AGENDA

PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

June 21, 2022
1:00 - 2:00 PM

Join ZoomGov Meeting
https://www.zoomgov.com/j/1605421162?pwd=Y24rL0hJUmFGV1hzdjNjSVJFZzNmZz09

Meeting ID: 160 542 1162

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Subcommittee members: Jackie Leung, Hongcheng Zhao, Rosemarie Hemmings, Veronica Irvin, Kelle Little, Jawad Khan, Dean Sidelinger

OHA staff: Victoria Demchak, Virginia Luka, Diane Leiva

1:00 – 1:15	**Welcome and Introductions** • Approve May meeting minutes • Welcome new members and staff • Recording of May 2021 PHAB meeting presentation with survey modernization partners: https://youtu.be/LEQN7kCy7rk	Diane Leiva, Oregon Health Authority
1:15 – 1:50	**Strategic Data Plan Framework components** • Purpose • Other topics for discussion	All
1:50 – 2:00	**Public comment**	

2:00　　　　　　**Adjourn**

Draft Minutes

PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

May 17, 2022
1:00 - 2:00 PM

Subcommittee members: Jackie Leung, Hongcheng Zhao and Veronica Irvin,

OHA staff: Victoria Demchak, Cara Biddlecom, Diane Leiva

Welcome and introductions

- **Overview:**
  - Have waited some time to meet with modernization partners. Making sure that we are centering modernization in how we collect data. In March PHAB meeting, discussed pulling group back together, PHAB recommended we continue to meet given the importance of data being collected, use of the data, and applying the recommendations that have come out.
- **What we've learned:**
  - Veronica - In depth review from surveys, great reach, comments and ideas that came back from surveys about wording and reach.
  - Hongcheng – lots of challenges we've been facing during the pandemic. Public Health department courage to face it and means to do it.
  - Look how we ground ourselves & surveys are relevant and brings up community. Started with behavioral risk factor surveillance survey, telephone survey. It has some issues and challenges of reaching people as well.
  - Working with several groups to collab with to use community identified priorities to guide analysis, interpretation contextualization data. Community led data collection.
- **PHAB role:**
  - What type of guidance for guiding OHA?
  - More systematic approach.
  - How we move these goals forward
    - Community led data collection systems

- State data systems for population based statewide estimates.
- Federally funded population-based surveys
- Local complementary surveys

Diane – requirement for federal funding but able to recommend. Complements modernization documents, innovation network participatory analysis, help develop and grow participation.

Work on a framework for the four ways that OHA partners with federal and local governments to collect and manage data and increase the way that those systems are focused on community

- Hongcheng - On right track with community led and working with communities of color. A way to lower the price tag. Concerned about only a small portion of east Asian included with Pacific Islanders. Should be just Asian & Pacific Islanders.
- Community-led research and bring that piece in. Time and cycles to be aware of it. How is this shared or not shared and process [for working with community members]. Concerns about communication through state. Be more upfront of benefits and how this help.
- Look at one system of data authority/ engagement each for framework, rather than all 4 due to complexity of all. Will be more tangible.

DRAFT FOR DISCUSSION: High level outline for PHAB Framework for Modern Public Health Data

May 29, 2022

1. Introduction
2. Acknowledgments
   - Survey modernization partners
3. Executive Summary
4. Values for modern public health data (with definitions)
   - Data justice
   - Data sovereignty
   - Dismantling white supremacy in public health practice
   - PHAB Accountability Metrics Shifts
5. Components of the public health data system
   - Framing: where we are today and where we need to move
   - Framing: dependencies on other public health system partners
   - Race, Ethnicity, Language and Disability (REALD) data
   - Sexual Orientation and Gender Identity (SOGI)
6. Continuum of public health data
   - Community-led data collection systems
   - State data systems for population-based statewide estimates
   - Federally-funded population-based surveys
   - Local complementary surveys

White Supremacy and the Core Functions of Public Health

Sirry Alang, PhD, Rachel Hardeman, PhD, MPH, J'Mag Karbeah, MPH, Odichinma Akosionu, MPH, Cydney McGuire, MPH, Hamdi Abdi, MPH, and Donna McAlpine, PhD

ABOUT THE AUTHORS

Sirry Alang is with the Department of Sociology and Anthropology, and the Program in Health, Medicine, and Society, Lehigh University, Bethlehem, PA. Rachel Hardeman, J'Mag Karbeah, Odichinma Akosionu, Cydney McGuire, Hamdi Abdi, and Donna McAlpine are with the Division of Health Policy and Management, University of Minnesota School of Public Health Minneapolis.

