AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

June 14, 2022
3:00-4:00 pm

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

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

Meeting Objectives:

- Approve April and May meeting minutes
- Review and update metrics selection criteria
- Discuss PHAB health equity review questions

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

OHA staff: Sara Beaudrault, Kusuma Madamala

PHAB's Health Equity Policy and Procedure

3:00-3:05 pm	**Welcome and introductions** • Approve April and May minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
3:05-3:30 pm	**Metrics selection criteria** • Review changes to metrics selection criteria and ensure alignment with updated framework • Do the criteria alignment with subcommittee expectations? Can they be applied when selecting metrics?	All
3:30-3:45 pm	**Public health modernization funding report and PHBA health equity review questions** • Review accountability metrics section of Public Health Modernization Funding Report	All

	• Discuss draft responses to PHAB health equity review questions	
3:45-3:50 pm	**Subcommittee business** • Identify subcommittee member to provide update at 6/16 PHAB meeting • Next meeting scheduled for July 20. Working to reschedule recurring meeting time	All
3:50-3:55 pm	**Public comment**	
3:55 pm	**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 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.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

April 20, 2022
8:30-9:30 am

Subcommittee members present: Cristy Muñoz, Kat Mastrangelo, Dr. Sarah Present, Dr. Ryan Petteway

Subcommittee members absent: Olivia Gonzales, Jeanne Savage

OHA staff: Sara Beaudrault, Kusuma Madamala, Lisa Rau, Ann Thomas, Sandra Rice, Tim Menza, Heather Jamieson, June Bancroft

PHAB's Health Equity Policy and Procedure

Meeting Objectives

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

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Welcome and Introduction

Sara B. welcomed everyone and asked committee members to introduce themselves. She mentioned this was a public meeting and asked the public to hold comments until the end. This meeting is recorded for the purpose of writing minutes but not published.

Meeting minutes were passed unanimously.

Metrics selection criteria, how accountability is demonstrated

Sara B. began with referring back to last summer and fall when these metrics were created. We want to make sure selection criteria still remains true, since they will be used for the next few years.

Sara B. showed a slideshow (see PowerPoint presentation) outlining the current deliverables for the committee:

<u>April and May, 2022</u>

- Review recommendations from Coalition of Local Health Official (CLHO) committees.

<u>June 2022</u>

- Metrics recommendations for PHAB approval.

<u>July 2022 and beyond</u>

- Develop 2022 accountability metrics report
- Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures.

Sara B. noted that we have two more meetings before an OHA report is due to the Legislative Fiscal Office which will include progress made by the committee so far.

Sara B. presented a slideshow and stated that the metrics have been revised, with the overarching theme of focusing on **actionable** metrics. She suggested one statement change from "may" to "will."

- "Disease outcomes ~~**may**~~ **will** be used as indicators of progress but are secondary to process measures of public health system accountability."

Kat shared that is she is in the HIE group, which has similar statements and language. Will our work be added to what other groups are doing? Will common definitions be established or will they stay separate?

Sara B. answered that those connections will not be made unless there is an intention to align. OHA can work to draw connections, but you and others on this committee can do so as well.

Kat agreed that it made sense to pull all common definitions together; i.e. data and data systems. We should verify terms and at the very least confirm that they do not contradict each other.

Questions for discussion on metrics selection criteria:

- *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?*
- *What do we mean when we say accountability and accountability metrics, and who are we accountable to?*

Kat asked if there was support for traditional cultures? She will follow up with Sara on her HEI meeting and what they discussed about this topic.

Ryan commented:

1. We should have examples of what each metric should look like. An example is tobacco use, where most measures don't consider context like environment, advertising, tobacco retail...
2. What do we mean by actionable? Need to be concrete. Sample-based and cross-sectional is not actionable.
3. Data availability – No accountability if we are basing metrics on data that are already available, based on funding. We don't have the data we need to address population health inequity and lack of data by design and because it hasn't been deemed important. It doesn't address who is responsible. If we are not committed up-front to using financial and human resources to get the data we need, we will not be able to make this actionable and it will be a waste of time.
4. Data comparability – This should not be the core thing of what is collected. we should not collect the same data from each county. Each county should collect data that is most applicable to their situation. Otherwise, we are tying ourselves to needs that are outside our own community. In terms of macro needs across the state, this is valuable data to collect, but in terms of actionable needs, we should be careful about comparing one community's needs to anothers.

