AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

August 25, 2022
2:00-4:00 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 June meeting minutes
- Fianlize metrics selection criteria
- Discuss process measure recommendations with Conference of Local Health Officials (CLHO) committee members

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

2:00-2:10 pm	**Welcome and introductions** • Approve April and June minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
2:10-2:40 pm	**Metrics selection criteria** • Review changes to metrics selection criteria and ensure alignment with updated framework • Do the criteria align with subcommittee expectations? • In what ways can they be applied when selecting metrics?	All

2:40-3:40 pm	**Recommended process measures for communicable disease and environmental health** • Hear from CLHO Communicable Disease and Environmental Health accountability metrics workgroups about recommended process measures • Provide guidance on continued development of process measures	Kathleen Rees Wendy Zeiker Kathleen Johnson All
3:40-3:45 pm	**Subcommittee business** • Identify subcommittee member to provide update at 9/8 PHAB meeting • Next meeting scheduled for September 15 from 2:00-4:00	All
3:45-3:50 pm	**Public comment**	
3:50 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.

PHAB Accountability Metrics subcommittee

Timeline for discussions and deliverables (Updated June 2022)

	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-June 2022	- Develop framework for public health accountability metrics - Finalize metrics selection criteria - Begin discussions on communicable disease and environmental health indicators	- Metrics framework - Metrics selection criteria
July-December 2022	- Identify and discuss communicable disease and environmental health indicators - Review recommendations from Coalition of Local Health Official (CLHO) committees -	- Metrics recommendations for PHAB approval

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

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:

April and May, 2022

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

June 2022

- Metrics recommendations for PHAB approval.

July 2022 and beyond

- 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 OHSU 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

June 14, 2022
3:00-4:00

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

Subcommittee members absent: Kat Mastrangelo, Sarah Present, Ryan Petteway

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

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Welcome and Introduction
Sara B. welcomed everyone and asked subcommittee members to introduce themselves.

The subcommittee unanimously approved May meeting minutes. The April minutes will need to be approved at a meeting with additional subcommittee members present.

Metrics selection criteria
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 finalizing metrics selection criteria for PHAB to review on Thursday.

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.

Jeanne asked, when we say accountability metrics, are we focusing on the public health system and the work it is doing? Do the metrics need to reflect the strategic work that public health is doing around public health modernization?

Sara B. agreed with this and said the focus is on the work that governmental health does, related to foundational capabilities.

Kusuma clarified that we are talking about local and state government for accountability metrics.

Jeanne asked whether this is in alignment with PHAB's charter. PHAB has responsibility to the public health system and reports to the Oregon Health Policy Board. We need to have metrics in place that reflect the drive and strategies, and the groups for whom PHAB helps to direct work.

Kusuma shared that larger contextual factors play into the indicators, but this is not necessarily where the accountability for governmental public health lies.

Sara B. said these are tough conversations, trying to focus in on what governmental public health is accountable for, which is described in the Public Health Modernization Manual. Some subcommittee conversations also seem to be about how to keep the state of Oregon, beyond public health, accountable. This can include political and societal factors that are much bigger than public health. It is hard to thread the needle on these.

Jocelyn asked about CBOs and their accountability for public funding. What is the accountability for CBOs if they are working on the same priorities for public health modernization?

Cristy said that for disaster resilience, CBO partners have been on the frontline and are doing a lot of work to create the new programming that is needed. She noted that her organization is receiving public health modernization funds and works with other funded organizations. These funds are helping CBOs create the new programming that is needed for moving forward. When we talk about accountability, she wants to be sure we are talking about the public sector and not CBOs. The requirements and expectations are different.

Kusuma thought back to last summer and discussions about what governmental public health was not able to do in its core functions for the COVID response. She believes that focus on governmental public health helps to not have the same issues that came up during the ongoing COVID response, in part through having infrastructure in place. She noted tat CBOs are accountable for areas of work outside of public health.

