# PUBLIC HEALTH ADVISORY BOARD
## Accountability Metrics Subcommittee

**February 16, 2022**
**8:30-9:30 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 November meeting minutes
- Discuss metrics shifts and ensure alignment with metrics selection criteria
- Review proposed framework for accountability metrics

**Subcommittee members:** Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Present, Jocelyn Warren

**OHA staff:** Sara Beaudrault, Kusuma Madamala

**PHAB's Health Equity Policy and Procedure**

| Time | Topic | Lead |
|---|---|---|
| 8:30-8:40 am | **Welcome and introductions** <br> • Approve October minutes <br> • Hear updates from subcommittee members <br> • Review updated subcommittee timeline | Sara Beaudrault, Oregon Health Authority |
| 8:40-9:15 am | **Metrics shifts to a new framework** <br> • Discuss shifts from previous metrics to an updated framework for public health accountability metrics <br> • Discuss deliverables that will communicate these shifts <br> • Review metrics selection criteria ensure alignment with updated framework | Sara Beaudrault <br><br> Kusuma Madamala, Program Design and Evaluation Services |
| 9:15-9:20 am | **Subcommittee business** | All |

- Select subcommittee member to provide update at March PHAB meeting
- Next meeting scheduled for 3/16

| | | |
|---|---|---|
| 9:20-9:25 am | **Public comment** | |
| 9:25 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

# PUBLIC HEALTH ADVISORY BOARD
## Accountability Metrics Subcommittee

**November 17, 2021**
**8:00-9:30 am**

**Subcommittee members present:** Cristy Muñoz, Kat Mastrangelo, Sarah Present

**Subcommittee members absent:** Jeanne Savage, Olivia Gonzalez

**OHA staff:** Sara Beaudrault, Kusuma Madamala, Diane Leiva, Michelle Barber, Ann Thomas, Heidi Behm

**PHAB's [Health Equity Policy and Procedure](#)**

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### Welcome and introductions
Sarah Present asked whether subcommittee meetings can proceed without a quorum.

Sara B. responded that since subcommittees do not take actions other than approving minutes, a quorum is not needed.

October meeting minutes were approved.

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### State and national initiatives that inform Oregon's public health accountability metrics
Sara B shared that today's meeting will focus on revisiting conversations to date and bringing together information from the state and national initiatives that have been discussed, as well as some new information on other national initiatives that are relevant to this subcommittee's work. The hope is to provide clarity on how to move forward with the task of updating metrics and overall framing for accountability metrics. At the end of the meeting OHA will share a shell of a framework and a plan for how to move forward.

Sara B. reviewed the five deliverables in the charter.

Kat asked who does the work of identifying partners and stakeholders referenced in the charter deliverables.

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Cristy said she reads this deliverable as being community-driven and a bottom-up participatory approach for an open and permeable conversation. This is exciting and she is curious whether this is a task for the subcommittee.

Sara B. said that when metrics were established in 2016, part of the subcommittee's work was to get feedback from other sectors, which was done through a survey primarily of CCOs, health care providers and local public health authorities. Community partners were not well-represented. Given where we are at now and thinking about lessons from survey modernization partners, it changes what community engagement needs to look like for data and metrics. At the same time, we need to move forward with accountability metrics even as we are evolving and improving in our work with community.

Kat asked whether we can hold this and keep moving forward, also thinking about partners and groups that should be included at a future time.

Sara B responded yes, and also noted that OHA presenters have been intentionally highlighting where communities have been involved in developing priorities or measures as a proxy for collecting new information at this point.

Cristy asked about the deliverable for sharing information with communities. She noted this is connected to the deliverable that Kat highlighted. Is it about getting information out or about making the information accessible to community members?

Kat recommends bringing information forward in a way that is accessible to communities.

Sara B asked if rewording would help to clarify that it is not about a one-time communication but ongoing communication that is relevant and accessible for the people represented in data and metrics.

Kat agreed with this change.

OHA staff will bring this change forward in edits for the subcommittee to review. OHA staff will also replace the word "stakeholder" and make explicit that the term partners includes community partners and members of communities.

