AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

July 21, 2021
8:00-9:30 am

Join ZoomGov Meeting
https://www.zoomgov.com/j/1601161415?pwd=Tmd1dHhXcGppd0VHOStZY3lOKy80dz09

Meeting ID: 160 116 1415
Passcode: 848357
(669) 254 5252

Meeting Objectives:
- Approve June meeting minutes
- Discuss and make recommendations for public health system accountability through accountability metrics
- Discuss opportunities to align Healthier Together Oregon and public health accountability metrics

Subcommittee members: Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Poe, Sarah Present

OHA staff: Sara Beaudrault, Kusuma Madamala

8:00-8:10 am	**Welcome and introductions** • Welcome new committee member • Approve June minutes • Updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
8:10-8:40 am	**Public health system accountability** • Review PHAB's Health Equity Policy and Procedure • Discuss and make recommendations for public health system accountability • Review changes to measure selection criteria to ensure accountability	All
8:40-9:20 am	**Healthier Together Oregon**	Christy Hudson, Oregon Health Authority

	• Hear overview of [Healthier Together Oregon](#) (HTO) and discuss its relation to public health accountability metrics • Discuss opportunities to align HTO indicators and strategies with accountability metrics	
9:20-9:25 am	**Subcommittee business** • Next meeting scheduled for 8/18	All
9:25-9:30 am	**Public comment**	
9:30 am	**Adjourn**	All

PHAB Accountability Metrics Group agreements

- Stay engaged

- Speak your truth and hear the truth of others

- Expect and accept non-closure

- Experience discomfort

- Name and account for power dynamics

- Move up, move back

- Confidentiality

- Acknowledge intent but center impact: ouch / oops

- Hold grace around the challenges of working in a virtual space

- Remember our interdependence and interconnectedness

- Share responsibility for the success of our work together

PHAB Accountability Metrics subcommittee

2021 timeline for discussions and deliverables

April	- Discuss charter and group agreements - Hear overview on public health modernization and accountability metrics statutory requirements
May	- No meeting
June	- Finalize charter - Discuss survey modernization findings and how to apply findings to public health accountability metrics - Discuss criteria for measure selection
July	- Discuss and make recommendations for public health system accountability - ~~Finalize criteria for measure selection (deliverable)~~ - Discuss *Healthier Together Oregon* and its relation to public health system accountability - Continue developing criteria for measure selection - Begin review of communicable disease and environmental health outcome measures
August	- Finalize criteria for measure selection (deliverable) - Continue review of measures
September	- Continue review of measures
October	- ~~Finalize recommendations for measures~~ - Continue review of measures
November	- Finalize recommendations for measures - Final PHAB approval
2022	- Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures. - Develop 2022 public health accountability metrics

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

June 16, 2021
8:00-9:30 am

Subcommittee members present: Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Present

Subcommittee members absent: Sarah Poe

OHA staff: Sara Beaudrault, Kusuma Madamala

Welcome and introductions

Sara B. welcomed subcommittee members and reviewed the agenda.

Sarah P. suggested reviewing subcommittee membership and whether additional members should be recruited.

Sara B. said that there are currently five members: three PHAB members and two community partners. OHA is trying to recruit an additional community partner. Typically PHAB subcommittees have had around five members, which is small enough to move the work forward but can place burden on a small number when other group members aren't able to join.

Kat clarified that the subcommittee makes recommendations and does deep dives into topics but does not make decisions.

Sarah P. said that it would be beneficial to ensure that there is a local public health administrator who is able to join since local public health has responsibility for these metrics. Since Sarah Poe is a health administrator, this need may already be in place.

April minutes were unanimously approved.

Sara B. showed the group agreements and reminded members that these are for the subcommittee's use.

Subcommittee charter

Sara B reviewed changes made to the metrics after the April meeting, which included:

- Updates to the list of stakeholders;
- Added deliverables for developing new metrics and making recommendations for sharing information with communities.
- Added an out of scope item, which was for developing metrics for groups other than public health.

