AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

April 20, 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 March meeting minutes
- Review and update metrics selection criteria, with focus on how accountability is demonstrated
- Hear update and discuss measurement of data and data systems
- Discuss inclusion of indicators in metrics framework and process for identifying indicators

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

OHA staff: Sara Beaudrault, Kusuma Madamala

PHAB's Health Equity Policy and Procedure

8:30-8:40 am	**Welcome and introductions** • Approve March minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
8:40-9:00 am	**Metrics selection criteria, how accountability is demonstrated** • Review metrics selection criteria and ensure alignment with updated framework • Discuss use of metrics to demonstrate accountability	Sara Beaudrault Kusuma Madamala, Program Design and Evaluation Services
9:00-9:15 am	**Measurement of data and data systems** • Hear update and discuss progress toward identifying metrics related to data and data systems	Sara Beaudrault Kusuma Madamala

	• Is this consistent with the direction provided by this subcommittee?	
9:15-9:20 am	**Population indicators** • In what ways do subcommittee envision indicators being used within the framework for accountability metrics? • What role does the subcommittee want to play in identifying indicators?	Sara Beaudrault Kusuma Madamala
9:20-9:25 am	**Subcommittee business** • Identify subcommittee member to provide update at 4/21 PHAB meeting • Next meeting scheduled for 5/18	All
9:25-9:30 am	**Public comment**	
9:30 am	**Adjourn**	All

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

March 16, 2022
8:30-9:30 am

Subcommittee members present: Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Sarah Present, Ryan Petteway

Subcommittee members absent: Jocelyn Warren, Olivia Gonzalez

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Kelly McDonald

PHAB's Health Equity Policy and Procedure

Welcome and introductions
February minutes were approved.

Sara B. brought attention to the group agreements, subcommittee deliverables and timeline.

Cristy asked whether the subcommittee will be able to see an assessment of percentages and themes from CBOs that applied for public health modernization funding, related to communicable disease control.

Sara B. said that she doesn't know exactly what information we'll be able to share, but there is interest in doing a broad look to better understand what applicants highlighted as priorities for their communities.

Jeanne asked whether OHA has plans to begin convening PHAB and subcommittees in person.

Sara B.

Metrics shifts to a new framework
Sara B. reviewed an updated version of the graphic that describes shifts in the accountability metrics framework. Based on the subcommittee's conversation last month, the new framework will include context for social determinants of health, systemic inequities and racism as the root causes of disparate health outcomes.

Jeanne said that she is proud of this group for highlighting these underlying factors. This is sometimes a new concept for people and not always well-accepted. It will be important for the subcommittee to continue to elevate this.

Kat brought attention to the dichotomy of urban and rural context. Is that included within the context of systemic inequities?

Cristy said that she would consider low income and rural communities as those experiencing institutionalized challenges when they don't have basic access.

Sarah P. said it can be considered a systemic issue because this is how our health care and public health systems are built. She brought this framework to the Health Officer Caucus recently. They discussed that shifting accountability to the public health system, rather than local public health, will help to bridge those public health and health care divides. The Health Officers also brought up the idea of regional metrics.

Cristy asked, how do we find accountability through community engagement at the local level, and how is it woven into metrics that people feel heard and seen within the context of their communities. This is challenging in rural communities where they may be lower trust in governmental agencies. She noted that we may see failure if the systems aren't created to achieve the metrics through community engagement, knowing that this has been a big challenge in many communities in rural Oregon. She noted a concern about high expectation and low support metrics without community buy-in and without systems in place to support communities to meet those goals.

Kusuma noted the importance of these comments and suggested we come back to them when the subcommittee talks about metrics selection criteria.

Jeanne said she likes the idea of understanding that rural and urban needs are different, but she hesitates to separate out what we do when what is at the root of inequities and differences in outcomes is poverty, racism, other systemic issues that all areas are facing. How can we all work toward the same thing while acknowledging differences.

Ryan brought attention to the social, political and cultural context in which poverty is occurring. A metric around poverty is not useful. If we're not measuring the structural aspects of class and neighborhood conditions that produce poverty and keep people in poverty, and tracking what we're doing to address those, we will not change poverty. To be accountable to what we're doing to address poverty, we need to unpack it and identify those systematic policy structures, for example who is paying a living wage, who is being underpaid.

Jeanne agreed and said it is important to be united in the shared work, and as we look at measures the concept of looking at systemic issues like pay wages is fantastic.

Sarah P. said that Health Officers are supportive of keeping outcome measures in the framework, focusing those within the sphere of control for public health. We need both process and outcome measures to be able to track where we're going and how we're doing.

Kusuma talked about the materials she is preparing for Coalition of Local Health Officials committees to begin identifying process measures in the areas of data, partnerships and policy. She is looking at public health accreditation measures and national public health improvement metrics around quality (improved responsiveness, expanded reach of service, improved quality of service or program and quality enhancements of data systems). Kusuma is looking at where accreditation criteria align with the Public Health Modernization Manual, and what metrics currently exist in the LPHA triennial review. Each of the areas of data, partnerships and policy connect back to each of the quality metrics.