Global outrage followed the murder of George Floyd by now former Minneapolis, Minnesota, police officers. The outrage was targeted at police brutality—police conduct that dehumanizes through the use of physical, emotional, or sexual violence as well as verbal and psychological intimidation, regardless of conscious intent—one of the oldest forms of structural racism.[1] In decrying police brutality, many public health organizations issued statements declaring racism a public health crisis, with promises of change. However, change is stymied if we do not critically evaluate how the discipline (scholarship, conceptual frameworks, methodologies), organizations (governmental, nonprofit, and private institutions that seek to promote population health), and public health professionals (in academia or practice) contribute to structural racism that is manifested in police brutality, among many other outcomes.

"Structural racism" here refers to policies and practices, in a constellation of institutions, that confer advantages on people considered White and ideologies that maintain and defend these advantages, while simultaneously oppressing other racialized groups.[2] Structural racism is sustained through White supremacy: the glossary of conditions, practices, and ideologies that underscore the hegemony of whiteness and White political, social, cultural, and economic domination.[3,4] White supremacy makes it possible for structural racism to reproduce over time, albeit with different mechanisms, from the enslavement of Black people to mass incarceration. Consideration of White supremacy makes visible that structural racism is "White controlled,"[4] and without examining the former, we will not dismantle the latter in public health.

Public health is organized in a framework of three core functions—assessment, policy development, and assurance—and 10 essential public health services (EPHSs). The framework is meant to help public health "speak with one voice" about what public health is and what it aspires to do.[5] This framework has been immensely influential. Accreditation of public health departments and educational programs partially relies on EPHSs and is included in some state statutes. The EPHSs are taught in our classrooms, are used for performance measurement and evaluation, and have helped to communicate to the public and policymakers what public health is about.[5]

The revised EPHSs were recently released, 25 years after the original framework was developed. The most important change is that the framework now centers equity, defined as a "fair and just opportunity for all to achieve good health and well-being."[6] In the equity statement, racism is mentioned as one of the "forms of oppression" that the EPHSs should address. Living up to the potential of equity requires directly addressing structural racism and White supremacy. We provide examples of strategies in the core functions and EPHSs to do so (Table 1 presents a summary of these).

ASSESSMENT

The core function of assessment is a focus on surveillance. The first EPHS is to "assess and monitor population health status, factors that influence health, and community needs and assets." The revision to this EPHS emphasizes "root causes of inequities." If police brutality and structural racism are root causes, then our health surveillance systems and surveys, such as the National Health Interview Survey and the Behavioral Risk Factor Surveillance System (BRFSS), should routinely track experiences of police brutality, as well as exposure to structural racism. Embedding geocoded information on racial inequities in socioeconomic status in the National Longitudinal Study of Adolescent Health is a good example of this approach.[7] We should assess indicators of structural racism, such as racial inequities in

TABLE 1— Public Health's Core Functions and Essential Services as an Organizing Framework for Dismantling White Supremacy