Sarah P. recommended using a term other than "developmental" metric, which may be associated with child development. Sara B. will make this change.

Subcommittee members agreed to consider the charter complete for the time being. It can be updated as needed.

Survey modernization

Kusuma provided an overview. Survey modernization began with two data collection systems, the Behavioral Risk Factor Surveillance Survey (BRFSS) and Oregon Healthy Teens Survey. Both are relied on by the State and nationally, covering risk behaviors, protective behaviors and health outcomes. For BRFSS a racial and ethnic oversample is conducted every few years. The survey is expensive and long, lacks estimates for smaller geographic areas, and there are concerns about representativeness due to lack of community engagement. Kusuma's team collaborated with four project teams: a Latinx group, a Black/African American group, an American Indian/Alaska Native group convened through the Northwest Portland Area Indian Health Board, and a Pacific Islander group. The first three groups reviewed the survey data that are already collected, reviewed gaps and identified areas that could be improved. These teams also provided additional data collection to begin filling gaps. The Pacific Islander group conducted a data collection process. At the same time, others on Kusuma's team were pilot testing some innovative methods for data collection. Those results will be integrated with the results from the project teams into a final report.

Kusuma shared some key themes from the data reviews related to:
- Small sample size. Even with racial and ethnic oversamples, questions were raised about representativeness.
- Concerns about health literacy.
- Lack of meaningful context in data collection.
- Questions need to be actionable and the way data are collected prohibits this.
- Need to integrate other data sources to tell a story.
- Intersectionality.

Kusuma shared preliminary recommendations from the project teams. When surveys don't ask, understand or map the possible reasons for health outcomes, the data aren't actionable. If they're not actionable, we can't hold ourselves accountable as public health agencies.
- Recognition that scientific integrity is compromised when community is not engaged in data collection, analysis and how data are used.
- Behavior questions, when presented without context, shift responsibility to individuals and let institutions off the hook.

- Misrepresents peoples' experiences.
- Equity needs to be a starting point in survey design.
- Questions and resulting data need to be actionable to drive policy and program changes.
- Time and resources for relationship development need to be built into projects.
- Long-term sustained, compensated, community led data collection.
- Learn from California Health Interview Survey.
- Integrate community leadership in survey development, analysis and use.

Kusuma encouraged members, as they think about accountability metrics, to think about the data source, what is collected by whom, how those data are shared, and who is accountable for progress. She echoed the need for actionable data.

Jeanne asked for an example of actionable data or data that communities would like to be connected.

Kusuma provided an example for school absenteeism. In OHT, now called Student Health Survey, there is only a focus on absenteeism and not the everyday lives of why a student is absent. There is a lack of meaningful context. What are the reasons that prevent someone from doing something and how can this be mapped to policy? A big piece of this is integration with other data sources.

Sarah P. expressed gratitude for this project and for how the information is being presented. She sees a path forward for how recommendations can be implemented. She provided an example of the built environment and explained local public health roles in environmental health. Current funding is for regulatory work. There is little to no funding for nonregulatory work. And while many LPHAs are ready to jump into this work with community partners, lack of funding is an issue. As we look to the metrics that will affect the next round of public health modernization funding. this discussion is really timely.

Sarah P. noted that Kusuma mentioned metrics for mental health. Sarah P. Is exploring metrics for how youth are affected by climate change and suggested that this subcommittee could keep that in mind as an area for looking at mental health and climate change.

Kat said the integration piece stands out to her. Just presenting a statistic doesn't help without broader connections. As the subcommittee gets into criteria pieces, there may be opportunities for how to illuminate disparities in a more actionable way. She also said that some of the issues being discussed happen at the city or parks and rec level and asked what the LPHA responsibility is to work at these levels of government.

Olivia agrees that it is necessary to make connections and integrate data. She said it is important to build from family units because education and changes start there. She provided an example of tobacco prevention, and it needs to start in communities and families themselves, and include settings like libraries, churches, parks and schools.