Kusuma stressed that the Survey Modernization team informed this new framing around having a lack of context in public health data. This is not currently in selection criteria. It should include lack of context and the need to address contextual factors. She agreed with Ryan and shared that the committee has discussed the need for flexibility in terms of measures that are locally tailored, but the standard around it should show that we are working toward the same thing. The subcommittee could include something about flexibility and locally tailored measures in the selection criteria. Kusuma noted that data availability is an important piece, but there has to be some acknowledgement of whether we have the local and state workforce to collect new data that is not currently available?

Cristy stated that her work is around community engagement and when it comes to metrics, data can become old. How long do we have before it becomes out-of-date? Do we need something that determines a timeline for gathering data--creating an expectation that we don't rely on data that are old?

Ryan pointed out in the chat that public health data may be 2-3 years old when finally made public, need to work more closely with community residents to collect and share real-time data.

Sarah P. acknowledged that there has been a lot of discussion about dismantling our current public health system and rebuilding it to meet community needs, but is still science and data driven, and the tension of doing this with an exhausted work force. There is tension around this issue, to be finding things that are truly doable and still create system change.

Sarah P. also pointed out that there is a lot of opportunity now for public and private partnerships, such as OSHU being a thought leader providing ideas and resources to the public health system. Public health encompasses more than just government public health system. Perhaps drawing on these partnerships can increase our capacity. Not sure if this should be a criteria or not.

Ryan added in the chat that it sounds like LHD capacity/workforce should be itself an accountability metric; for example, how do we do this work without first making investments in the resources needed to do it?

Kusuma wanted to go back to the charter and reviewing what local and state governmental health are actually accountable for. We should make sure we're learning from the past, like lessons learned in the Health Officer Caucus Report to the Covid Response and doing the basics well before we add other requirements.

Measurement of data and data systems

Questions 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?*

Sara shared slides that showed the CLHO committee discussion which focused on communicable diseases with a subset of data and data systems for communicable disease within the government system. In the future we hope to add a set of metrics around community partnership and policy for communicable disease control. Then at a higher level, we would identify population indicators and why we would need to be making these improvements in our communicable disease data.

Ryan agreed that the data looks good from a communicable disease standpoint but not sure how it transfers to population and community health. Also, examples would be helpful here, especially explaining context issues: such as risk factors related to living wage or sick leave. If we don't have this kind of data, it makes it difficult to intervene and provide resources to those who need them. This data is very good but needs to be reworked to serve accountability purposes.

Kusuma asked Ryan if he thinks that integrating additional data sources into our communicable disease data analysis and reporting would provide the additional context needed. Is there a possible measure for data use agreements with other agencies and integrating external data sources?

Ryan replied that he's not sure of OHA's data use agreements but feels as public government, we should have access to such databases as: transportation indicators: wage, property ownership, and tax data; parks and rec data; school data; Medicare and Medicaid and other databases relevant to public health. Therefore, the first step should be to see what other data sources are out there. Then, we need to think about how to fill in the gaps for data that is not available or that we do not have access to.

June Bancroft added in the chat - We do have our communicable disease data in a mapping portal with the CDC social vulnerability index which includes minorities, unemployed, % below poverty.

Ryan added in the chat, "I also think we need to spend some time accounting for the (limited) role of data as form of evidence/testimony in context of policy/politics. It's an important piece in policy decisions (or at least should be), but it's hardly ever the only piece or the most important piece. So we need to be asking ourselves which kinds/forms of data are most useful/valuable to complement other community health organizing/advocacy strategies."

Ann agreed with Ryan, and is curious if Ryan is referring to obtaining individual data or census-track data? She asked how he envisions this working.

Ryan added in the chat that this work will inevitably require making asks of private entities for data as well. Many may be available at an ecological, neighborhood level. Identified data are aggregated as individual points and geocoded.

Ryan added a link in the chat:
Health affairs piece: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489

Ann believes there is still a lot of data that we could get at the census-track level. She referenced CDC's social vulnerability index. OHA developed a COVID vulnerability index that took into account a lot of these other factors mentioned based on census level tract.

Sara B. chimed in that data use agreements could be a state-level metric. It is long-term work to get those in place. Community information exchange is another mechanism for risk factor and population health data.

