AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

October 4, 2022
9:00-11:00 AM

Join ZoomGov Meeting
https://www.zoomgov.com/j/1608415649?pwd=NUZQNloxYjVyR2VlVml0RHArdnBGUT09

Meeting ID: 160 841 5649
Passcode: 153368
(669) 254 5252

Meeting Objectives:

- Approve August meeting minutes
- Finalize framework, measure tiers and metrics selection criteria
- Discuss measure review process

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

OHA staff: Sara Beaudrault, Kusuma Madamala

Guests: Members of the Conference of Local Health Officials (CLHO) Communicable Disease and Environmental Health Accountability Metrics workgroups

PHAB's Health Equity Policy and Procedure

9:00-9:10 am	**Welcome and introductions** • Approve August minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
9:10-9:50 am	**Framework, measure tiers and metrics selection criteria** • Review proposal for framework and tiers of measures to be included in accountability metrics. • Review changes to metrics selection criteria • Come to agreement on framework, measure tiers and metrics selection criteria	All

9:50-10:20 am	**Measure selection** • Hear from CLHO workgroups on concepts for priority issues and related measures across tiers. • Provide guidance to committees on continuing to develop measure proposals • Discuss opportunities for alignment with HTO indicators • Discuss how the subcommittee would like to review proposed measures	All
10:20-10:30 am	**Subcommittee business** • Identify subcommittee member to provide update at October 13 meeting • Discuss meeting schedule for the remainder of the year • Next meeting scheduled for October 21	All
10:30-10:40 am	**Public comment**	
10:40 am	**Adjourn**	All

PHAB Accountability Metrics
Group agreements

- Stay engaged
- Speak your truth and hear the truth of others
- Expect and accept non-closure
- Experience discomfort
- Name and account for power dynamics
- Move up, move back
- Confidentiality
- Acknowledge intent but center impact: ouch / oops
- Hold grace around the challenges of working in a virtual space
- Remember our interdependence and interconnectedness
- Share responsibility for the success of our work together

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

August 25, 2022
2:00-4:00 pm

Subcommittee members present: Jeanne Savage, Kat Mastrangelo, Sarah Present, Jocelyn Warren

Subcommittee members absent: Cristy Muñoz, Ryan Petteway

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Ann Thomas, Kim Tham, June Bancroft, Zints Beldavs, Corinna Hazard

Guest presenters: Lisa Ferguson, Tyra Jansson, Kathleen Johnson

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Welcome and introductions

April and June meeting minutes were approved.

Sara B. reviewed the group agreements and timeline for deliverables.

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? OHA has envisioned that the criteria will be used to review each proposed measure and determine whether it should be recommended to PHAB.

Based on framework, OHA staff envision that we are talking about two tracks of measures. These are shown on page 20 of the meeting packet. Indicators bring attention to priority issues and may be health outcome measures or measures of social determinants of health that require cross sectoral work. Process measures assess the daily work of governmental public health authorities and their accountability for core work that's necessary for making improvements in indicators.

Sara B. reviewed changes to the metrics selection criteria. She and Kusuma reorganized the selection criteria to align with the framework developed by PHAB.

Jeanne commented that measures must align with the Public Health Modernization Manual. She said that the Manual came out before current discussions about social justice and structural racism. Is the Manual up to date enough to represent current efforts in the health equity space?

Jocelyn replied that the way Oregon adopted the foundational public health services to center health equity, which the national model did not. Oregon was ahead in terms of thinking about it. There are some things that are missing but overall it is pretty great in terms of equity and community partnership. They show up across the whole Manual.

Jeanne asked whether it would be useful to walk through an example. She suggested percentage of home ownership among people of color. Home ownership and generational wealth can lead to significant differences in public health and health outcomes. A process measure could be work in terms of advocacy or something similar. Or is this too big and not something that an LPHA could affect?

Kusuma mentioned an opportunity to align indicators with Healthier Together Oregon, the state health improvement plan.

The group proceeded to walk through an indicator example, using "home ownership among people of color".