Sara B. asked if there is other information the subcommittee would like to support the subcommittee's work.

Sarah P. asked if the survey modernization community partners will continue to work together.

Kusuma responded that the survey modernization team leads plan to meet with PHAB members again to allow time for discussion and next steps.

Jeanne said that she is working toward equity in the CCO space, in particular for reworking how to utilize data to inform decisions and restructuring surveys to collect and interpret data differently. Going forward, will this subcommittee be open to scrapping metrics that were adopted previously to look for meaningful metrics to communities?

Sara B. responded that this is a good question to ask. The subcommittee has a challenging task in working to identify metrics now, even as the broader work continues to evolve over time. This subcommittee's work will be iterative. The work over the next year may not encompass everything in survey modernization, but there will be opportunities to continue to improve.

Jeanne said the big question is, who are we accountable to? We need to make sure the work reflects that.

Kusuma said survey modernization is about questioning the data source and how data are collected, how data are presented and shared, and how we are measuring progress that results in accountability.

Subcommittee deliverables

Sara B. reviewed the draft timeline for deliverables. She noted that this timeline is not set in stone and should continue to evolve.

Sara B. said that focus areas for metrics discussions this year should center on communicable disease and environmental health since these are the areas funded through public health modernization. In July, she will invite Christy Hudson, who coordinates the State Health Improvement Plan, to talk about *Healthier Together Oregon* and opportunities for alignment.

Sara B. said that, ideally, we will have measures for communicable disease and environmental health this year. There is opportunity to talk about new measures that need to be developed over time.

Sara B. noted that the subcommittee may want to add time for the subcommittee to discuss who the public health system is accountable to.

Jeanne agreed and also suggested adding accountability into the charter as well. She said that public health is accountable to all people in Oregon. Given Oregon's racist roots, it is important to prioritize accountability to communities of color who have been harmed by systemic racism.

Sara B. said she will add a discussion on accountability for the July meeting.

Sarah P. suggested not finalizing metrics selection criteria until after a discussion about accountability.

Olivia asked whether survey data and results are available to PHAB members.

Kusuma responded that this is available and we're happy to provide that.

Kat asked whether all subcommittee meetings have been scheduled out.

Sara B. responded that subcommittee meetings should be on the calendar for the third Wednesdays of each month, and she will confirm that these are scheduled through the end of the year.

Olivia shared that she is unable to attend the July meeting and asked whether the July meeting can be rescheduled to the week prior.

Sara B. said she will send out some other possible meeting times for the prior week. If the subcommittee can't settle on a new date, we will keep the original meeting date and time.

Jeanne noted that there needs to be time built in to hear from communities and subject matter experts.

Measure selection criteria

Sara B. reviewed draft metric selection criteria. The table provided is adapted from criteria used previously by this subcommittee, for *Healthier Together Oregon*, and for CCO incentive metrics.

Kat said that she would like to include insurance status under the category for "promotes health equity". She also suggested including criteria for census tract data or Medicare Referral District (Dartmouth Health Atlas) data. Looking at the county level does not show the nuances within county borders.

Sarah P. noted challenges with small numbers and how we could address translatability as part of criteria. We want to be able to look at communities with small numbers without reporting small numbers that jeopardize privacy.

Kusuma responded that if the accountability metric looks at actionable policies that describe what is being done upstream to alleviate inequities, this may get around issues with small numbers. Kusuma's team heard from survey modernization partners that small numbers should not prevent us from looking at the data.

Kat responded that having census tract-level data that show disparities is more actionable to take to planners to drive change.

Sarah P. noted that actionable metrics focused on policies may not be reportable be race, ethnicity, etc and this should be incorporated into the definition. She suggested that not all metrics may be at the individual level and asked whether the policies can be the measures.

Kusuma and Sarah P. voiced support for considering how actionable policies can be the metrics evaluated.