Ann replied that statewide communicable disease databases include demographic data such as age, gender, race, ethnicity, and we geocode all of our data. Data can change according to the disease being tracked. She referenced proposed metrics she shared last fall, one part of which addressed decreasing disease transmissions in the houseless population.

Heather added in the chat: "OHA PHD ACDP : housing status, SOGI, REAL D, occupation *for reportable diseases that receive interview."

Tim Menza agreed with Ryan that there is plenty of opportunities to pull together and integrate information. CDC metrics don't necessarily explain Oregon context – they are made for national use and not for the local level. Took social vulnerability index from CDC and made one for Oregon specifically. We need to do more of this work. It is a complex process. Tim referenced a Health Affairs article, discussing measurement of structural racism in research or in explanatory data. This is a big question with great applications to public health, and not rely on things like race and ethnicity.

Cristy shared that there might be some states that are already working on improving the measurement of structural racism and added two resources in the chat:

1. Institute for the study for race and ethnicity : https://kirwaninstitute.osu.edu/
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489
2. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489

Sara B. summarized that we need to create useful metrics that will be relevant over the next few years. These metrics can be used to leverage the changes we need to make to be an accountable and equity-centered public health system. This is long-term work.

Population Indicators

Questions to be asked:

- *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?*

This discussion will be carried over to the next subcommittee meeting in May.

Next steps

There were some changes suggested to the selection criteria.

- De-emphasizing that we already have data available and not wanted to lead with that.
- De-emphasizing data comparability
- Building in flexibility

Subcommittee business

Kat was chosen to present today's update to the 4/21 PHAB meeting.

Public Comment

None.

Adjourn

Next meeting is 5/18/22.

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

May 18, 2022
8:30-9:30 am

Subcommittee members present: Cristy Muñoz, Ryan Petteway, Jeanne Savage, Jocelyn Warren

Subcommittee members absent: Kat Mastrangelo, Sarah Present

OHA staff: Sara Beaudrault, Kusuma Madamala, Lisa Rau, Ann Thomas, Diane Leiva

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Welcome and Introduction

Sara B. welcomed everyone and asked the committee members to introduce themselves. She acknowledged that the group has been meeting for a year. And while this work may have felt both slow and challenging at times, Sara stressed that sometimes we must work through challenging questions to build a robust health system for Oregon. She thanked everyone for their participation in this important work.

Jeanne mentioned in the chat that she finds this work very valuable and has utilized these types of discussions in other venues.

Sara B. asked if we could move the schedule around and approve the minutes at the end of the meeting to give Dr. Ann Thomas more time for her presentation. She announced that Ann will walk through potential indicators for communicable diseases and the high-level priority indicators where inequities exist. This is separate from accountability metrics which are defined as the actions the governmental public health system takes to make changes.

Sara B. then reviewed the agenda, the PHAB Accountability Metrics Group agreements, and the PHAB Accountability Metrics subcommittee deliverables.

Metrics selection criteria, how accountability is demonstrated

Sara B. presented the metrics selection criteria and reminded everyone that these are the same items we've been working on, with the focus today being on how the indicators fit into the overall

framework. She stressed that the selection criteria are still draft, and the committee can change it as they choose. Ultimately these criteria will be used to select indicators and accountability metrics.

Sara B. described indicators as data points that draw attention to priority communicable diseases and environmental health issues that affect the people of Oregon. Indicators will change over time, but rarely in a two-year funding cycle. Indicators are different from accountability metrics, which reflect changes the government makes to move the needle on any of these indicators. We've been talking about public health data, community partnership development and the work around policy, which Kusuma will talk more about in the second half of the meeting.

Ryan asked if our accountability metrics have metrics of their own that track which health data is used or not used in actual legislative processes? If no one uses the data to make changes and advance the policy argument, then the data is just for us. We need to make sure we can show how the data that OHA is producing is tangibly making changes in terms of structural and policy elements. Otherwise, it is not true accountability.

Kusuma agreed this is essential. She reminded everyone that we've been talking about the data pieces and partnership pieces but have not yet gotten to the connection points yet. That is necessary for the accountability.

Jeanne asked for clarification on Ryan's question--are you saying we need a separate metric to analyze the metrics we're putting in place to make sure the data is valuable and being used to change policy, or are you saying we need to check that every metric we look at is utilizing the data and is being used? How can we make sure we are using the right data?

