Percent of patients that can access a place they call their "medical care home" within two weeks' time (indicator)
34. Patient satisfaction with medical encounters as a measure of culturally and linguistically appropriate care (indicator)
35. Number of medical schools that integrate healthcare disparities and community learning throughout entire curriculum and training (indicator)

ENDNOTES

1 Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA*. 2004;291(10):1238-1245.

2 Commission on Social Determinants of Health (CSDH), World Health Organization. Closing the Gap in a Generation: Health Equity through action on the social determinants of health. Final report of the CSDH. 2008.

3 Geronimus AT. Understanding and eliminating racial inequalities in women's health in the United States: The role of the weathering conceptual framework. *J Am Med Womens Assoc*. 2001;56:133-6, 149-50.

4 Commission on Social Determinants of Health (CSDH), World Health Organization. Closing the Gap in a Generation: Health Equity through action on the social determinants of health. Final report of the CSDH. 2008.

5 House JS, and Williams DR. Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health. In: Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington DC: Institute of Medicine/National Academy Press; 2000: 81-124.

6 The World Bank. World Development Indicators: GINI Index. 2014. Retrieved from: http://data.worldbank.org/indicator/SI.POV.GINI

7 Iceland J, Steinmetz E, Weinberg DH. Measurement of Segregation by the U.S. Bureau of the Census. In: Racial and Ethnic Residential Segregation in the United States: 1980-2000.

8 Morenoff JD, Sampson RJ, Raudenbush SW. Neighborhood inequality, collective efficacy, and the spatial dynamics of urban violence. *Criminology* 39.3 (2001): 517-558.

9 Green LW, Sim, L, Breiner H. Evaluating Obesity Prevention Efforts: A Plan for Measuring Progress. Institute of Medicine. 2012.

10 Connecticut Health Equity Index Online Tool. 2010. Retrieved from: https://www.sdoh.org/

11 Virginia Dept of Health. Virginia Health Equity Report 2012. 2012.

12 Los Angeles County Dept of Public Health. Health Atlas for the City of Los Angeles. United States: Center for Disease Control and Prevention; 2013.

13 Kirwan Institute, The Puget Sound Regional Council. Equity, Opportunity, and Sustainability in the Central Puget Sound Region. Kirwan Institute; May 2012.

14 California Department of Public Health (CDPH). Health Community Indicators Working Draft, Core List. CDPH; 2013.

15 Advancement Project, Violence Prevention Coalition of Greater Los Angeles (n.d.). Community Safety Scorecard. City of Los Angeles: Advancement Project, Violence Prevention Coalition; 2011. Retrieved from http://www.vpcgla.org/wp-content/uploads/2014/10/CommunitySafetyScorecardFINAL10-25-11.pdf

16 California Department of Public Health. Health Community Indicators Core List. Working Draft. 2013.

17 Green LW, Sim, L, Breiner H. Evaluating Obesity Prevention Efforts: A Plan for Measuring Progress. Institute of Medicine. 2012

Health equity and cultural responsiveness

Vision: Ensure equal opportunity to achieve the highest attainable level of health for all populations through policies, programs and strategies that respond to the cultural factors that affect health. Correct historic injustices borne by certain populations. Prioritize development of strong cultural responsiveness by public health organizations.

Six essential components

The six essential components to health equity work listed below are critical to successful implementation of the health equity and cultural responsiveness foundational capability. These components should be applied within the core system functions listed below.

- Identify the current challenges to achieving health equity and eliminating avoidable health gaps and health disparities in Oregon's public health system. Place emphasis on measurements of equity best suited to Oregon's diverse populations.
- Implement a system-wide assessment of health equity to address and measure health and social determinant (social/economic/environmental factors) outcomes by income, race, ethnicity, language, geography and disability. Place emphasis on defining a meaningful community engagement and feedback process.
- Co-create objectives, milestones and outcome measures for resource allocations, funding allocations, work plans and implementation timelines with priority populations. Integrate these across foundational capabilities and foundational programs.
- Work collaboratively across the foundational capabilities and programs to create accountability structures and internal metrics for health equity through position descriptions, strategic planning and program management.
- Co-create strategies and resources with priority populations to build a more diverse leadership and workforce in Oregon's public health system.
- Make financial investments to support effective, equitable and quality public health policies, programs and strategies that are responsive to cultural health beliefs and practices, preferred languages and literacy level.