Sarah P. said that her first question is about governmental public health's sphere of control and whether it is actionable by public health. Public health can raise awareness. She would like additional discussion on the criteria that a measure is actionable. Do we mean actionable by state and local public health?

Ann said that in the state communicable disease measure, they proposed measures such as reducing rates of certain diseases of people experiencing houselessness, including hepatitis A or foodborne illnesses. The interventions might include vaccination or efforts to improve sanitation. She noted racial disparities in certain communicable diseases. This is another area to think about interventions to improve community engagement and cultural competence.

Sarah P. said the ideas of what we can do will continue to be challenges. If we take this as an example, she sees sphere of control addressed on the second page of selection criteria and recommends including this for both indicators and process measures.

Jeanne suggested stratifying the levels at which measures are impactful. There needs to be change at the level within sphere of control, but also at the policy level. PHAB has the ability to impact policy through OHPB. She wants to continue to work on disease outcomes, but it is also a bit far down the line and it doesn't encompass everything she would like to work on through these measures. She recommended a legislative level of impact, and an on the ground level of impact. The root causes of disease are issues like lack of housing and substance use, and we need to focus measures on these root causes.

Kusuma asked whether the criteria on data, policy and community partnerships gets at levels of impact. The process measures are more on the ground and within the control of state and local public health authorities.

Jeanne said this sounds right, for the example of home ownership. There could be a policy level, community level for on the ground work, and data interventions. Legislative could include policy to help with subsidized loans or supports to people at risk of losing housing or help people purchase homes. Could we partner with communities to support home ownership and employment. She's not sure what a data intervention might look like.

Kat asked whether there are ways that public health works with other state level agencies, like ODOT, that transportation is supportive of communities and health.

Jocelyn said there are other agencies who more directly are involved in housing. But there are not other agencies that are doing communicable disease control, There is an imperative to focus on public health's core work. She noted that policy and community priorities are public health work, and in her county's CHIP, housing is the number one priority. Public health coordinates with community partners and other agencies doing the work. But she's not sure that housing itself should be the measure, rather than the policy and partnership work of public health.

Sara B moved to the group to the next criteria for community leadership and community-led metrics. How would the subcommittee look at this for a measure of home ownership?

Sarah P. said she has assumptions about community priorities for home ownership, and she would want some background information on where community engagement has occurred.

Sara B agreed and said we could look to CHIP and SHIP engagement or engagement and feedback from other agencies or sectors.

Kathleen noted that when thinking about housing, PHAB could also think about integrating concepts like climate ready or healthy homes, especially as it relates to affordable housing.

Jeanne noted that the framework and selection criteria is allowing for a great discussion with the appropriate points for determining whether something is a good indicator and how to bring the process measures into line with public health sphere of control. It seems like they get to the heart of the right discussion.

Sara B. reviewed the next rows of the metrics selection criteria.

Jeanne asked what is meant by "public health has control over the measure". Is this ability to affect change?

Sara B. suggested as a starting place that the measure reflects the work of state and local public health and is within the scope of public health.

Kusuma noted alignment with public health accreditation standards.

Lisa said that public health sometimes has federal requirements over which state and local public health does not have control.

Sarah P. returned to the housing example. Public health can have influence and provide information. But local public health does this through partnerships; it is not within local public health's control.

Jeanne noted that PHAB does have an ability to influence at a legislative level, and it makes more sense that a public health authority may not.

Sarah P. noted that these measures relate to public health funding. She can see measures for making data available or increasing education, but not having local public health accountable for percentage of home ownership among people of color.

Sara B reviewed the last row of the metrics selection criteria, for alignment with other state and national initiatives.

Kusuma asked whether this row is for both indicators and process measures.

Sara B said she thinks it is for both. Alignment with CHIP and SHIP priorities relates to indicators, but alignment with public health accreditation standards is more closely tied to process measures.

To wrap up, Sara B noted that the criteria seems to generate the discussion that subcommittee members should have when selecting measures. She and Kusuma will take the idea for levels of indicators and think about what that could look like in the selection criteria.