Ryan - I'm looking at the examples, and if we say we are collecting physical activity data and we are successful, that's great, that's accountability. But will that data be used to inform policy so we can change structural and environmental issues and pursue advocacy or policy change? If not, then I think that is a lack of accountability. We can hold ourselves accountable, but we need to hold the government accountable. Otherwise, there's no need to collect data if it won't be used or make an impact.

Kusuma mentioned that this topic will come up again when we discuss selection criteria. It will be helpful to remember to include the policy implications rather than just the data collection.

Sara stated that OHA has a Public Health Modernization Manual that lists the roles and functions of the governmental public health system in Oregon. The work Ryan is describing is solidly in this manual. We need to make this information available to our community partners so they can advocate for policy changes as well. How do we put that into a measure and hold ourselves accountable?

Sara shared a slide about current communicable disease indicators that are tracked by OHA, stating that these give this committee a sample of the data that OHA looks at now. The goal would be for subcommittee members to recommend choosing 1-3 indicators for both communicable disease control and environmental health.

Slideshow and presentation by Dr. Ann Thomas

Ann presented a PowerPoint about her work in the OHA Acute and Communicable Disease Prevention Section.

She began by giving a background on health inequity relating to communicable disease. Covid brought the discrepancies to the forefront. She discussed risk factors for communicable disease transmission and that many diseases have a disproportionate effect on people of color. Her slides are included in the May meeting packet.

Ryan mentioned in the chat that one of the slides used the descriptor “Blacks" and suggested to use the following terminology instead: Black, Black American, Black Populations.

Sara B. followed up Ryan’s question by asking Ann what the official OHA demographic category is for describing black populations.

Ann was not sure what the official version is. Sara said she would follow up with subcommittee members through email.

Sara summarized Ann’s presentation by saying that the information presented shows a new way to look at indicators—by looking at the vulnerable and higher-risk populations first, rather than starting with specific communicable diseases. Then she asked for the committee’s feedback.

Population Indicators and Feedback

Jeanne liked this approach, a breakdown of what we have available to us and a breakdown in terms of race and ethnicity. She thinks this data ties into what Ryan was talking about earlier and can help drive policy about where we provide treatment, and then moving upstream to prevention. She liked this as a metric and as a tie-in with overall priorities and thought it was a great start.

Ryan liked the focus on disaggregating the data. Sometimes data on populations who are experiencing disproportionate inequities gets buried in aggregations. It’s hard to hold ourselves accountable if we’re not getting the resolution we need. The disaggregation helps us direct the resources to where they need to go.

He followed up by asking what the resolution of geographic data is on this information? Was it county level? Are there other options available, like pinpointing parts of a county or city?

Ann replied that yes, that’s become a big focus due to Covid. Communicable disease data is geo-coded to census tracks. Unfortunately, the data is never as current as we’d like. However, it’s still useful because we can create visualizations of different scenarios. Ann said she could share a link

that shows the number of cases by county. OHA publishes general numbers on a dashboard for the public but have a more granular breakdown for state and local public health authorities.

Ann replied to Ryan that as to his earlier question, we want to get as much data as possible while keeping in mind the limits of confidentiality. We could expand our dashboard to include risk factors if we decide to go that route.

Sara B. thanked Ann and asked Jocelyn if these indicators are relevant at the local level if we can't provide a smaller breakdown.

Jocelyn really appreciated the indicators, and if the data was complete, these would be ideal. However, she has some concerns about data quality. Orpheus, the statewide communicable disease database, needs to be improved to make this a helpful tool. How often are metrics reviewed? Is this an annual review?

Sara B. stated that OHA and PHAB have published accountability metrics reports annually in the past. We're required to do them every two years. We won't see a lot of shift in indicators but we should be reporting on accountability pieces annually.

The question was asked, are these indicators shared mostly with the public health sector or is there the ability for these data to be shared with other sectors as well? How can OHA statewide indicators be aligned with community work such as youth, education, schools, CBOs?

Sara B. answered that this report is not intended to only be for the public health system but can be used to draw attention to population health priorities. It can demonstrate the work that the governmental public health system is doing and can be leveraged to guide communications, policy and partnerships so we can work together with community.

Jocelyn asked how we contextualize this data. It is problem-centered on individuals, and there is a need for de-colonizing data. How do we make it more community-focused?

Jeanne agreed. We need to look at conditions in the community and how these problems are created. How do we go about gathering data, leveling it with the community factors, presenting it to CBOs who are doing the work, and then asking them how can we best work with this data to help you? How do we have the community be part of the conversation so that we are guided by them?