Core Functions	Essential Services	Example Strategies for Dismantling White Supremacy
1. Assessment	1. Assess and monitor population health status, factors that influence health, and community needs and assets	Routinely track and report respondents' exposures to and experiences of police brutality and other indicators of structural racism and White supremacy
	2. Investigate, diagnose, and address health problems and hazards affecting the population	Investigate the complex mechanisms through which White supremacy shapes health outcomes
2. Policy development	3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it	Educate the public and policymakers on indicators of White supremacy and how these might shape the social determinants of health
	4. Strengthen, support, and mobilize communities and partnerships to improve health	Ensure equitable allocation of resources and redistribution of power in community partnerships
	5. Create, champion, and implement policies, plans, and laws that affect health	Policies must center the experiences of those most affected by structural racism and White supremacy
	6. Utilize legal and regulatory actions designed to improve and protect the public's health	Develop and enforce regulations and policies to dismantle practices that maintain structural racism and White supremacy
3. Assurance	7. Ensure an effective system that enables equitable access to the individual services and care needed to be healthy	Acknowledge racist systems, advocate antiracist policies, and link Black people, Latinx people, Indigenous people, and other people of color with a range of resources
	8. Build and support a diverse and skilled public health workforce	Set clear expectations for education on equity. Schools of public health and public health institutions should set measurable goals on racial equity competency for students and practitioners
	9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement	Focus on critical race conceptual frameworks and antiracist methodologies. Mandate measuring and reporting diversity, equity, and inclusion efforts
	10. Build and maintain a strong organizational infrastructure for public health	The infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed

opportunities, legislation, and policy outcomes; criminalization and incarceration; and neighborhood- or zip code–level inequities in assets, debts, political participation, housing, and employment patterns.[8,9]

In 2002, BRFSS added an optional module, Reactions to Race, but few states administered it. That our surveillance systems do not routinely collect data on racism is one indication of how White supremacy plays out in public health: ignoring everyday experiences of, and exposures to, salient stressors among Black people, Indigenous people, and other people of color (BIPOC). Expanding analyses of the impact of structural racism and White supremacy on the distribution of needs and assets

in communities should be a critical aspect of assessment.

The second EPHS is to "investigate, diagnose, and address health problems and hazards." Using the example of police brutality, scholars need to continue to identify mechanisms such as mass incarceration, stress proliferation, institutional mistrust, and economic and financial strain that link health with exposure to and experiences of police brutality.[1] We must also investigate the mechanisms through which other indicators of structural racism and White supremacy shape health outcomes. Hitherto, public health has accounted for race in health disparities research but has rarely examined the role of structural racism.[10]

POLICY DEVELOPMENT

Public health's third essential service is to "communicate effectively to inform and educate people about health, factors that influence it, and how to improve it." Global protests against racism and the attention to racial inequities in the impact of COVID-19 present no better time to confront White supremacy in communication. However, public health institutions such as the Centers for Disease Control and Prevention did not issue any specific official statements on structural racism. Statements that some other public health organizations have released fall short. For example, the American Public Health Association stated:

[The organization] denounces the use of violent methods by law enforcement against peaceful protesters. The current protests are the result of the American people rightfully demanding an end to the racial profiling by some police officers and a system of structured racism resulting in disproportionate harm to the health of individuals and communities of color.[11]

Although the full statement acknowledges racism as a public health crisis, it neither educates readers on the meaning and manifestations of racism nor implicates White supremacy. Public health has largely failed to take advantage of this opportunity to educate the public about racism and White supremacy, beyond well-intentioned statements that can often be distilled to "racism is bad" and "'they' [the police, other institutions, and people who are racist] need to do better." Public health organizations, institutions, and practitioners must actively educate the public about the role of racism in producing health inequities. For example, speaking up against the recent surgeon general's report on maternal mortality,[12] which does not mention racism as a fundamental cause of racial inequities in maternal health outcomes, and against policies such as former president Trump's Executive Order 13950, which banned training in critical race theory, are necessary actions for educating the public about factors that influence health.

The fourth EPHS is "strengthen, support, and mobilize communities and partnerships to improve health." The revised version focuses on authentic relationships to promote equity. Authenticity is difficult to achieve given inherent power differentials. Public health leaders, most of whom are White,

primarily make decisions about the allocation of resources for research and practice, shape engagement of stakeholders, and determine whether and how the perspectives of community members are used.[13] Redistributing power in community partnerships can help challenge White supremacy. Our community partnerships should be characterized by frequent open conversations about power dynamics that are at play. We also think it is time for our funding agencies to not fund community-based research unless researchers demonstrate that the allocation of resources is fair and there is equitable compensation for community partners.