Sara B reviewed some of the discussions to date, which have included survey modernization, the State Health Improvement Plan *Healthier Together Oregon*, and discussions about priorities and metrics for communicable disease control and environmental health. The themes from survey modernization and Healthier Together Oregon were considered in the development of metrics selection criteria.

Sara B also reviewed the framework for public health modernization and the Public Health Modernization Manual. The Public Health Modernization Manual includes core functions for the governmental public health system and also lists separate but complementary roles for state and

local public health authorities. The Manual is a source of information for considering state and local accountability metrics.

Kat asked about where issues like chronic disease exacerbated by stress and social determinants of health falls into the public health modernization framework.

Sara B. agreed that it is challenging to see where social determinants of health fit into the framework and to define public health's core functions.

Sarah Present said that within the framework, the foundational capabilities are all used for all of the public health programs. You can't work on one without working on all. For example, as we build capabilities for emergency preparedness, we are also building policy and planning, communications, and health equity and cultural responsiveness. Although public health modernization only funds some programmatic work, public health organizations have other funding for other programs, and there are efforts to modernize all public health programs. When we run programs, social determinants of health are always part of the understanding. But direct programs to address social determinants of health are beyond the scope of public health modernization funding.

Cristy asked who has access to public health modernization funding.

Sara B. described how the current $60.6 million is allocated to local public health authorities, federally recognized Tribes and now also to community-based organizations. Some funds also remain with OHA to provide state functions and oversee the investment.

Sarah Present said that some of the local public health funds also go to community-based organizations.

Cristy noted that the spirit of modernization and the framework are calling on cross sectoral collaboration and suggested that this is something we could explicitly try to call out. How is collaboration between community-based organizations and public health authorities going, and how are we keeping each other accountable in trying to connect with community to meet these goals? Within the disaster sector, lack of collaboration is a huge issue in trying to figure out how to work better together in moments of crisis. This may be an area for the subcommittee to go deeper.

Kusuma noted that cross sector collaboration will come up in some of the other frameworks to be discussed at this meeting.

Kat asked whether this includes relationships with city governments and schools, in addition to state and county government. Is health in all policies still a concept that is promoted?

Sara B said that it is. Working across sectors is necessary for work related to social determinants of health.

Kusuma provided a review of national public health accreditation standards. The reason we are bringing these frameworks to the subcommittee is because all these different frameworks are all aligning in a direction for governmental public health. Public health accreditation standards are a measurement of public health department performance against a set of nationally recognized standards that were established in 2011. What are health departments accountable for and responsible for. There are twelve domains that align with what is in the public health modernization framework. The OHA Public Health Division, 15 LPHAs and Yellowhawk Tribal Health Center are all accredited.

Kusuma shared that the Robert Wood Johnson Foundation launched a first of its kind commission to make recommendations to transform public health data systems. The commission report has been released and a webinar recording is available, and OHA will provide links to both. The report is really to reimagine how our data are collected, shared and used to identify improvements that are needed to improve health equity. Within the report there are three key overarching recommendations. 1. Center health equity and well-being in narrative change. 2. Prioritize equitable governance and community engagement. 3. Ensure public health measurement captures and addresses structural racism and other inequities. Within each of these overarching recommendations, there are specific actions that governmental public health can take. There is a specific call out to public health to convene across sectors for public health data sharing and local decision-making.

Kusuma reviewed the framework for the CDC data modernization initiative included in the slides.

Sarah Present appreciated seeing the frameworks. Among local health officers, discussions focus on modernizing our data systems as key to modernizing our public health system. There are a lot of lessons from the COVID pandemic. Many stem from data and technology systems. This includes needing new technology that works, but also how to share data, communicate data and have a public health workforce that is data driven. We pride ourselves on being data driven but realize how much data we don't have or how many critical data-focused staff we don't have. The local health officers have reviewed lessons learned from COVID and made big picture recommendations for how to move forward in governmental public health. One calls for a new view of technology. The pandemic has shown that the public health workforce can work effectively in remote settings. Our current budgeting treats physical space gently. We need to build a budgeting vision that treats technology systems on the same level as brick and mortar investments. We need to put the systems we use in all work on equal par with the outcomes we want.