Core system functions

Core system functions for heath equity and cultural responsiveness are based on Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NAACHO) standards.(1,2) The governmental public health system will:

a. Monitor health status and track the conditions that influence health issues.

b. Foster shared understanding and will to achieve health equity and cultural responsiveness.

c. Engage with the community to identify and eliminate health inequities.

d. Leverage and engage partnerships in health equity solutions.

e. Develop public health policies and plans to achieve health equity, protect people from health hazards and prevent health problems.

f. Leverage existing and new funding for health equity.

g. Build and maintain a competent, representative and culturally responsive public health workforce.

h. Strengthen organizational effectiveness in support of health equity.

i. Contribute to and apply the evidence base of public health and relevant fields.

Roles

Monitor health status and track the conditions that influence health issues.

State	Local		
✓		a.	Collect and maintain data that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.
	✓		Collect and maintain data, or use data provided by PHD that reveal inequities in the distribution of disease. Focus on the social conditions (including strengths, assets and protective factors) that influence health.
✓		b.	Make data and reports available to local public health authorities, partners and stakeholders, and other groups.
✓		c.	Compile comprehensive data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through partnerships with relevant state and local agencies.
	✓		Compile local data on health resources and health threats (e.g., schools, parks, housing, transportation, employment, economic well-being and environmental quality) through local partnerships, or use information collected and provided by PHD.

State	Local		
✓	✓	**d.**	Identify population subgroups or geographic areas characterized by: i. An excess burden of adverse health or socioeconomic outcomes; ii. An excess burden of environmental health threats; or iii. Inadequate health resources that affect health (e.g., quality parks and schools).
✓		**e.**	Implement the Race, Ethnicity, Language and Disability (REAL+D) law (ORS 413.161), and collect and maintain meaningful, disaggregated, standardized and actionable demographic data.
✓		**f.**	Based on REAL+D data, conduct cultural and linguistic assessments of relevant policies, programs and strategies to: i. Measure the gaps; ii. Develop continuous improvement plans; ii. Monitor and evaluate health equity outcomes; and iv. Inform implementation of policies, programs and strategies.

Foster shared understanding and will to achieve health equity and cultural responsiveness.

State	Local		
✓	✓	**a.**	Develop and promote shared understanding of the determinants of health, health equity and lifelong health.
✓	✓	**b.**	Promote a common understanding of cultural responsiveness.
✓	✓	**c.**	Promote understanding of the extent and consequences of systems of oppression.
✓	✓	**d.**	Make the economic case for health equity, including the value of investment in cultural responsiveness.
✓		**e.**	Increase the value for cultural responsiveness in PHD and among local public health authorities.
✓		**f.**	Develop or support mass media educational efforts that uncover the fundamental social, economic and environmental causes of health inequities.

Engage with the community to identify and eliminate health inequities.

State	Local		
✓	✓	**a.**	Make data and information available on health status and conditions that influence health status by race, ethnicity, language, geography, disability and income. Consider health literacy, preferred languages, cultural health beliefs and practices, and other communication needs when releasing data and information.
	✓	**b.**	Communicate with constituents about the health of their community, especially on policies and decisions relating to health equity priorities.

