AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

January 26, 2017
10:00-11:00 am
Portland State Office Building, room 918

Conference line: (888) 251-2909 Access code: 8975738
Webinar link: https://attendee.gotowebinar.com/register/5839128403240375555

Meeting Objectives

- Approve December meeting minutes
- Review and provide feedback on draft proposal for developing accountability metrics
- Plan for subcommittee meetings in 2017

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

10:00-10:05 am	**Welcome and introductions** • Review and approve December 6 minutes	Sara Beaudrault, Oregon Health Authority
10:05-10:35 am	**Proposal for developing accountability metrics** • Review draft proposal provided by OHA staff • Provide feedback on proposal, including the role for the Accountability Metrics subcommittee	All
10:35-10:45 am	**Subcommittee business** • Confirm that Jennifer will provide update at February PHAB meeting, or determine which subcommittee member will provide update • Determine meeting frequency for 2017 • Plan agenda for next subcommittee meeting	All
10:40-10:50 am	**Public comment**	
11:00 am	**Adjourn**	

PUBLIC HEALTH ADVISORY BOARD
DRAFT Accountability Metrics Subcommittee Meeting Minutes

December 6, 2016
1:00 – 3:00pm

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

PHAB Subcommittee members absent: none

OHA staff: Sara Beaudrault, Myde Boles, Angela Rowland

Members of the public: Kelly McDonald, Kathleen Johnson

Welcome and introductions

The November 8th draft meeting minutes were unanimously approved by the subcommittee.

Debrief PHAB discussion

Subcommittee members discussed the feedback they received at the November PHAB meeting and whether any changes to the current approach are needed based on the feedback:

- Teri noted that at the November PHAB meeting and in other discussions, she is hearing that the metrics should be tied to the deliverables in the *Public Health Modernization Manual*. This group can work backward from deliverables to identify the corresponding measures.
- PHAB was supportive of 2-3 metrics for each foundational capability and program
- PHAB discussed the approach for health equity measures. This subcommittee's current recommendation is to have a set of stand-alone health equity measures while also ensuring that health equity is woven into all other measurement areas. Eva offered to collect suggestions or resources from PHAB members on the development of health equity measures but did not receive anything.
- Eli recommended inviting someone from the OHA Metrics and Scoring Technical Advisory Group (TAG) committee to attend an Accountability Metrics subcommittee meeting. Metrics and Scoring has a robust process for identifying and developing metrics. Eli also recommended that this group continue to seek

out relevant national data sets or outside expertise to inform this subcommittee's work.

Subcommittee members clarified that what goes forward in the statewide modernization plan does not need to be final or complete. Work to date will be included, with a statement that work will continue to develop and finalize accountability measures in 2017.

Measure selection for communicable disease, environmental health and emergency preparedness

Subcommittee members discussed CLHO measure recommendations. Eli requested a merged and consolidated spreadsheet of measures to work from.

Subcommittee members discussed how to work backward from deliverables to measures. Muriel stated the group could take the deliverables of a modern public health system and then identify the outcome of fulfilling that deliverable.

Emergency Preparedness

- Public health's work is to plan, prepare and engage. It may not seem transformative, but it is core to emergency preparedness.
- Subcommittee members identified these as potential areas to focus: staff training and community engagement

Environmental health

Subcommittee members discussed a measure proposed by the CLHO healthy communities committee: the LHD's ability to provide timely, accurate and culturally appropriate technical assistance to partners and the community on environmental health hazards. This measurement concept focuses on the need for public health to be able to respond to any emerging environmental health need. This puts public health in the position to be proactive rather than reactive. Subcommittee members agreed this measure should be included.

Subcommittee members discussed whether to include a measure to assess whether community health improvement plans include environmental health priorities. CHIPs tend to be medically-focused. Subcommittee members discussed opportunities for incorporating environmental health priorities locally and were supportive of using this as an accountability metric. This would also give public health authorities more credibility to push for environmental health to be included in shared CHIPs.