Kat wonders about where structural racism shows up. For example, broadband access and how it limits people's participation and in community policing. Public health can do great work but it can be decimated if other agencies are not supportive of public health interventions.

Sarah Present said if we don't have a data system that gives us the information to tell the story, we are not able to advocate for the changes needed. We need a technology system that can hold the data across sectors, for example health outcomes based on housing status or neighborhood walkability.

Cristy asked about other committees tasked with creating metrics. Where do the metrics come into play in the process and system of rolling out changes like those Sarah is highlighting.

Sara B. shared her perspective, which is that it is important to use this opportunity to push for what we need the public health system to be and do. It may not be something we can achieve in 18 or 24 months, like radical changes to data infrastructure and how we use public health data, that's long-term work. But when we push ourselves through metrics, it's a good way to leverage attention and resources to move the work forward.

Cristy asked where recommendations would be implemented, including all the great recommendations provided to this subcommittee. How can we help elevate some of the new data we have and upstream, community-driven strategies.

Kusuma suggested going back to the metrics selection criteria. For her, these metrics are about state and local public health accountability and the intersection between the two.

**Proposed framework for accountability metrics**
Sara B reviewed a framework. Previously, metrics have been disease-focused without context for the root causes of disparities. This framework places emphasis on which groups are most vulnerable and on providing context for inequities.

There are four components in this proposed framework.
1. Vision. Can start with the vision included in the Public Health Modernization Manual and make changes if needed for communicable disease and environmental health.
2. Context. Providing the context matters and keeps the focus and responsibility on the public health system, and not the individuals experiencing poorer health outcomes. This section would describe background for inequities and disease risks, the intersectionality among risk factors, the impacts of social determinants of health and the groups who are at higher risk.
3. Indicators. Data points or measures that demonstrate the context.
4. Public health accountability metrics. Includes state and local public health accountability. Accountability metrics need to be actionable. OHA's recommendation is for OHA to work directly with LPHA subject matter experts to develop these metrics, which would then come to this committee for discussion and guidance. Accountability metrics can focus on the foundational capabilities that have been emphasized by this subcommittee: public health data; community partnerships and policy. LPHAs and this subcommittee can also decide whether to include metrics that are more programmatic or intervention-based.

Sara B. reviewed an example for communicable disease control. Ara asked if this is moving in the right direction.

Kat said she appreciated the discussion last month to better understand communicable disease indicators.

Sarah Present said she likes where this is going, including working more with LPHAs at the forefront. Overall the big picture goals are aligning well with what she has heard from other LPHAs. When she looks at indicators, she is challenged in thinking about what needs to be done versus what public health has capacity to do, for example hepatitis C. She also noted challenges about small numbers and in setting metrics for diseases like hepatitis A that can be unpredictable because of outbreaks.

Cristy said that a week ago OHA-PHD staff presented on modernization plans to approximately 25 community of color leaders who are part of the disaster resilience learning collaborative program. A pretty consistent concern raised was about uninsured individuals, what does health care for all mean and who qualifies, and how does modernization increase health care accessibility for undocumented workers. We are very much an open community and we need to support all community members to collectively be healthy. We need to activate community to encourage legislation.

Ann said that by placing focus on, for example, vaccination for hepatitis A and B and COVID among undocumented workers, you are also developing systems for outreach and opportunities to screen for many conditions or diseases.

Kat asked about the indicator for vaccine preventable diseases stratified by race and ethnicity.

Ann responded that for COVID and other reportable diseases, during case interviews public health collects information on race and ethnicity and housing status. What's measured for counties would be vaccination rates among these populations. The immunization registry captures race and ethnicity but not housing status.

Sara B. said that, moving forward, the subcommittee can continue to focus on context and higher level indicators, and OHA will also begin working with LPHAs on digging into a6accountability metrics for data, partnerships and policy.