Jeanne said she doesn't know if it is within the purview of PHAB to look at the accountability of CBOs. Those are relationships that OHA has set up, and the way they've gone about funding CBOs and the structure that they are creating is lending to abrasion and friction amongst organizations that received different funding levels for different things. It is the same as when public health said it needed to have contracts with CCOs, which also created frictions. OHA in general needs to look at their own strategy and go back to that. But in this subcommittee, she doesn't think CBO accountability is within the purview of this subcommittee. If it is within purview, then we need to go back to the framework.

Sara agreed that it is out of scope. OHA funding to CBOs is something that is in the Public Health Modernization Manual as a core function for state public health. OHA is accountable for doing it. But she doesn't see how it carries through to organizations that do not have the public health authority or governmental functions of state and local public health authorities.

Jocelyn said that she thought that was true as well. But in hearing presentations from OHA In the past year, she sees that CBOs, OHA and LPHAs comprise the public health system, that the public health system has been redefined by OHA and that governmental public health was redefined to include CBOs. She is trying to understand what the system is now and how the parts work together.

Kusuma asked, if CBOs are considered to be governmental public health, then what about all the other types of partners that public health works with, like schools?

Jeanne said that her CCO funds both LPHAs and CBOs. Do we need to answer this question in order to answer the accountability metrics question?

Kusuma said she believes we do. She notes the metrics selection criteria for public health system accountability, and the specific item for alignment with the Public Health Modernization Manual which only addresses state and local public health authorities. If this is changing, we need to talk about it.

Sara B. agreed that this is important for the subcommittee to discuss. Sara said that she continues to see the governmental public health system as OHA, LPHAs and Tribes. The investments in CBOs are investing in the larger community health system, but it is not governmental. OHA needs to do more to differentiate the essential role of LPHAs, which is very different from what CBOs provide. OHA needs to do more to communicate how and why we are using funding to bring these parts of the system together.

Jocelyn said she agrees with this and hasn't heard it before from OHA. How does LPHA and CBO funding complement each other to leverage differing roles and maximize impact through the specific work that they do.

Jeanne reiterated what she heard, which is that governmental public health is OHA, LPHA and tribes. Are CBOs considered extensions of LPHAs?

Sara said no, they are not extensions of LPHAs. They are part of the broader community health or public health system. OHAs, LPHAs and tribes have statutory authority for protecting health and wellbeing. There are no similar laws for CBOs.

Cristy said that CBOs are their own separate entities and sector with really different expectations for how they meet community need. They are often small and grassroot. CBOs don't work for governmental entities; they work with governmental entities. There is a power dynamic between CBOs and governmental agencies, which the modernization funds start to address. Most CBOs don't apply for large governmental grants because of the bureaucracy and education gap in understanding how to navigate partnerships and relationships with CBOs that work with marginalized groups. This is where reparations are happening between large agencies like OHA and small organizations. Some CBOs work in the Ven diagram of public health, advocacy and policy, and direct frontline services.

Kusuma noted how this contributes to CHAs and CHIPs that are the foundation of so much in public health.

Kusuma asked whether, based on the discussion, the group agrees that the public health accountability measures were not intended to be used as a mechanism for BCO accountability.

Subcommittee members agreed.

Kusuma returned the group to looking at the metrics selection criteria.

Sara B. said that we are moving toward a framework with two levels of measures: indicators and accountability metrics. It is similar to the existing public health accountability measures, which include health outcome measures and local public health process measures. There has been talk about only including the accountability metrics that look at the granular work of state and local public health related to public health data, community partnerships and policy. Sarah Present has shared that health officers across the state feel it is important to have indicators because it shows the “so what”? Why does it matter to improve data systems? We need to be able to demonstrate a connection to long-term health improvements. Ryan has talked about the importance of articulating the community context that affects the indicators, to demonstrate that the differences in health outcomes are rooted in injustice and are the responsibility of the systems that are set up around people.

Sara asked whether the framework with two levels of measures makes sense.

Jocelyn said it makes sense and said we’ve been struggling with this for years. Public health is a long game and we won’t see changes in indicators from year to year. Having indicators is important to show the goals and what we’re aiming for. She appreciates the attention to process metrics. It is challenging to find the right ones that are convincing and important. This is a place where CBOs could come in. As we widen public health modernization, the involvement of more and more organizations in public health is important and helps create a greater understanding at the community level about where public health system is headed and why.