Public health's fifth EPHS is to "create, champion, and implement policies, plans, and laws that affect health." The knowledge that informs policy should be grounded in the experiences of those most affected. But policymakers and academic researchers are predominantly White.[14,15] As a result, White intellectual dominance characterizes the production of knowledge, its translation into practice, and the formulation of policy. As a profession, we need to address the reality that research led by Black scholars who have the experiential knowledge of how racism and White supremacy affect health is less likely to be funded than research led by their White counterparts.[16] We must also prioritize work that centers the experiences of historically excluded populations most affected by White supremacy. One way forward is to engage more meaningfully with grassroots organizations such as Black Lives Matter and to extend our professional responsibilities to include community-engaged advocacy for the policy priorities these organizations have articulated. Public health must be intentional about finding ways to create space for those

without formal power to influence decision-making through the expertise of their lived experiences, especially experiences of racism.[13]

The sixth EPHS is "utilize legal and regulatory actions designed to improve and protect the public's health." Public health performs this service well when it comes to enforcement in areas such as immunization, tobacco, and alcohol regulations. However, the field is yet to develop regulations to dismantle practices that specifically uphold structural racism and White supremacy. For example, public health should be at the forefront of enforcing regulations to prevent disposal of toxic waste in Black and Indigenous communities. Mandating restorative justice practices that prevent the disproportionate incarceration of BIPOC is necessary.

ASSURANCE

Under the core function of assurance, the seventh EPHS is ensuring "an effective system that enables equitable access to the individual services and care needed to be healthy." We must first recognize areas of significant need and acknowledge how historical and contemporary forms of racism act as barriers to accessing services that meet these needs. For example, public health institutions and organizations should address the ongoing mistrust in medical institutions and the COVID-19 vaccine hesitancy by first acknowledging the harm science and medicine have inflicted on Black, Latinx, and Indigenous communities. Promoting vaccine uptake must be done simultaneously with advocating policies to ensure access to testing, treatment, and other resources needed to survive the pandemic. For communities to trust in public health and utilize the services and systems we

provide, public health must first be trustworthy.[17]

The eighth EPHS is "build and support a diverse and skilled public health workforce." We know that the public health workforce is disproportionately White, especially at the supervisory and managerial levels.[14] Schools of public health are also disproportionately White. In 2017, only 0.2% of tenured faculty were Native American, 3.8% were Black, and 7.4% were Latinx/Hispanic, and those numbers have barely budged in years.[15] That a predominantly White profession and discipline is charged with educating and addressing the needs of communities that are disproportionately Black, Indigenous, and Latinx sustains White supremacy within public health. White frames dominate the information we convey, the interventions we develop, and the policies we implement, all of which are often completely disconnected from the experiences of the people most likely to experience health inequities.

The training that public health practitioners often receive is partially responsible for our inability to address structural racism and White supremacy. Leading textbooks intended for undergraduate education often fail to critically analyze the concept of race and barely touch on racism. Moreover, a recent review of 59 accredited schools of public health found that only 33% mentioned diversity, inclusion, or equity in their public mission, vision, or values statements, and 20% made no mention of any of these terms in their goals, objectives, or strategic plans.[18] It is encouraging that the revised EPHS now mentions building a workforce that "practices cultural humility." But cultural humility in place of discussions of structural racism and White supremacy will not change much and echoes hanging our hats on the term "implicit bias,"

rather than talking about forms of racism. To begin to make antiracist training real, it is imperative that the Council on Education for Public Health set clear expectations for education on equity and racism and that schools and organizations set goals for racial equity competency for students and practitioners that are measurable and for which someone is accountable. Metzl and Hansen[19] have made the case for structural competency to be integrated into medical education, and the same should be promoted in public health.

The ninth EPHS is "improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement." It has been 10 years since Ford and Airhihenbuwa[20] laid the foundation of how critical race theory could help examine and address health inequities, but much of public health research still documents how health risks, behaviors, and outcomes vary by race, rarely naming racism[10] and with the concept of White supremacy almost invisible. We fully support the recommendations of Boyd et al.[21] for standards that include rejecting the publication of articles that use race but do not examine racism. Dismantling White supremacy through quality improvement also requires us to make diversity, equity, and inclusion a meaningful part of the Public Health Accreditation Board and Council on Education for Public Health accreditation standards by requiring institutions and organizations to publicly report student, faculty, and workforce statistics by racial group.