**Subcommittee business**

**Public comment**
Daniela Moreno is in opposition to COVID vaccination mandates. She has been tracking OHA COVID-19 data and reviewed rates and metrics. She stated that case and death rates are inflated and reviewed vaccine adverse events data. This is government overreach and children should not be vaccinated. She asked that OHA step outside of CDC recommendations and look to local data.

Harry Sanger shared a concern that community trust has been lost by not following the science around COVID. Children are not dying from COVID in Oregon yet Oregon is pushing experimental therapies on children through vaccination. Harry also expressed concern about an identity-based approach to public health. Rural areas need more assistance but it is because services are not available to them. As OHA approaches technology-based initiatives, Oregonians are leery of technology and see large issues with employment department and other state agencies.

Alex Elkin is a father of three, ranging from 6-16 years. He is opposed to COVID vaccine being used on children. Children are susceptible to asymptomatic or mild symptoms from COVID infections. Why are we putting into children a vaccine that causes the same symptoms as they would have received through natural immunity?

Tresa Beaver is concerned about the type of data the CDC is putting out to encourage vaccines, especially for children. The recovery rate in children is 99.9% and children do not die from COVID. The narrative is to control and manipulate the population. She encourages OHA to review VAERS reports to study people who have died and been injured by vaccines. She spoke about Ivermectin as a cure for COVID.

Jennifer Gustafson attempted to provide public comment but lost audio while speaking. No comment was provided.

**Submitted written comments**

**From:** truthandlovearewinning <truthandlovearewinning@protonmail.com>
**Sent:** Wednesday, November 17, 2021 10:18 AM
**To:** Public Health Policy <PublicHealth.Policy@dhsoha.state.or.us>
**Subject:** RE: Public comment Public Health Advisory Board (PHAB) ACCOUNTABILITY METRICS SUBCOMMITTEE

> You don't often get email from truthandlovearewinning@protonmail.com. Learn why this is important

Hello Sarah,

I'm writing to share the public comment that I gave today orally in writing, find it below. I hope that you will share it with your team. I'd be more than happy to jump on a call with you to show you exactly how I got to this data and answer any questions that you may have.

I have to say though that leaving public comment at the end of the meeting doesn't seem very fair. The meeting went on for 90 minutes and since we had to go after the meeting scheduled time, members of your team had to drop off. I'll keep attending these meetings. Maybe in the future at the beginning and/or middle of the call you can ask how many people are there for public comment so you can end the conversation early enough to give us time to give public comment and have everyone's' attention, like you all did.

**PUBLIC COMMENT:**

Thank you for this opportunity to speak today. I LOVE hearing that Oregon is seeking for community input.

I'm here because I have the responsibility to tell you my findings and sound the alarm as loud as I can.

I'm in absolute opposition to the one size fits all COVID19 experimental vaccine push.

The current vaccine mandates are unconstitutional and in violation of serious national and international laws.

I've been tracking Oregon Health Authority data on a weekly basis.

Here are the Stats for our State and some of the metrics that I propose you track too:

- COVID19 Survival rate: 99.97%
- Children death rate: 0%
- The 5 people from 0 to 19 years old who died WITH COVID had pre-existing conditions.
- Over 89% of deaths in our State were people over 60 years old WITH pre-existing conditions
- Population Overall Hospitalization rate of less than 0.0045%

Meanwhile CNN, MSNBC media and friends talk about COVID as a scary deadly virus.

The number of positive cases is irrelevant and inflated.

Death numbers are inflated, many of the reported deaths are not FROM COVID, they are WITH COVID.

Vaccine performance is a failure:

- Vaccine Efficacy keeps dropping.
- Vaccinated people can still contract and transmit the virus.
- 'No vaccine is perfect' but this one is the worst of all.
- There are more adverse effects, including deaths and permanent disabilities reported in 11 months for COVID19 vaccines than all other

vaccines combined in 30+ years.
- We have more covid19 reported deaths in 2021 than we did in 2020 before any vaccine existed.

This is not about the virus anymore, this is a deep issue of government overreach.

Coercion is not consent.