State	Local		
✓	✓	**c.**	Learn about the culture, values, needs, major concerns and resources of the community. Respect local community knowledge and seek to understand and formally evaluate it.
✓	✓	**d.**	Provide technical assistance to communities to analyze data, set priorities, identify levers of power and develop policies, programs and strategies.
✓	✓	**e.**	Enhance people's capacity to conduct their own research and participate in health impact assessments based on the principles of Community-Based Participatory Research, CDC's Community Engagement Principles and the National Environmental Justice Advisory Council's community collaboration principles.
✓	✓	**f.**	Support the community's analysis of and advocacy for policies and activities to eliminate health inequities. Share, discuss and respond to feedback from people on civil rights law implementation using tracked findings to report ways to decrease civil rights violations.
✓	✓	**g.**	Support community engagement task forces to develop and recommend strategies to engage low income, racial/ethnic and disabled community members in state and local government.
✓	✓	**h.**	Routinely invite and involve community members and representatives from community-based organizations in public health authority planning, procedures, evaluation and policies. Offer means of engagement to suit the unique cultures of community members.
✓	✓	**i.**	Increase racial and ethnic representation on councils and committees.
✓	✓	**j.**	Provide public health services that are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
✓		**k.**	Work with local public health authorities when working with local communities.

Leverage and engage partnerships in health equity solutions.

State	Local		
✓	✓	**a.**	Support, implement and evaluate strategies that tackle the root causes of health inequities through strategic, lasting partnerships with public and private organizations and social movements.
✓	✓	**b.**	Engage in dialogue with people, governing bodies and elected officials about governmental policies responsible for health inequities, improvements being made in those policies and priority health issues not yet being adequately addressed.
✓	✓	**c.**	Partner to enhance multidisciplinary and multi-sector capacity to address health equity. Support health equity in all policies.
✓	✓	**d.**	Work collaboratively across the governmental public health system on state and local policies, programs and strategies intended to ensure health equity.
✓		**e.**	Advocate for health equity in health system reform.

Develop public health policies and plans to achieve health equity, protect people from health hazards and prevent health problems.

State	Local		
✓	✓	**a.**	Play a leadership role in reducing or mitigating existing social and economic inequities and conditions that lead to inequities in the distribution of disease, premature death and illness.
✓	✓	**b.**	Use existing evidence-based measures or develop public health measures of neighborhood conditions, institutional power and social inequalities that lead to prevention strategies focused on the social and environmental determinants of health.
✓	✓	**c.**	Advocate for comprehensive policies that improve physical, environmental, social and economic conditions in the community that affect the public's health.
✓		**d.**	Ensure routine review and revisions of statutes that govern PHD and other regulations and codes to ensure nondiscrimination in the distribution of public health benefits and interventions.
✓		**e.**	Monitor relevant issues under discussion by governing and legislative bodies.

Leverage existing and new funding for health equity

State	Local		
✓	✓	**a.**	Leverage health system reform funding for health equity and to build cultural responsiveness into health care delivery and funding mechanisms.
✓	✓	**b.**	Monitor funding allocations to ensure sustainable impacts on health equity.
✓	✓	**c.**	Increase flexible categorical and non-categorical funding to address health equity.
✓	✓	**d.**	Promote public and private investments in community infrastructure that sustain and improve community health, such as education, childhood development, mass transit, employment, healthy design in the built environment and neighborhood grocery stores.
✓	✓	**e.**	Expand policies to require focus on health equity and cultural responsiveness in all funding opportunities.

Build and maintain a competent, representative and culturally responsive public health workforce.

State	Local		
✓		**a.**	Develop an ongoing process of continuous learning, training and structured dialogue for all staff across PHD that: i. Explores the evidence of health inequity and its sources; ii. Explains the root causes of health inequities and the changes needed to address those root causes; iii. Examines the values and needs of the community; iv. Assists in providing core competencies and skills that achieve health equity; v. Increases staff capacity to modify and improve program implementation and service delivery in response to cultural practices, values and beliefs; and vi. Strengthens staff knowledge and skills in collecting, analyzing, interpreting and applying health inequity data.
✓	✓	**b.**	Draw on the skills and knowledge of staff who are members of communities most affected by inequities.
✓		**c.**	Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities. Make these tools available to local public health authorities.
	✓		Assess staff knowledge and capabilities about health inequity. Develop or use an existing training to improve staff knowledge and capabilities.
✓		**d.**	Develop or use an existing antidiscrimination training to build a competent workforce. Make training available to local public health authorities.
	✓		Develop or use an existing antidiscrimination training to build a competent workforce.
✓	✓	**e.**	Commit and invest existing and additional resources in recruitment, retention and advancement efforts to improve workplace equity.
✓	✓	**f.**	Establish parity goals and create specific metrics with benchmarks to track progress.
✓	✓	**g.**	Increase awareness and practice of health equity among hiring managers and supervisors so sensitivities to and understanding of root causes of health inequities are part of hiring. Include willingness to learn, cultural humility, creativity and listening skills to address cultural dominance.
✓	✓	**h.**	Hire staff with the skills, knowledge and abilities to take part in community organizing, negotiation and power dynamics, and who can mobilize people, particularly those from communities served.
✓		**i.**	Develop an ongoing community engagement process for recruitment.
✓		**j.**	Establish greater flexibility in job classifications to tackle the root causes of health inequity.
✓		**k.**	Develop relationships with high schools and colleges to ensure diverse groups of youth will join the public health workforce.