Jeanne asked about adding to this category to include PHAB's goals for health equity. She noted this category is very passive as written for collection of data, and she would like to see more active language for actionable metrics to eradicate racism. Subcommittee members agreed.

Sarah P. said that for the category "relevant to the community," she would like to see this include that communities have been able to provide input into metrics.

Jeanne said that this could be changed to "measure is driven by the community/the local perspective".

Sara B. asked if there is a place in these selection criteria to include integration of data across data sources and ensuring that metrics are actionable.

Jeanne suggested metrics should be directly connected to policies that PHAB has identified that need to change in order to dismantle existing policies that are inherently racist.

Sara B. noted that this will be a great discussion next month alongside *Healthier Together Oregon*.

Kat noted a connection to public safety, and specifically law enforcement.

Sara B. also noted previous comments from Olivia about ensuring that work is grounded in families and communities because that is where change occurs.

Sara B. will update the document and bring it back to the July meeting.

Kusuma suggested changing "community voice" to "community leadership". Subcommittee members were supportive of this change.

Subcommittee business

Sarah P. offered to provide the subcommittee update at the 6/17 PHAB meeting.

Sara B. will send out options to reschedule the July meeting.

Public comment

No public comment provided

Adjourn

Subcommittee meeting was adjourned.

Background

The Public Health Advisory Board (PHAB), established in ORS 431.122, serves as the accountable body for governmental public health in Oregon. PHAB reports to the Oregon Health Policy Board (OHPB) and makes recommendations to OHPB on the development of statewide public health policies and goals. PHAB is committed to centering equity and using best practices to inform its recommendations to OHPB on policies needed to address priority health issues in Oregon, including the social determinants of health.

Definition of health equity

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Equity framework

Identifying and implementing effective solutions to advance health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities due to racism.
- Engagement of a wide range of partners representing diverse constituencies and points of view.

- Direct involvement of affected communities as partners and leaders in change efforts.

Leading with racial equity

Racism is defined by Dr. Camara Jones as *"a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."*[1]

PHAB acknowledges historic and contemporary racial injustice and commits to eradicating racial injustice. PHAB acknowledges the pervasive racist and white supremacist history of Oregon, including in its constitution; in the theft of land from indigenous communities; the use of stolen labor and the laws that have perpetuated unjust outcomes among communities of color and tribal communities.

Because of Oregon's history of racism, the public health system, as described in the Health Equity Guide, chooses to *"lead explicitly — though not exclusively — with race because racial inequities persist in every system [across Oregon], including health, education, criminal justice and employment. Racism is embedded in the creation and ongoing policies of our government and institutions, and unless otherwise countered, racism operates at individual, institutional, and structural levels and is present in every system we examine."*[2]

The public health system leads with race because communities of color and tribal communities[i] have been intentionally excluded from power and decision-making. The public health system leads with race as described by the Government Alliance on Racial Equity: *"Within other identities — income, gender, sexuality, education, ability, age, citizenship and geography — there are inequities based on race. Knowing this helps the [public health system] take an intersectional approach, while always naming the role that race plays in people's experiences and outcomes.*

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[1] Jones, C. (n.d.) Racism and health. American Public Health Association. Available at www.apha.org/racism.
[2] Health Equity Guide. (2019). Why lead with race. Available at https://healthequityguide.org/about/why-lead-with-race/.

To have maximum impact, focus and specificity are necessary. Strategies to achieve racial equity differ from those to achieve equity in other areas. "One-size-fits all" strategies are rarely successful.

A racial equity framework that is clear about the differences between individual, institutional and structural racism, as well as the history and current reality of inequities, has applications for other marginalized groups.

Race can be an issue that keeps other marginalized communities from effectively coming together. An approach that recognizes the inter-connected ways in which marginalization takes place will help to achieve greater unity across communities."[3]

How health equity is attained

Achieving health equity requires engagement and co-creation of policies, programs and decisions with the community in order to ensure the equitable distribution of resources and power. This level of community engagement results in the elimination of gaps in health outcomes between and within different social groups.