The 10th EPHS is to "build and maintain a strong organizational infrastructure for public health." This service emphasizes ethical leadership, transparency, inclusivity, accountability, and equitable distribution of resources.

Yet, many public health teaching institutions reside on land and have built endowments by selling land taken from Indigenous people through displacement and genocide.[22] The wealth of other institutions is grounded in the selling of Black persons who were enslaved.[23] Public health institutions have to thoughtfully engage with the reparations movement within their own institutions and nationally. And the infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed.

CONCLUSIONS

The core functions and EPHSs have alternatively been called "guidelines," "vocabulary standards," a "framework," and "principles." They provide a way of making sense of what public health is to us and to others. It is encouraging that the most recent revision centers the concept of equity. But to live up to equity in our EPHSs, they must also tackle structural racism and its roots: White supremacy. In the tradition of public health, we advocate going upstream to deliver the EPHSs, but fully going upstream requires naming and dismantling White supremacy. Success requires building alliances across systems to address the range of social determinants of health caused by White supremacy.

Assessment must include data collection, monitoring, and reporting racism pertinent to the health of BIPOC. Policy development must center on communication about White supremacy, building authentic community partnerships, eliminating regulations that sustain White supremacy, and centering the experiences of people most affected by White supremacy. Assurance requires us to

analyze the impact of White supremacy on training curricula, scholarship, the racial composition of the public health workforce, and the public health infrastructure.

Sustained underinvestment in public health is a considerable barrier to achieving equity in the EPHSs, but this barrier fades in comparison with the disproportionately greater underinvestment in people who are more likely to experience early mortality because of White supremacy. We believe that addressing White supremacy does not require more money; it requires the reallocation of resources.

Although the strategies presented here are based on deeply and honestly examining the field and profession of public health, we echo an earlier call for self-reflection by individual scholars and practitioners: "We must ask ourselves if our own research, teaching, and service are fundamentally and unapologetically antiracist."[1(p664)] *AJPH*

CORRESPONDENCE

Correspondence should be sent to Sirry Alang, Associate Professor of Sociology and Health, Medicine and Society, Lehigh University, 31 Williams Dr, Suite 280, Bethlehem, PA 18015 (e-mail: sma206@lehigh.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