Cristy asked about feedback loops. Will there be a feedback loop with community once measures are identified through community listening sessions?

Sara said that determining how to get community feedback is within the scope of work for this subcommittee. She asked how we can use feedback gathered through community feedback processes for Healthier Together Oregon or other similar efforts? Will the subcommittee want to ask the community to provide feedback on more granular public health process measures? The subcommittee will need to work through questions like this as we start to identify measures.

Jeanne thought if we are looking at measures already informed by communities that have been marginalized recently, and through actively an antiracist data collection manner, then yes, it would be great to look at feedback already collected. For process measures, can we count on PHAB,

representing different sectors, as a decent representative to look at process measures, or would it need to go out for community input? She doesn't know the answers.

Kusuma asked the subcommittee to what extent indicators and accountability metrics need to be connected. She hopes to see direct alignment. As we walk through selection criteria, it would be helpful to think about indicators and accountability metrics as they relate to each other.

Sara said the CLHO communicable disease committee chairs will be invited to the next subcommittee meeting. They are thinking about data measures like completeness of REALD data, how state-level data are made available to LPHAs and workforce. Next month we'll be able to start seeing what measures could look like. Identifying indicators sits with this committee, and OHA will be bringing more content experts to talk with the subcommittee about what potential indicators could be.

Sara said we will keep the metrics selection criteria in draft form. It will be important to continue to look at it once the subcommittee is reviewing proposed measures.

Kusuma asked whether the selection criteria align with the new framework and where do they not align. It seems like we've been talking about accountability metrics first, but the metrics slection criteria lists indicators first. Are the metrics selection criteria phases necessary? She noted that the framework addresses the importance of context and on accountability metrics for data, community partnerships and policy, but she doesn't see those reflected in the metrics selection criteria.

Sara noted that the metrics selection criteria could be organized to line up with the framework, but we don't have that right now. We can add data, partnerships, and policy into the selection criteria, noting that PHAB has prioritized these three areas.

Subcommittee members agreed.

Sara asked about how to incorporate use of context to the metrics selection criteria.

Kusuma said this fits with selection of indicators more than in the accountability metrics.

Sara asked how it could be used to determine whether an indicator is a good fit to be adopted by PHAB.

Kusuma thinks about using data from other data systems or data use agreements as ways that governmental public health can be accountable.

Jeanne said she thinks of it as, is the indicator reflective of the populations that have been marginalized and suffering from a faulty system. If we pick an indicator and we look the context of social determinants of health, systemic inequities and systemic racism, does the indicator help us improve the conditions of people who have been marginalized? If it does not, then it is useless. We need indicators that reflect the populations we want to serve and provide reparations for.

Jocelyn wondered whether we could think about indicator points less as individual level outcomes and instead look at something like differences in life expectancy among racial and ethnic groups as the things we're trying to change. It may be too general and broad. The focus should be on context and not focus on the individual. Maybe what we're interested in are differences between groups that are not attributable to individual behavior, but are influenced by the context in which people live. It could be differences in infections between racial groups or based on other risk factors like housing status. The differences themselves are attributable to systemic oppression and differences in opportunity, among other things.

Sara and Kusuma will clean up the metrics criteria for PHAB but keep them as a draft and label them as preliminary. This has been an important conversation and more conversation is needed.

Health equity review questions for PHAB discussion
Cristy wrote in the chat that the document reflects our commitments to equity.

Jeanne noted that it is clear that we're challenged by identifying the correct indicators and accountability metrics and the subcommittee is still trying to figure this out. She is okay with sharing the health equity review questions.

Public Comment
None.

Adjourn
Next meeting is currently scheduled for 7/20. OHA staff are still trying to find a recurring meeting time that works for all subcommittee members.

PHAB Accountability Metrics Subcommittee
Metrics selection criteria
August 2022

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

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 and systemic inequities resulting from systemic racism and oppression**
Focus on disease outcome measures	Disease outcomes 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**.