Strengthen organizational effectiveness in support of health equity.

State	Local		
✓	✓	a.	Ensure health equity and cultural responsiveness are fully integrated in state and local strategic priorities and plans, including state and community health improvement plans.
✓		b.	Conduct an internal assessment, of PHD's overall capacity to act on the root causes of health inequities. Include organizational structure and culture.
	✓		Conduct an internal assessment of the local public health authority's overall capacity to act on the root causes of health inequities. Include organizational structure and culture and ability to deliver public health services and programs to people within the context of their cultural background.
✓	✓	c.	Ensure all PHD and local public health authority programs integrate achieving health equity as a measurable outcome through cultural responsiveness of staff and program delivery.
✓		d.	Develop and provide health equity and cultural responsiveness best practices, technical assistance and tools to local public health authorities.

Contribute to and apply the evidence base of public health and relevant fields.

State	Local		
✓	✓	a.	Stay current with the literature on health equity, synthesize research and disseminate findings applicable to staff and the community.
✓	✓	b.	Evaluate and disseminate knowledge of findings and efforts on health equity (e.g., conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities).
✓		c.	Support research on the social processes and decisions that generate and maintain health inequities based on race, class, gender, disability and national origin.
✓		d.	Conduct and disseminate research that supports and honors the value of community actions to address the fundamental environmental, social and economic causes of health inequities.

Deliverables

State	Local		
✓	✓	a.	Internal assessment, completed within the previous five years, of the state or local authority's overall capacity to apply a health equity lens to programs and services, provide culturally responsive programming and services, and status of the division's structure and culture as a barrier or facilitator for achieving health equity.
✓	✓	b.	Action plan that addresses key findings from the internal assessment and includes organizational changes that support a health equity lens and cultural responsiveness. Action plan includes metrics and an accountability structure that identifies responsible work units, tasks, timelines and performance measures.
✓	✓	c.	Documentation that demographic data are used to evaluate the impact of public health policies, programs and strategies on health equity and health outcomes, and to inform public health action moving forward.

State	Local		
✓	✓	**d.**	Training plan to increase staff capacity to address the causes of health inequities, promote health equity and implement culturally responsive programs. Documentation that training is provided to staff annually.
✓	✓	**e.**	State or community health improvement plan, developed within the previous five years, that specifically addresses health equity and cultural responsiveness.
✓		**f.**	Documented strategy to increase the diversity of PHD workforce by 10 percent in five years.

Critical tools and resources

State	Local		
	✓	**a.**	Roots of Health Inequity; National Association of City and County Health Officials (http://naccho.org/topics/justice/roots.cfm).
	✓	**b.**	Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A guide for local health department epidemiologist and public health professionals (http://barhii.org/resources/sdoh-indicator-guide/).
✓		**c.**	OHA/DHS Learning Center
✓		**d.**	Academic partnership
✓		**e.**	National Association of Chronic Disease Director's Health Equity Council (https://chronicdisease.site-ym.com/?HETools)
✓	✓	**f.**	National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (www.thinkculturalhealth.hhs.gov/content/clas.asp)
✓		**g.**	OHA Office of Equity and Inclusion