PUBLICATION INFORMATION

CONTRIBUTORS

S. Alang and D. McAlpine conceptualized the article and wrote the initial draft. R. Hardeman, J. Karbeah, O. Akosionu, C. McGuire, and H. Abdi edited subsequent versions. All authors contributed to the final revised version.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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						Demographics					
Major Data Source Name	Brief Description	What value does this data provide?	Data Category (Claims, Survey, etc)	Data Information Source (Public Health Modernization)	Major Limitations	Age (open text)	Geography (smallest area)	SES (open text)	Race/Ethnicity	Language	Disability
Adolescent Suicide Attempt Data System (ASADS)	Adolescent Suicide Attempt Data System (ASADS) was established in 1987 by Oregon Revised Statute 441.750, mandating that hospitals refer youth who attempt suicide to in-patient or out- patient community resources, crisis intervention or other appropriate intervention by the patient's attending physician, hospital social work staff or other appropriate staff, provide information to patients, and report attempt information to the Oregon Health Authority.	Estimate the magnitude of suicide attempts among Oregon adolescents and monitor possible increases, decreases and trends. Understand factors associated with suicide and suicide attempts among adolescents. Increase public awareness and develop programs	Special data form	Reportable data	Not every suicide attempt is identified and reported. It is a challenge to differentiate between suicidal behavior and non-suicidal self harm. Only based on hospital reports.	0-17 years old	City	No	Race and ethnicity	No	No
Ahlers/ScreenWise - Breast and Cervical Cancer (BCC)	Annual assessments of clients seeking breast and cervical cancer screening services from enrolled providers. Client demographics, screening history, screening procedures, results, and progression to treatment (if needed) are recorded, and claims data are collected. Data collection is on-going. We retrieve data files from our third party vendor, Ahlers and Associates, on a monthly basis.	Data is used to assess the quality of breast and cervical cancer screeening services received by underserved women. Clients are tracked over time.	Provider assessments/reports and claims data	Health Services data	Data is limited to women (and men) 21-65 years of age under 250% FPL or underinsured. Resident status is not assessed. Self-report often left blank.	21-65 years old	State	<250% FPL; income; family size	Race and ethnicity	Yes	Yes
Ahlers/ScreenWise - WISEWOMAN	Annual assessments of BCC clients (female age 40-64) seeking cardiovascular disease screening and counseling services from enrolled providers. Client demographics, screening history, screening procedures, health coaching/lifestyle counseling services (if needed) are recorded, and claims data are collected. Data collection is on-going. We retrieve data files from our third party vendor, Ahlers and Associates, on a monthly basis.	Data is used to assess the quality of cardiovascular disease screening and counseling services received by underserved women	Provider assessments/reports and claims data	Health Services data	Data is limited to women age 40-64 enrolled in the BCC program. Resident status is not assessed. Low participation in program; clients from limited geographical area; limited number of healthcare providers participate in program resulting in unrepresentative sample.	40-64 years old	State	<250% FPL; income; family size	Race and ethnicity	Yes	Yes
ALERT IIS (also referred to as Oregon Immunization Information System IIS)	ALERT IIS is a nationally recognized population-based registry of consolidated immunization records for Oregonians across their lifespan. The ALERT IIS vision is to improve the immunization status of all Oregonians and prevent vaccine preventable disease by consolidating immunization information and sharing it with authorized users, in an effort to ensure that all Oregonians are immunized appropriately and have a complete record in ALERT IIS. The primary purpose of the registry is to provide clinical support to our partners.	ALERT IIS data are available to authorized users to support a wide variety of clinical and public health purposes. This includes clinical decision support at the point of care, evaluation, surveillance, quality improvement, and access to immunization records. ALERT IIS also supports the inventory management, ordering, accountability, and vaccination rate assessments necessary for the Vaccines for Children (VFC) Program, as well as meeting school immunization requirements. ALERT IIS supports real-time, bidirectional interfaces for exchange of immunization history and forecast between provider electronic health record systems (EHRs) and ALERT IIS. Additionally, we collaborate with Oregon's newly formed Coordinated Care Organizations (CCOs) to supply data needed to meet the 2016 CCO Incentive Measures.	Data captured in ALERT IIS include demographic and immunization events at client level. ALERT IIS data sharing partners include but are not limited to: public and private clinics, non-traditional immunization providers, state and local public health agencies, schools and children's facilities, Indian Health Services (IHS), hospitals, pharmacies, long-term care, facilities, correctional facilities, health plans and CCOs, independent practice associations (IPAs). Current OHA bi-directional data feeds include ORKids (nightly batch), WIC (weekly batch), and EDHI (monthly batch). Vital Records sends Electronic Birth Record System data to ALERT IIS weekly. Most recently, ORPHEUS/ALERT IIS real-time querying enhancements were made to enable staff access to immunization histories as warranted for applicable case reports.	Health Services data	ALERT IIS data is specific to immunizations; no other medical information is collected. ALERT IIS is based on mandatory reporting from pharmacists and for state-supplied vaccine; otherwise reporting is voluntary. Data completeness is high but may vary by subpopulation, age, or region High data capture for 0-18 and increasing capture among adult population; SES, race, and ethnicity are not commonly reported by immunization providers. ALERT IIS averages 25,000 real-time queries per day, a significant growth in the past four years. Staff reductions have eliminated all but one position that is dedicated to perform record deduplication. OIP is looking for system enhancements and temporary staffing options to keep up with this critical data cleaning.	All	Address	No	Race and ethnicity	No	No