Kusuma said that in the area of policy, for public health accreditation public health departments are required to examine and contribute to policies and laws. One example would be health department staff providing testimony on certain policies. She is trying to get to where the state and local public health roles are for data, partnerships and policy.

Ryan said it sounds like both an opportunity and a challenge. He sees opportunity for alignment and also the possibility that health departments will be put in a position to act on behalf of their communities and also do what's needed for accreditation. Metrics like quality improvement and expanded reach come from a biomedical model, but it appears that the accountability metrics are toward population health.

Sarah P. said that the modernization movement calls public health to move away from providing direct clinical services. But we've learned from the pandemic that we need to reengage in services in a way that public health was moving away from while moving toward assurances and policy. There are still really big gaps that public health ends up filling. What is the ideal state for public health within the public health and health delivery system?

Sara B. said it isn't a question of whether public health should or shouldn't provide clinical services, but what is the process to work with health care providers and other organizations in the community to understand barriers and gaps, and then deciding whether public health will be a provider of services. It's not a default but a decision based on ever-changing dynamics within a community.

Kusuma asked what subcommittee members' thoughts are around policy measures related to communicable disease and environmental health. We have talked about wastewater surveillance and farmworker health, and related policy implications.

Sara B. said we can revisit this question and metrics selection criteria at the next meeting, and will soon begin seeing metrics recommendations from the Coalition of Local Health Officials committees.

Subcommittee business

- Sarah Present will provide the subcommittee update at the 3/17 PHAB meeting
- Next meeting scheduled for 4/20

Public comment

Adjourn

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 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.

PHAB Accountability Metrics subcommittee

Timeline for discussions and deliverables

	Topics	Work products
April-November 2021	- Public health modernization and accountability metrics statutory requirements - Survey modernization findings and connections to public health accountability metrics - *Healthier Together Oregon* and its relation to public health system accountability - Communicable disease and environmental health outcome measures - Alignment with national initiatives (RWJF *Charting a Couse Toward an Equity-Centered Data System*, data modernization, accreditation)	- Charter - Group agreements - Metrics selection criteria
February 2022	- Shifts from previous metrics set to a new direction for accountability metrics - 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 - Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures.	-

Framework for public health accountability metrics

Past accountability metrics	New metrics framework
Minimal context provided for disease risks and root causes of health inequities	Provides context for social determinants of health, systemic inequities and systemic racism
Focus on disease outcome measures	Disease outcomes may be used as indicators of progress, but are secondary to process measures of public health system accountability
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.

Metrics selection criteria
For discussion

- Are additional changes needed to metrics selection criteria to align with the metrics framework?
- In what ways can accountability metrics be used to demonstrate accountability to communities and for system-wide improvements?

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 Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination 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 Measure is of interest from a local perspective Measure is acceptable to communities represented in public health data
Transformative potential	Measure is actionable and would drive system change Opportunity exists to triangulate and 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 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 When applicable, data are reportable by: - Race and ethnicity - Gender - Sexual orientation - Age - Disability - Income level - Insurance status
Feasibility of measurement	Data are already collected, or a mechanism for data collection has been identified 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 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 Local public health expertise exists
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

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

Metrics for data and data systems
For discussion

- What questions, ideas or concerns do subcommittee members have about discussions on measurement of data and data systems?
- Is this consistent with the direction provided by this subcommittee?

PHAB Accountability Metrics
Measures of data and data systems
April 2022

Process

- Working with Conference of Local Health Officials (CLHO) Communicable Disease committee workgroup
- Identifying priorities at the intersection of Public Health Modernization Manual, public health accreditation standards, and current local public health measures.
- Starting with data and data systems; will also identify measures for community partnerships and public health policy.

Overarching CLHO committee discussion

- Concept for bundled measures that address data accessibility, completeness, utilization and workforce.
- Measures should be broad enough for each LPHA to address local priorities and capacity, but specific enough to demonstrate improvements across the system.
- Menu of options or tiered approach.
- What are the common benchmarks?
- Should strive to identify metrics that OHA can pull.

Areas for measurement

<u>Accessibility</u>

- How quickly data are made available through culturally relevant channels
- Linguistic capacity
- Trainings in communication science
- Routine communications on a quarterly basis
- Maintain communication infrastructure with CBOs established during COVID

<u>Completeness</u>

- Completeness of REALD*, SOGI and housing status data across communicable diseases

- Interview rate among BIPOC communities, people who are homeless or people who inject drugs

Utilization

- State-level dashboards that are accessible by LPHAs and provided necessary data
- LPHA increased access to mine data, for example looking at risk factors across disease areas

Workforce

- FTE with necessary skillset (epidemiologists, disease investigation specialists, community outreach)
- Representativeness of community served
- Training completion

* REALD: Race, Ethnicity, Language and Disability
SOGI: Sexual orientation and gender identity

Population indicators
For discussion

- In what ways would the subcommittee recommend including indicators within the framework for accountability metrics?
- What role does the subcommittee want to play in identifying metrics?