Another measurement area is around the built environment: transportation, land use planning, biking and walking paths, etc. Jennifer asked whether built environment fits better with chronic disease accountability metrics because of the connection with obesity prevention. However, built environmental also includes industrial land use, air quality, etc. Eli called attention to the *Public Health Modernization Manual* deliverable

DRAFT

related to built and natural environments. Teri discussed the need to build and demonstrate capacity – for example sending staff to health impact assessment trainings – before being able to engage fully in shaping the built and natural environment. Eli proposed "Demonstrate capacity to address challenges to health resulting from changes in the built and natural environment" as a metric, and other subcommittee members agreed.

Communicable disease

Subcommittee members discussed communicable disease measures at the September meeting. At that time subcommittee members supported measures related to sexually transmitted infections, immunization, and possibly foodborne illness and TB. In September subcommittee members did not support including healthcare-associated infection measures.

Teri cautioned against looking at STI numbers because the ability to move the numbers varies from health department to health department. The public health system needs to demonstrate that it has the expertise for health education and technical assistance for health care providers. Jennifer stated that this is consistent with the priorities of health officers who are concerned that the public health system be nimble, credible and leaders.

Eli asked whether a measure could be around tracking epidemics and having the ability to react quickly to disease trends. PHD staff will craft a measure.

Muriel suggested having one concrete, disease-based measure. It is easier for partners and others to understand. Teri questioned using STIs for a disease-based measure because outbreaks are unpredictable and can be based on the culture of local communities.

Jennifer proposed "partner notification around STI cases" as a tangible measure. Partner notification is squarely within public health's wheelhouse, is a proven strategy and is an area where public health could make significant improvements. She suggests focusing on syphilis, gonnorhea and HIV.

Teri noted that, since every local health department will have a unique baseline, each health department should also have specific improvement targets. Eli stated that this method – the Minnesota Method – is used for the CCOs.

Subcommittee members discussed including an immunization measure. Subcommittee members expressed concern about including a measure since some health departments no longer give immunizations. Muriel stated that local health departments can promote immunizations and work with partners but cannot be held responsible for rates. However, because two year old immunization rates are a CCO incentive measure, this presents an opportunity for public health and CCOs to have shared responsibility. Teri stated that, as some health departments move away from providing immunizations, they need to continue to be the experts in immunization as a proven

DRAFT

population health intervention and should convene community approaches to improve immunization rates. PHD staff will draft a metric to capture this.

PHD staff will send draft metrics to the subcommittee to review prior to the 12/15 PHAB meeting.

Review accountability metrics overview

Subcommittee members reviewed the Accountability Metrics overview that will be included in the statewide modernization plan. Subcommittee members provided feedback on the "next steps" section of the overview, including a stakeholder survey on proposed public health metrics. There will likely be a public health modernization legislative concept in 2017 that will clarify use of accountability metrics.

Eli questioned how data for these measures will be collected and described the mechanisms used for CCO incentive measures. OHA had included resources for accountability metrics data collection, analysis and reporting in its policy option package proposal. Since this policy option package was not included in the Governor's recommended budget, it is not clear at this point what resources will be available.

Subcommittee members again expressed interest in a joint meeting with the PHAB Incentives and Funding subcommittee.

Subcommittee Business
2017 subcommittee meeting structure – subcommittee members discussed whether to continue to meet monthly for one or two hours, or whether a different process should be used, PHD staff will talk with other OHA staff to learn more about the process used to develop CCO incentive metrics. PHD staff will draft a proposal for this group to review on how to move forward in 2017.

Sara will look at the order subcommittee members have given updates at PHAB meetings and contact the next person in line.

Public comment
Kathleen Johnson, Coalition of Local Health Officials

Adjournment

The meeting was adjourned.

DRAFT

PHAB Accountability Metrics subcommittee
January 26, 2017
Public Health Accountability Metrics Proposal

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

The Public Health Advisory Board Accountability Metrics subcommittee formed in May 2016 to develop recommendations for public health accountability metrics. Accountability metrics are critical to demonstrating progress toward achieving improved system performance and health outcomes.