All-payer all-claims database (APAC)	APAC comprises medical and pharmacy claims, information about members and provider associated with claims, premium data and, starting in September 2017, Alterntative Payment Method (APM) data as collected from health insurance payers for residents of the State of Oregon. APAC includes data from commercial health insurance carriers, licensed third party administrators, pharmacy benefit managers, CCOs, and Medicare FFS data from CMS.	Aggregated claims databases provide an unprecedented view of care across all settings. APAC provides an opportunity to develop a deeper understanding of Oregon's health care delivery system by providing access to data essential for understanding health care coverage, cost, and utilization in Oregon.	Claims	Health Services data	APAC is not a complete view of health care in Oregon and does not include uninsured and self-pay individuals, dental claims, federal programs like Tricare and Indian Health Services, carriers or TPAs with fewer than 5,000 covered lives, and masks claims related to substance use, genetic testing, or HIV/AIDS; due to the way claims are processed by submitters, data is generally not mature and available for release until 2 years later; data users must be familiar with claims data and how to use it.	All	Address	No	Race and ethnicity	No	No
Ambulatory Surgical Centers (ASCs)	We discontinued collection on ASCs in July 2015 and refer researchers to APAC for data. Our historic data sets are the same structure as Hospital Discharge Data, but contain information for free standing ambulatory surgical centers	Administrative records for ambulatory surgical centers discharges. Diagnosis codes, procedure codes, dates of service and billed amounts	Administrative abstracted data	Health care quality data	Administrative data does not have doctors notes or qualitative information about the stay. Billed amount does not related to the actual amounts paid or received for the service. ASCs do not submit institutional claims and therefore are have fewer data elements than hospital facilities. No patient identifiers Data quality inconsistent; unstable clinics - frequently go out of practice.	All	Zip	No	Race and ethnicity	No	No
Behavioral Risk Factor Surveillance System (BRFSS)	The BRFSS is the largest, continuously conducted, telephone health survey in the world. It enables the Center for Disease Control and Prevention (CDC), state health departments, and other health agencies to monitor modifiable risk factors for chronic diseases and other leading causes of death. Data are collected via a telephone survey (both landline and cell phones).	The objective of the BRFSS is to collect uniform, state-specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. Factors assessed by the BRFSS include access to health care, tobacco/e-cigarette, alcohol and marijuana use, physical activity, dietary practices, use of cancer screening services, prevalence of chronic conditions (diabetes, arthritis, cardiovascular disease, asthma, depression, etc.), and other health-related topics. Health departments use the data for a variety of purposes, including identification of health disparities, targeting services, addressing emergent and critical health issues, proposing legislation for health initiatives and measuring progress toward state and national health objectives.	Telephone (both landline and cell phone) survey.	Survey data	Survey is limited to non-institutional adult Oregon residents with landline and/or cell phone service. Industry-wide declining responses rates for both landline and cell phones are an ongoing concern. Small numbers for specific populations - missing institutionalized, homeless, disabled, non-English/Spanish speaking. BRFSS has included those living in dorms for the past several years. Number/percentage of cell phone interviews is increasing (accounts for roughly half of completed interviews in the last year or two). Cell phone interviews can be conducted with homeless respondents.	18 years old and older	Zip	Education level; household income; employment status; home ownership; education	Race and ethnicity	Yes	Yes

Behavioral Risk Factor Surveillance System (BRFSS) survey of State and School Employees (BSSE)	Every two years a telephone survey is conducted among Oregon's public sector workforce to assess its overall health. Employees covered by the Public Employees Benefit Board (PEBB) include those working in State Agencies and the Oregon University System. Employees covered by teh Oregon Educators Benefit Board (OEBB) include those working in K-12 School Districts, Educational Service Districts, Community Colleges, and some charter schools.	The BSSE's results inform efforts to establish, monitor, and modify benefits and programs to fit the health needs of PEBB and OEBB members. The BSSE helps identify appropriate benefits and grpograms to support all Oreogn state and school employees and their families. BSSE results also inform Worksite Wellness strategies for public health organizations and partners working with state and local systems to create healthy work and school environments.	Survey	Survey data	Data are self-reported. Results are applicable to employees who are primary subscribers, not the entire PEBB and OEBB member population. Low response rates, small numbers for specific populations. Missing those without phone number at work or home.	18 years and older	County	Education; income; employment status	Race and ethnicity	Yes	Yes

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	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.