Health equity also requires that public health professionals look for solutions outside of the health care system, such as in the transportation, justice or housing sectors and through the distribution of power and resources, to improve health with communities. By redirecting resources that further the damage caused by white supremacy and oppression into services and programs that uplift communities and repair past harms, equity can be achieved.

Policy

PHAB demonstrates its commitment to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. Board members will participate in an equity analysis prior to making any motions. In addition, all presenters to the Board will be expected to specifically address how the topic being discussed is expected to affect health

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[3] Government Alliance on Racial Equity. (2020). Why lead with race? Available at https://www.racialequityalliance.org/about/our-approach/race/.

disparities or health equity. The purpose of this policy is to ensure all Board guidance and decision-making will advance health equity and reduce the potential for unintended consequences that may perpetuate disparities.

Procedure

Board work products, reports and deliverables

The questions below are designed to ensure that decisions made by PHAB promote health equity. The questions below may not be able to be answered for every policy or decision brought before PHAB but serve as a platform for further discussion prior to the adoption of any motion.

Subcommittees or board members will consistently consider the questions in the assessment tool while developing work products and deliverables to bring to the full board.

Subcommittee members bringing a work product will independently review and respond to these questions. PHAB members will discuss and respond to each of the following questions prior to taking any formal motions or votes.

Staff materials will include answers to the following questions to provide context for the PHAB or PHAB subcommittees:

1. What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?
2. How does the work product, report or deliverable engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
3. How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?

PHAB members shall allow the questions to be discussed prior to taking a vote. Review questions should be provided to the Board with each vote.

OHA staff will be prepared to respond to questions and discussion as a part of the review process. Staff are expected to provide background and context for PHAB decisions that will use the questions below.

The PHAB review process includes the following questions:

1. How does the work product, report or deliverable:
    a. Contribute to racial justice?
    b. Rectify past injustices and health inequities?
    c. Differ from the current status?
    d. Support individuals in reaching their full health potential
    e. Ensure equitable distribution of resources and power?
    f. Engage the community to affect changes in its health status
2. Which sources of health inequity does the work product, report or deliverable address (race/racism, ethnicity, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?
3. How will data be used to monitor the impact on health equity resulting from this work product, report or deliverable?

Presentations to the Board

OHA staff will work with presenters prior to PHAB meetings to ensure that presenters specifically address the following, as applicable:

1. What health inequities exist among which groups? Which health inequities does the presenter and their work aim to eliminate?
2. How does the presentation topic engage other sectors for solutions outside of the health care system, such as in the transportation or housing sectors?
3. How was the community engaged in the presentation topic? How does the presentation topic or related work affect the community?
4. How does the presentation topic:
    a. Contribute to racial justice?
    b. Rectify past health inequities?
    c. Differ from the current status?
    d. Support individuals in reaching their full health potential

    e. Ensure equitable distribution of resources and power?

    f. Engage the community to affect changes in its health status

5. Which sources of health inequity does the presentation topic address (race/racism, ethnicity, social and economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance)?

6. How will data be used to monitor the impact on health equity resulting from this presentation topic?

Policy and procedure review

The PHAB health equity review policy and procedure will be reviewed annually by a workgroup of the Board. This workgroup will also propose changes to the PHAB charter and bylaws in order to center the charter and bylaws in equity. Board members will discuss whether the policy and procedure has had the intended effect of mitigating injustice, reducing inequities or improving health equity to determine whether changes are needed to the policy and procedure.

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[i] PHAB acknowledges that terminology that communities wish to use is evolving. PHAB recognizes the need to regularly update the language included in this policy and procedure based on community input.

PHAB Accountability Metrics Subcommittee
Metrics selection criteria
July~~ne~~ 2021, draft

Purpose: Provide standard criteria used to evaluate metrics for inclusion in the set of public health accountability metrics.