Preliminary

Public health accountability metrics

Indicators Communicable disease control and environmental health	Public health process measures Public health data, partnerships and policy
Bring attention to priority issues that affect health and wellbeing.	Measures of governmental public health system core functions for which the system is accountable.
Provide context for societal, political and systemic factors.	Focus on core functions for public health data, community partnerships and policy.
When possible, reported by race, ethnicity and other demographic and risk factor data.	Not reported at a population level or by race, ethnicity, or other demographic or risk factors.
Over time, show whether Oregon is making progress toward eliminating health inequities through public health modernization investments	Within the control of state and local public health authorities

Accountability metrics selection criteria

Framework	Metrics selection criteria
Advances health equity and an antiracist society **(Indicators and process measures)**	Measure addresses an area where health inequities exist Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination Measure is actionable, through policy change and community-level interventions
Community leadership and community-led metrics **(Indicators and process measures)**	Communities have provided input and have demonstrated support
Provides context for **social determinants of health, systemic inequities resulting from systemic racism and oppression (Indicators)**	Information is available to provide the community, societal, systemic, and political context that creates and upholds inequities. Opportunity exists to triangulate and integrate data across data sources
Disease outcomes used as **indicators of progress.** These are **secondary to** process measures of **public health system accountability (Indicators)**	Issue has been identified as a population health priority by community members and/or public health professionals Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District 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. May include data from other sectors. When applicable, data are reportable by race and ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data.

preliminary

Focus on **governmental public health system accountability (Process measures)** Focus on **data** and data systems, community **partnerships**, and **policy (Process measures)**	State and local public health authorities have control over the measure. Measure successfully communicates what is expected of the governmental public health system, specifically state and local public health authorities. 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. 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 Funding is available or likely to be available Local and state public health expertise exists 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
Direct and explicit **connections to state and national initiatives**	Measure aligns with State Health Indicators or priorities in community health improvement plans and the state health improvement plan, *Healthier Together Oregon*

preliminary

	Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures. Measure aligns with national Public Health Accreditation Board standards and measures.

preliminary

Metrics selection criteria

- Do selection criteria align with the updated metrics framework?
- Do the selection criteria align with subcommittee members expectations?
- In what ways can they be applied when selecting metrics?

Conference of Local Health Officials (CLHO) committees, accountability metrics workgroups

- Have been meeting since March (CLHO communicable disease) and July (CLHO Environmental Health)
- Include local and state subject matter experts
- Focus on developing process measures for public health data, community partnerships and policy

Process measure recommendations

- Are recommendations with what PHAB subcommittee members expected to see?
- What direction can the subcommittee provide to CLHO committees for continued development of process measures?
- How would the subcommittee like to see developmental measures used, moving forward?

CLHO CD Accountability Metrics Workgroup; prelimiary discussions on data measures for communicable disease

Proposed communicable disease accountability metrics	Measure	State/local/both	Data source	CLHO CD Workgroup meeting notes
Data and data systems				
Accessibility and utilization				
Access to communicable disease data **Goal:** Increase LPHA access to communicable disease data, which is needed in order to identify disease risks and trends and to inform program and policy decision-making.	# of state-level dashboards that are accessible by LPHAs # of categories of information included on dashboards #/% of dashboards with summary data that can be downloaded	State	PHD program tracking	OHA is working on this and will expand further as we move to a SQL database (tableau dashboards will be connected to SQL and will be more timely). A measure could include the number of dashboards available, the categories of information available or the number of reports that include summary data for download. May also be able to count downloads. LPHAs need more than rates. Need data to identify geographic trends including risk factors; clusters; higher than expected rates. Use data more efficiently to prevent disease. Incorporate Social Vulnerability Index by census tracts. This is currently available to Orpheus users. (SB: what would it look like to incorporate SVI data?)
	#/% of LPHAs with access to raw data for customized queries and analysis	State	PHD program tracking	Metric needs to be broad to allow for different levels of specific technical capacity and expertise. SQL will allow LPHAs with technical exterise to pull the data, and tableau dashboards will provide easier-to-access info for other LPHAs. Requires that OHA technical support is available. (SB: should we add this as a measure?)
	LPHA use of communicable disease data	Local	LPHA reporting/OHA survey to LPHAs	Report on the ways in which LPHAs are accessing and using dashboards and/or raw data. What supports are in place for LPHAs that don't have data-focused staff to run reports or do analyses? What is accessible to LPHAs, what resources are available. Standard framework for how LPHAs can request TA from OHA. Working toward equitable use of data. Mulntomah County is willing to work with OHA on this. Multnomah County has a lot of code for analyzing. (Current mechanisms include Orpheus User Group, trainings, 1:1 TA. These could be built upon).
	Developmental: In the future, develop measures for access to communicable disease data by partners and the public.			
Completeness				