There is no reason to vaccinate healthy children, data shows that they don't have a risk for the disease and if they get COVID, their natural
immunity kicks it like champs.

Healthy People are getting injured from the vaccine but their stories are swept under the rug.

Please step outside of the 'CDC recommendations' box and take a fresh look at the story told by your own local data, you will see a story of
successful pandemic management. Congratulations, the pandemic is over.

We're not in a State of Emergency, we're in a state of oppression and censorship.

**LIFT THE STATE OF EMERGENCY. STOP THE MANDATES.**

Global vaccination including healthy children with such a new gene MRNA technology, fundamentally different from standard vaccines, with

such short term safety data, for a virus with over 99% survival rate is **MADNESS AND A CRIME AGAINST HUMANITY.**

This is not safe science. This is an irresponsible experiment.

The legitimacy of the CDC, FDA and pharma data is currently under scrutiny in the legal field.

You still have a chance to turn this ship around and do your research outside the CDC recommendations but we're running out of time.

Please Help Us!

Thank you,

**Adjourn**

PHAB Accountability Metrics subcommittee

Timeline for discussions and deliverables

| | Topics | Work products |
|---|---|---|
| April-November 2021 | - Public health modernization and accountability metrics statutory requirements<br>- Survey modernization findings and connections to public health accountability metrics<br>- *Healthier Together Oregon* and its relation to public health system accountability<br>- Communicable disease and environmental health outcome measures<br>- Alignment with national initiatives (RWJF *Charting a Couse Toward an Equity-Centered Data System*, data modernization, accreditation) | - Charter<br>- Group agreements<br>- Metrics selection criteria |
| February 2022 | - Shifts from previous metrics set to a new direction for accountability metrics<br>- Metrics selection criteria | - |
| March 2022 | - TBD | - Overview of accountability metrics shifts |
| April 2022 | - Review recommendations from Coalition of Local Health Official (CLHO) committees | - |

| | | |
|---|---|---|
| May 2022 | - Review recommendations from Coalition of Local Health Official (CLHO) committees | - |
| June 2022 | - Review recommendations from Coalition of Local Health Official (CLHO) committees | - Metrics recommendations for PHAB approval |
| July 2022 and ongoing | - Develop 2022 accountability metrics report<br>- Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures. | - |

# PHAB Accountability Metrics subcommittee deliverables

1. Recommendations for updates to public health accountability metrics framing and use, including to eliminate health inequities.
2. Recommendations for updates to communicable disease and environmental health metrics.
3. Recommendations on engagement with partners and key stakeholders, as needed.
4. Recommendations for developing new metrics, as needed.
5. Recommendations for sharing information with communities.

Oregon Health Authority

# For discussion

- What are your reactions to the changes to the framework for metrics? Do these changes align with subcommittee discussions to date?

- To what extent does the subcommittee want to include health outcome indicators in the framework?

- Are additional changes needed to metrics selection criteria?

- Will these changes demonstrate accountability to communities throughout Oregon?

# Alignment with other initiatives

- Feedback from previous years' reports
- Healthier Together Oregon
- PHAB presentations from partners who developed community-specific data briefs
- Public Health Forward: Modernizing the U.S. Public Health System
- RWJF: Charting a Course for an Equity-Centered Data System
- Public health accreditation

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# Current and updated metrics

| Current accountability metrics | Updated accountability metrics |
|---|---|
| Minimal context provided for disease risks and root causes of health inequities | Discussions ongoing |
| Focus on disease outcome measures | Discussions ongoing |
| Focus on programmatic process measures | Focus on data and data systems; community partnerships; and policy. |
| Focus on LPHA accountability | Focus on governmental public health system accountability. |
| Minimal connection to other state and national initiatives | Direct and explicit connections to state and national initiatives. |

Oregon Health Authority

# Metrics changes we expect to see

- Movement away from:
  - Disease-specific metrics
  - Health outcome metrics
- Movement toward
  - Actionable metrics
  - Metrics that represent community priorities
  - Metrics that can be used to advance health equity
  - Focus on public health data and data systems, community partnerships and policy.