Selection criteria	Definition
~~Promotes~~ Actively advances health equity and eradicates racism	Measure addresses an area where health ~~disparities~~ inequities exist Measure is actionable, which may include policies or community-level interventions ~~Data are reportable by:~~ ~~Race and ethnicity~~ ~~Gender~~ ~~Sexual orientation~~ ~~Age~~ ~~Disability~~ ~~Income level~~
Community leadership and community-driven metrics	Communities have provided input and have demonstrated support Measure is of interest from a local perspective Measure is acceptable to communities represented in public health data
Data disaggregation	Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District When applicable, data are reportable by: - Race and ethnicity - Gender - Sexual orientation - Age - Disability - Income level - Insurance status

~~Relevant to the community~~	~~Data are reportable at the county level or for similar geographic breakdowns~~ ~~Measure is of interest from a local perspective~~
Resourced or likely to be resourced	Funding is available or likely to be available Local public health expertise exists
Transformative potential	Measure is actionable and would ~~help~~ drive system change Opportunity exists to integrate data across data sources Measure aligns with core public health functions in the Public Health Modernization Manual
Alignment with other strategic initiatives	Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other local health plans Measure is nationally validated National or other benchmarks exist for performance on this measure
Feasibility of measurement	Data are already collected, or a mechanism for data collection has been identified Updated data available on an annual basis
~~Community voice~~	~~Measure is acceptable to communities represented in Public health data~~ ~~Measure successfully communicates what is expected of the public health system~~
Accuracy	Changes in public health system performance will be visible in the measure

	Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years
Public health system accountability	State and local public health authorities have some control over the outcome in the measure Measure successfully communicates what is expected of the public health system

*Adapted from selection criteria used previously by the PHAB Accountability Metrics subcommittee and for selection of Healthier Together Oregon indicators and measures.

Healthier Together Oregon

Our 2020-2024 State Health Improvement Plan is called *Healthier Together Oregon*.

We want to live in a state where we can all have long, healthy lives. The social issues that affect health are the places we live, work, learn and play. They are the main reasons people are healthy, or not. These include things like:

Purpose of HTO

- Identifies our state's health priorities
- Addresses unjust and unacceptable health inequities
- Tool for aligning efforts with cross-sector partners
- Inform Community Health Improvement Plans
- Inform policy, priorities and investments for OHA and other state agencies
- Requirement of public health accreditation
- Plan for equitable recovery from COVID-19

Oregon Health Authority

Implementation Framework

1 VISION — To achieve health equity

5 PRIORITIES — Our most urgent health challenges

8 IMPLEMENTATION AREAS — To organize our collective work

16 HEALTHIER TOGETHER OREGON INDICATORS — How we will measure our progress

62 STRATEGIES — Actions we will take for improvement

Implementation Areas

Equity and Justice	Healthy Communities
Housing and Food	Behavioral Health
Healthy Families	Healthy Youth
Workforce Development	Technology and Health

Community Engagement

- Online surveys in English and Spanish
- Mini-grants to community based organizations
    - Eastern Oregon Center for Independent Living
    - Self Enhancement, Inc.
    - Next Door
    - Unite Oregon
    - So Health-E Oregon
    - Q Center
    - Micronesian Islander Community (of APANO)
    - Northwest Portland Area Indian Health Board
- Other community forums

Oregon Health Authority

Community Engagement: Phase 1

Priority identification

Through online surveys and mini-grants, we asked community members to identify five priorities, from a total of 14 priority issues that were initially identified. A summary of this effort and the results can be found here. This feedback was used by the past PartnerSHIP to identify the five priorities of the current plan.

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Community Engagement: Phase 2

Strategy vetting.

Through online surveys and mini-grants, we asked communities to provide feedback on the strategies that had been identified by subcommittees. Overall, communities were very supportive of the strategies, but a few modifications and adjustments were made to strategies before finalization.