In 2016 the subcommittee reviewed existing state and national measure sets and identified preliminary measures for five foundational capabilities and programs. Throughout this process a number of barriers were identified, including:

- Lack of existing public health data sets;
- Challenges to identifying measures for which public health is solely responsible;
- Feasibility of measuring the impact of public health interventions;
- The time needed to see changes in population health outcomes resulting from public health interventions;
- Insufficient subject matter expertise for making recommendations on measures for specific health areas.

This proposal attempts to address these barriers while laying out a process for developing public health accountability metrics in 2017. Proposed bodies of work are listed below.

Identify population health outcome metrics for each foundational program (Feb-April 2017)
Population health outcome metrics will demonstrate progress for the public health system, not individual local public health authorities.

1. Public Health Division will make recommendations for 1-3 state health profile indicators or other health outcome metrics for each foundational program.
2. Public Health Division will make recommendations for statewide benchmarks.
3. Recommendations will be provided to Accountability Metrics subcommittee.

Identify local public health accountability metrics (February-June 2017)
Local public health accountability metrics will demonstrate progress toward achieving public health system roles and functions outlined in the Public Health Modernization Manual. These roles and functions are essential for improve population health outcomes.

1. PHD staff will convene small groups of subject matter experts (SMEs) to identify and develop local public health accountability metrics.

DRAFT

2. Small groups will include state and local public health staff. PHAB subcommittee members are welcome to be involved.
3. One to two small groups will be formed initially to focus on accountability metrics for 1-2 foundational programs. (possibly communicable disease and chronic disease)
    a. These groups can look at PHAST measures, *Public Health Modernization Manual* deliverables, etc.
4. Small groups will use the criteria established by Accountability Metrics subcommittee to select measures.
5. Recommendations will be provided to Accountability Metrics subcommittee
6. Small groups will also define measurement criteria (what information is collected, pass/no pass)

Identify and establish mechanism for data collection (July-September 2017)

1. Public Health Division will identify short-term and long-term data collection mechanisms.
2. Public Health Division will make recommendations to the Accountability Metrics subcommittee

Conduct stakeholder survey (July-September 2017)

The Oregon Health Authority and PHAB Accountability Metrics subcommittee will field a survey to inform the development of accountability metrics. The intent will be to collect feedback from a variety of stakeholders on a set of proposed accountability measures for public health.

1. Activities to be determined

Collect baseline data (timeline TBD)

1. Collect and analyze baseline data
2. Set benchmark and improvement targets
3. Issue accountability metrics report

Develop mechanism for awarding performance-based incentives to local public health authorities (timeline TBD)

1. Work with Incentives and Funding subcommittee to develop a mechanism for awarding performance-based incentives to local public health authorities through the local public health funding formula.

DRAFT

Initial proposal for accountability metrics		
Achieving improved health for all people in Oregon requires comprehensive, multi-sector approaches. The public health modernization accountability metrics measure both the specific roles and functions that are the primary responsibility of public health authorities and the health outcomes that are expected to improve when those roles and functions are achieved. The PHAB subcommittee will continue to develop this initial set of accountability metrics in 2017.		
Foundational program/capability	**Local public health authority metrics**	**Statewide population health metrics** (Note: this column was not included in the statewide modernization plan. PHD proposes adding a short list of population health metrics to the framework for accountability metrics)
	These metrics measure progress toward achieving public health system roles and functions that are essential for improve population health outcomes. Achieving these measures is within the control of state and local public health agencies. In the future a subset of these measures may be used to award performance-based incentives.	These metrics measure progress toward achieving population health outcomes. Making improvement in these population health indicators requires comprehensive, cross-sector approaches. Achieving the local public health authority metrics will directly lead to improvements in these population health outcomes. The metrics listed below are existing state health profile indicators.
Communicable disease control	**Increase capacity to respond to epidemiological changes and communicable disease threats** • Documented provision of timely and relevant epidemiological information to community members	Pertussis among infants Influenza hospitalizations Salmonellosis incidence HIV infections Clostridium difficile incidence