REALD, SOGI and risk factor data **Goal:** Increase collection of REALD, SOGI and other risk factor data for communicable diseases, which is needed to identify and address racial and other inequities.	Completeness of REALD, SOGI and housing status data across communicable diseases when a case interview is initiated	Local	Orpheus	We don't have risk factor or demographic data unless an interview is conducted. Don't know what portion of the population is being missed. Would need to include "refused" and partial records. Could possibly measure an increase in attempts at collecting REALD, rather than completeness. Measure could include all communicable diseases that require an interview. Could have a separate measure for STIs. LPHAs need new ways to find people who show up in ED other than phone/letter. Need more of a DIS approach to all communicable diseases. Focus on quality of interviews or outreach to cases. Perhaps start with the people LPHAs do get to talk with and the quality of the interviews and resulting completeness. Refused/partial is an indication of quality and could inform training. This could be expanded to consider community outreach , how many people are or are not being reached.
	#/% of LPHA staff who conduct case interviews and have received training in REALD and SOGI data collection	State/Local	LPHA reporting	Opportunity to highlight what the trainings should look like, and better standardize. How best to support staff in getting complete data during the interviews. Improve quality of interviews. Also need to capture how training is happening. Leadership commitment. (SB: not sure how we would get an LPHA staff denominator)
	Documented data exchange with other state data systems to increase data completeness	State	Orpheus	Potential future statewide database - OEI REALD repository Shorter term improvments may include data exchange for Medicaid One and COVID, or data exchange between Opera and Orpheus.
	Developmental: Completeness of REALD and SOGI data for all communicable diseases when a case interview is indicated.			This would begin to look at how many people/who is not being reached and shifts focus from quality of interview to community outreach.
Workforce				
Communicable disease workforce **Goal:** Have a public health system communicable disease workforce that is sufficient, skilled and representative of communities served.	# of local epidemiologists, disease investigation specialists or positions fulfilling related functions # of LPHAs meeting national benchmarks epidemiology or disease investigation specialist positions # of positions above in permanent positions with benefits Improved/expanded processes for recruitment of sufficient and diverse candidate pools	Local	LPHA reporting	Could also consider counting CD FTE and allow each org to determine which ones make the most sense to include. Look at KSAs rather than job classifications. Question about KSAs… do they meet Oregon intent to focus on equity? Would need to look into this before focusing on nationally published KSAs or competencies. Could also look at unfilled vacancies. Public health modernization evaluation will place focus on workforce. Implement higher pay scales for PH staff. (PH Nurses, DIS). #/% employees being paid at or above a living wage ($15 per hour is not high enough in some areas of the state) Types of positions posted (LD, with or without benefits), how and where positions are posted. Bring attention to the fact that we need more permanent positions. Fiscal staff Positions like DIS employed by OHA but serving counties, especially when they are tno able to hire these positions Process for recruiting diverse candidates. At least initially, process may be more important than outcome Can look at related job classifications/which positions are available (HE2 and DIS). Get DIS in working title,

	# of informaticists or positions fulfilling similar functions	State	PHD reporting	Positions to process public health data, build dashboards, analysis, build data streams, visualization. State function to provide this capacity to LPHAs that don't have it. Caution that terms get used interchangably but may not be interchangable. Looking for staff with wide range of tools
	# state permanent positions providing support to LPHAs to increase local capacity for epidemiology, case investigation and informatics	State	PHD reporting	Concern about setting this as metric due to COVID workforce shifts, LD positions.
	Developmental: # of outreach specialists or related positions that focus on communicable disease prevention and control	Local	LPHA reporting	Specific job classifications and other position types responsible for community outreach. This developmental measure relates to Data Completeness developmental measure