Feedback received via surveys can be seen at the following links:
Institutional bias
Adversity trauma and toxic stress
Behavioral health
Access to equitable preventive health care
Economic drivers of health

PUBLIC HEALTH DIVISION

Office of the State Public Health Director

PHAB Accountability Metrics and the 2015-2019 SHIP

Foundational Program	Accountability Metrics	2015-2019 State Health Improvement Plan – Priority targets
Communicable Disease	Two year old immunization rates Gonorrhea rates	Two year old immunizations Gonorrhea rates
Environmental Health	Active transportation Drinking water standards	
Prevention and Health Promotion	Adults who smoke cigarettes Opioid overdose deaths	Adults who smoke cigarettes Opioid overdose deaths
Access to Clinical Preventive Services	Effective contraceptive use Dental visits for 0-5 year olds	Third graders with cavities in permanent teeth

Oregon Health Authority

Measuring Healthier Together Oregon

Long term indicators - 16

- Long term, outcome changes
- Identified by subcommittees
- Identified by priority area
- 4 additional indicators from Alcohol and Drug Policy Commission (substance use disorder, and alcohol, tobacco and other drug related deaths)

Short term indicators ~ 40

- Shorter term, process changes
- Identified by subcommittees and OHA staff
- Identified for every strategy
- Some measures are still underdevelopment

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HTO – Key Indicators

Priority area	Indicator and data source
Institutional bias	Disciplinary Action (Department of Education)
	Premature death/years of potential life lost (Center for Health Statistics)
Adversity, trauma and toxic stress	Adverse childhood experiences (National Survey of Children's Health)
	Chronic absenteeism (Department of Education)
	Concentrated disadvantage (American Community Survey)
Behavioral health	Unmet emotional or mental health care need among youth (Student Health Survey)
	Suicide rate (Oregon Vital Statistics)
	Adults with poor mental health in past month (Behavioral Risk Factor Surveillance Survey)
Economic drivers of health	Third-grade reading proficiency (Department of Education)
	Opportunity Index economy dimension (Opportunity Index)
	Childcare cost burden (OSU Oregon Child Care Market Price Study, and American Community Survey)
	Food insecurity (Map the meal gap)
	Housing cost burden among renters (American Community Survey)
Access to equitable preventive health care	Childhood immunizations (ALERT IIS)
	Colorectal cancer screening (Behavioral Risk Factor Surveillance Survey)
	Adults with a dental visit in past year (Behavioral Risk Factor Surveillance Survey)

HTO – Short term measures

- Oregon legislature declares racism a public health crisis (Oregon Administrative Statutes)
- Oregon's national ranking for broadband access (Broadband now)
- % of children aged 0-5 with access to a childcare slot (Early Learning Map of Oregon)
- % of 11th graders reporting they learned about healthy and respectful relationships in schools (Student Health Survey)
- Home ownership by race/ethnicity (Oregon Housing and Community Services)
- % of CCOs that met SBIRT incentive improvement benchmark (CCO reporting)
- % of behavioral health care providers by race/ethnicity (OHA – Healthcare Workforce Reporting Program)
- % of Oregon Health Plan health care services delivered via telehealth in rural counties (APAC data)

Oregon Health Authority

Potential alignment ideas

Foundational Program	HTO measures
Communicable Disease	• Two-year-old immunization rates* (OHA – ALERT) • Gonorrhea rates (OHA – ORPHEUS)
Environmental Health	• % of population with a park within a 10-minute walk from their home (Trust for Public Land) • # of Community Based Organizations that have meaningfully partnered with PHD, tribal and local public health authorities to build community resilience (OHA – Environmental Health) • % of full-voting representation of BIPOC-AI/AN on state rule making and grants advisory committees (Department of Land Conservation and Development) • % of people who use active transportation to get to work (American Community Survey) • Index of factors that contribute to a healthy food environment (County Health Rankings)

Oregon Health Authority

Discussion

How can HTO be a tool for alignment in Public Health Accountability Metrics?