DRAFT

	• Evidence that outbreak summaries have been made available to community members **Demonstrate public health expertise by providing health education resources and technical assistance for vaccine-preventable diseases, health care-associated infections, antibiotic resistance and related issues.** **Increase partner notification for HIV, syphilis and gonorrhea (Update)** • Number of sexually transmitted infection (STI) contacts followed by the public health authority in the past 12 months • Number of FTE trained and employed to conduct STI case management including: client interviewing, partner notification and referral, untreated patient referral, education, and consultation for individuals diagnosed with an STI • The portion of cases that had at least one contact that received treatment (all syphilis and gonorrhea cases who are HIV co-infected) **Convene health care, early learning and other partners to develop state and community strategies to improve childhood and adolescent immunization rates** • Documented state and local plans to improve childhood immunization rates that include ongoing evaluation and reporting	Norovirus outbreaks in long-term care facilities Tuberculosis incidence Gonorrhea incidence Syphilis incidence *100% of Oregonians diagnosed with HIV are in medical care within 30 days. (Proposed by Dr. Vines)* *The percentage of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within 3 months after diagnosis (Proposed by Dr. Vines)*

DRAFT

Environmental health	**Demonstrate public health expertise by providing timely, accurate and culturally appropriate technical assistance to partners and the community on environmental health hazards.** • Documented assessments of environmental health hazards and protection recommendations • Documented health analyses prepared for other organizations **Demonstrate public health expertise to address challenges in health resulting from changes to the built and natural environment** • Documentation of reports on projected changes in health resulting from changes to the built or natural environment • Documentation of trained state and local public health staff in health impact assessments **Demonstrate local planning for environmental health and environmentally-related disease** • Evidence that state and local community health assessments include data and information on environmental health and environmentally related diseases • Evidence that state and community health improvement plans include strategies to address environmental health threats and reduce environmentally related diseases	To be developed through *Healthy Places Initiative*

DRAFT

Prevention and Health Promotion		Opioid-related overdose deaths Suicide deaths Falls among older adults Lung cancer Heart attack hospitalizations Tooth decay Diabetes prevalence Obesity in children, adolescents and adults Alcohol-related deaths Binge drinking Current cigarette smoking Marijuana use Sugar-sweetened beverage consumption Physical activity
Access to Clinical Preventive Services		Childhood developmental screening Effective contraceptive use Dental visits Influenza vaccination HPV vaccination rates Colorectal cancer diagnosis and screening Breast and cervical cancer screening
Emergency preparedness	**Increase state and local capacity to respond during an event**	

DRAFT

	• Evidence of training for all state and local staff that would be called upon to assist during an event • Evidence of current emergency preparedness plans in all state and local jurisdictions that meet established state and federal guidelines **Increase community engagement in emergency preparedness activities** • Evidence of community engagement strategy in emergency preparedness plans • Documented evaluation of community needs and engagement efforts in situational assessments and after-action plans	
Health equity	**Health equity will be a component in metrics for all foundational program and capabilities, in addition to being a stand-alone set of metrics.** **Reduce health disparities by ensuring measure sets for all 2017–19 priority areas include a focus on achieving health equity.** **Increase capacity for state and local public health authorities for advancing health equity. This will be measured by:** • Evidence of increased workforce recruitment from communities adversely affected by health disparities *(NACCHO measure)* • Increased percentage of state and local public health authorities with policies for training, engagement and recruitment *(Public Health Modernization Manual)*	

DRAFT

	• Increased percentage of state and local public health authorities that have fully integrated health equity into the strategic plan and SHIP/CHIP *(Public Health Modernization Manual)*	
Public health system change	**Increase public health leadership, expertise and involvement in state and local policy that may affect health. This will be measured by:** • Prepared issue briefs and recommendations for policymakers *(NACCHO measure)* • Technical assistance provided to legislative, regulatory or advocacy groups *(NACCHO measure)* • Evidence of health in all policies **Increase the efficiency and effectiveness of the public health system through cross-jurisdictional sharing. This will be measured by:** • Increased percentage of LPHAs with MOUS or contracts for cross-jurisdictional sharing with other LPHAs or the Oregon Public Health Division **Increase the impact of health interventions by forming cross-sector partnerships and collaborations. This will be measured by:** • Increased percentage of state and local public health authorities with MOUs, contracts or shared work plans in place with health care and early learning providers, CCOs and other community partners • Evidence of evaluation of shared projects or initiatives	

DRAFT