**PHAB Accountability Metrics Subcommittee**
**Metrics selection criteria**
August 2021, draft

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

Criteria can be applied in two phases:

1. Community priorities and acceptance
2. Suitability of measurement and public health sphere of control

| Phase 1: Community priorities and acceptance | |
| --- | --- |
| Selection criteria | Definition |
| Actively advances health equity and an antiracist society | Measure addresses an area where health inequities exist<br><br>Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination<br><br>Measure is actionable, which may include policies or community-level interventions |
| Community leadership and community-driven metrics | Communities have provided input and have demonstrated support<br><br>Measure is of interest from a local perspective<br><br>Measure is acceptable to communities represented in public health data |
| Transformative potential | Measure is actionable and would drive system change<br><br>Opportunity exists to triangulate and integrate data across data sources<br><br>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 locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.

National or other benchmarks exist for performance on this measure

| Phase 2: Suitability of measurement and public health sphere of control | |
|---|---|
| **Data disaggregation** | Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District<br><br>When applicable, data are reportable by:<br>- Race and ethnicity<br>- Gender<br>- Sexual orientation<br>- Age<br>- Disability<br>- Income level<br>- Insurance status |
| **Feasibility of measurement** | Data are already collected, or a mechanism for data collection has been identified<br><br>Updated data available on an annual basis |
| **Public health system accountability** | State and local public health authorities have some control over the outcome in the measure<br><br>Measure successfully communicates what is expected of the public health system |
| **Resourced or likely to be resourced** | Funding is available or likely to be available<br><br>Local public health expertise exists |
| **Accuracy** | Changes in public health system performance will be visible in the measure<br><br>Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years |

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

# Proposed framework and example for Public Health Accountability Metrics

*Under this proposed framework, there are four components to how public health accountability metrics will be collected and reported.*

**Vision:** *Use the vision included in the Public Health Modernization Manual*

**Context:** *Provide background for inequities in disease risks and describe the intersectionality that place someone at greater risk. Describe impacts of social determinants of health. Describe the groups that are most vulnerable.*

**Indicators:** *Include data points/measures that demonstrate the context.*

**Public health accountability metrics (State and local accountability):**

*Include actionable metrics demonstrating state and local accountability.*

*Involve local public health authorities in developing accountability metrics. Recommendations will come to this committee for discussion and guidance.*

*Based on discussions in this subcommittee to date, accountability metrics may focus on foundational capabilities for:*

- *Assessment and epidemiology (i.e. core functions for ensuring accessible, shareable and useable data).*
- *Community partnerships*
- *Policy*

*Accountability metrics may also focus on programmatic/community-based interventions*

# Communicable Disease Control Example

**Vision:** *Ensure everyone in Oregon is protected from communicable disease threats.*

**Context:** *Discuss inequities in communicable disease risks in Oregon, for example housing stability and housing conditions, food security and access to health care. Discuss vulnerable groups (i.e. people who are homeless; people who inject drugs; men who have sex with men; BIPOC, immigrant, refugee and migrant and seasonal farmworkers). Also frame within the context of COVID-19.*

**Indicators:**

- *HIV; congenital syphilis, acute hepatitis A/B/C; with proportion occurring among people who inject drugs.*
- *Chronic cases of hepatitis C under the age of 30 years.*
- *Vaccine preventable disease rates such as hepatitis A, hepatitis B and pertussis, with proportion occurring in homeless individuals.*
- *Foodborne diseases (Salmonella, Shigella, STEC, with proportion of cases occurring in homeless individuals.*
- *Vaccine preventable diseases stratified by race and ethnicity.*
- *Foodborne diseases stratified by race and ethnicity.*
- *Proportion of people newly diagnosed with HIV who achieve viral suppression within 90 days of diagnosis.*

**Public health accountability metrics (State and local accountability):**

*To be developed*

# Next steps

- Ongoing work with CLHO Communicable Disease and Environmental Health committees to develop metrics recommendations.

- Committee recommendations will be taken to CLHO and then back to the PHAB Accountability Metrics subcommittee.