Sara told Jeanne that she would like to hear more about these ideas in the June meeting.

Jeanne said she would be happy to bring her health equity data team and present it at the June meeting.

Ryan commented in the chat, "Why track ID that we know are associated with structural inequality if we're not also tracking measures of structural inequality/political silence/political antagonism? For example, an indicator showing IDU and ID in a city paired with proportion of city/county budget

allocated to interventions known to reduce IDU; or ratio of council members/county commissioners who have voted in support of/against such use of resources. That's accountability."

Jocelyn and Jeanne added their agreement with Ryan in the chat.

Kusuma stated that she hopes we can take Ryan's ideas and incorporate some of them into the selection criteria to help frame what we will select as accountability measures, as opposed to indicators.

Subcommittee business

Sara explained that the committee is required to submit a report to the legislative fiscal office by the end of June. When we started this committee a year ago, the plan was to have metrics by now, and we don't have them yet. This is okay, but we do need to provide some sort of update. We can give an update on our process, the direction we're heading, and framing instead.

Next month, OHA will be working with local public health officials through CLHO so health officials can have input on our discussions before we submit anything to the legislature. Also, PHAB will take action to approve the direction for accountability metrics at their June meeting.

Sara also mentioned that this time does not work well with a lot of committee members, and so she will be sending out a Doodle poll to find a more agreeable time.

Jocelyn volunteered to present today's update to the 5/26 PHAB meeting.

The April minutes were not approved and will need to be approved at next month's meeting.

Public Comment
None.

Adjourn
Next meeting is 6/15/22.

New framework for public health accountability metrics

Current 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	Health outcomes will 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.

PHAB Accountability Metrics Subcommittee

Metrics selection criteria

May 2022, draft

Updates in blue

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

Definitions:

Indicators

- Data points that draw attention to priority communicable disease and environmental health issues that affect the health and wellbeing of people in Oregon.
- Over time, changes in indicator data show whether Oregon is making progress toward eliminating inequities and whether health outcomes are improving as a result of investments in the governmental public health system and other sectors.
- The core public health functions reflected in selected accountability metrics are necessary for achieving improvements in the indicators.
- When possible, indicator data are reported by race, ethnicity and other demographic and risk factor data.

Accountability metrics

- Process measures of the governmental public health system's core functions for which the system is accountable.
- These core public health functions are necessary for achieving improvements in communicable disease and environmental health indicators.
- Over time, changes in accountability metrics show whether the governmental public health system is increasing capacity for providing core functions.
- Accountability metrics are not reported at a population level and are not reported by race, ethnicity and other demographic factors.
- Examples may include completeness of communicable disease risk factor data or provision of data to community partners for decision-making.

Example indicators and accountability metrics

Indicator	Accountability metrics
Acute hepatitis infections among homeless populations	Percent of acute hepatitis infection case interviews with complete REALD, SOGI and housing status data (Local)

Commented [MK1]: Still thinking about if/how the selection criteria address the new frame slide. I can see possibly where state & LPHA focus could be captured (KM note under PH system accountability). "Alignment to strategic initiatives" includes state but the new frame says national initiatives as well. Addressing context is noted below. Is there a need to articulate new frame focus on data, partnerships and policy in the selection criteria as well?

Commented [MK2]: I'm thinking about the statement above under indicators "Over time, changes in indicator data show whether Oregon is making progress toward eliminating inequities and whether health outcomes are improving as a result of investments in the governmental public health system and other sectors." And think it's hard to see the direct connection between more complete data and decrease in acute hep infections. Just b/c we have more complete data – not sure if we'll see any impact on the indicator. Complete data allows us to do what to then get to addressing the indicator?

	Percent increase in REALD data completeness as a result of data exchange with other state data systems. (State)
Heat-related emergency department and urgent care visits	Percent of LPHAs that provide routine data to partners and the community highlighting communities/populations most at risk of heat-related illness. (Local) Number/percent of LPHAs with documented dissemination of communications materials for implementing protections for outdoor workers during heat events. (Local/State)

Metrics criteria can be applied in three phases:

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

Phase 1: Indicators of population health priorities	
Selection criteria	Definition
Population health priority	Indicator has been identified as a population health priority by community members and/or public health professionals Information is available to provide the community, societal, systemic, and political context that creates and upholds inequities.
Data ~~disaggregation~~ relevance	Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District Data provide context for health outcomes, which includes systemic issues that result in poorer health outcomes for certain groups. Updated data are routinely available to ensure that the public health system does not rely on data that are old, outdated or no longer relevant. When applicable, data are reportable by race and ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data.

Commented [BS3]: Consider moving community leadership/community-led metrics to this section.

Commented [BS4]: Sarah Present: Criteria for LPHA feasibility needs more thought and discussion. Committee needs to be clear on goals and set realistic expectations.

Commented [BS5]: Cristy's comment from 4/20: Data can become old. How long do we have before it is out of date? Do we have an expectation for timeliness so we don't rely on data that are old?

Alignment with strategic initiatives	Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other 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: 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-led 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~~

Commented [MK6]: I'm not sure how this is assessed

Commented [BS7R6]: This is why I wonder about moving this to the indicator section. If an indicator aligns with Healthier Together Oregon, End HIV, or other statewide initiatives, then there has likely already been an extensive engagement process. PHAB might also consider soliciting feedback from communities on indicators later this year.

	~~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 3: 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, which could include establishing data sharing agreements with other sectors. 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 governmental public health system, specifically state and local. Measure aligns with core system functions in the Public Health Modernization Manual Allows for each public health authority to tailor how work toward achieving the metric is implemented in order to be responsive to local context and priorities. Context provided shows how locally tailored metrics are working toward common goals.

Commented [BS8]: Ryan's comment from 4/20: Should not base metrics on data that are already available. We don't have the data to address population health inequities. Need to commit financial and human resources to get the data that are needed.

Commented [BS9]: Ryan's comment from 4/20: data comparability should not be the goal. Each county should collect data that is applicable to local situation.

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

Public health accountability metrics

Indicators
Communicable disease control and environmental health

- Bring attention to priority issues that affect health and wellbeing.
- Context provided for societal, political and systemic factors.
- When possible, reported by race, ethnicity and other demographic and risk factor data.
- Over time, show whether Oregon is making progress toward eliminating health inequities through public health modernization investments

Public health accountability metrics
Public health data, partnerships and policy

- Measures of governmental public health system core functions for which the system is accountable.
- Focus on core functions for public health data, community partnerships and policy.
- Not reported at a population level or by race, ethnicity, or other demographic or risk factors.
- Within the control of state and local public health authorities

Notes
- Core system functions, roles and deliverables are defined in the Public Health Modernization Manual.
- Refer to Metrics Selection Criteria for additional measure definitions

PHAB Incentives and Funding
Health equity review for public health accountability metrics

What are the primary changes to public health accountability metrics?

1. The PHAB Accountability Metrics subcommittee is making revisions to center community priorities and the role of governmental public health to address systemic racism and oppression.
2. Revisions will bring attention to economic and social injustices that result in health inequities and whether Oregon is taking steps to rectify injustices through policy and resources.
3. Public health accountability metrics will focus on state and local public health authority core functions for public health data, partnerships and policy for communicable disease prevention and environmental justice.
4. PHAB expected to vote to adopt new metrics in the second half of 2022.

What health inequities exist among which groups? Which health inequities does the work product, report or deliverable aim to eliminate?

PHAB is focusing on metrics for communicable disease control and prevention and environmental health.

As the PHAB subcommittee discusses indicators, the subcommittee will identify health inequities and use annual reports to bring attention to the economic, social and systemic causes for inequities.

Corresponding accountability metrics will measure the actions that state and local public health authorities are taking to eliminate health inequities through core functions for data, community partnerships and policy.

The PHAB subcommittee has spent much of the last year developing metrics selection criteria that they will use to evaluate potential indicators and accountability metrics to ensure that metrics actively advance health equity and an antiracist public health system and society.

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?

Indicators and the explicit inclusion of context that describes the reasons for health inequities brings attention to the responsibilities of government agencies, beyond public health.

The PHAB subcommittee has not directly engaged with other sectors.

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?

Central to the revised framework is that indicators and accountability metrics reflect community priorities and are acceptable to the communities represented in measures. The PHAB subcommittee continues to discuss opportunities to align with Healthier Together Oregon and other state and local plans that are community-led, and the subcommittee is building from lessons shared with PHAB by survey modernization partners.

The PHAB subcommittee has not engaged broadly with community partners. Three community partners have been members of the PHAB Accountability Metrics subcommittee since April 2021.