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

Sara B. introduced Lisa Ferguson and Tyra Jansson from the Conference of Local Health Officials Communicable Disease committee, and Kathleen Johnson from the Conference of Local Health Officials Environmental Health committee. Each committee has established accountability metrics workgroups that are working with OHA to develop state and local process measures to bring to this subcommittee for consideration. These workgroups have focused on process measures related to public health data, community partnerships and policy.

Tyra began by talking about communicable disease. She noted the collaboration between OHA and LPHAs to develop process measure proposals, and that the workgroup has also focused on funding.

Lisa said that she appreciates the frame for measures and has felt that the framework has allowed for digging deeper, beyond measures that count interventions to the things that will make a longer-term difference.

Lisa reviewed the first section of the handout on access and utilization of communicable disease data to ensure that LPHAs have the data needed to understand what's happening in their county, trends and what interventions or policy changes are needed. The workgroup has talked about process measures related to dashboards. These dashboards exist through the state communicable disease system called Orpheus. A measure could include the number of dashboards available, number of categories of information included on dashboards, and number with data that can be downloaded for further analysis. Lisa noted there is so much variety in capacity for data analysis among LPHAs. LPHAs with less capacity may rely on OHA to have the same level of access to local data. OHA technical support needs to be available for these LPHAs. LPHA use of communicable disease could be another process measure. The focus needs to be on ensuring that LPHAs have access to data, so that in the future LPHAs can make data available to community partners.

Kusuma noted challenges in access to data that have come up in discussions.

Lisa gave an example of hMPXV. There is state level data, but an LPHA needs to be able to identify differences in their community from statewide trends, to be able to work with partners to do additional outreach to communities being impacted.

Tyra noted capacity to communicate about communicable disease data locally, in addition to outreach. In some areas of the state, OHA is not a trusted entity, but the LPHA is.

Jocelyn said that these measures are things we hold ourselves accountable to. It requires access and this is a necessary condition. But the thing they're doing with communicable disease data is communication and outreach. Is access the right word for the goal? The goal is sharing meaningful data, rather than access itself.

Lisa noted that this can be incorporated to include what the end result is.

Lisa reviewed the section for data completeness, which includes REALD, SOGI and risk factor data and shared contextual information from the workgroup discussions.

Jeanne asked at what age is SOGI data collection started? Presenters didn't know this information.

Jeanne clarified that the purpose is not to evaluating measures today.

Sara B. agreed. Today's discussion is to get information about the direction that the workgroups are heading and to provide feedback to the CLHO workgroups.

Jocelyn said that data completeness measures for data exchange and a REALD repository will help to alleviate burden on individuals who will potentially be asked REALD and SOGI questions repeatedly.

Jeanne agreed and said in her system they have to document that a person is asked these questions once per year. But the Medicaid systems don't talk to the public health system. There is a need for people asking these questions to understand the purpose of collecting this information. Jeanne said that in her community, there are questions about whether it is appropriate to ask some of these questions of younger ages. Maybe there should be a broader campaign around SOGI and why this information is collected.

Sara B. said that a lot of the oversight of REALD and SOGI sits within the OHA Equity and Inclusion Division, and they are interested in working with PHAB on these measures, especially as it relates to a future REALD repository. The repository will provide more complete data through data exchange, but it will always need to be completed with case interviews. Sara noted other risk factor information that is collected through case interviews, like housing status.

Lisa said that housing status is a good example of the nuance of case interviews. People who are unhoused are often harder to reach through case interviews, so public health does not get a complete picture of housing status.

Tyra reviewed the workforce section.

Jocelyn asked whether we have a definition of what we're trying to accomplish with accountability metrics. She thinks accountability is about the work we are doing, like case interviews, investigations, innovative approaches and work tied to the foundational capabilities. Workforce questions seem to get at whether the system is being adequately resourced. These seem like different questions. It is the doing something, not having something, that is captured in process measures.

Sarah P. said that addressing capacity is part of becoming a modern public health system. She said there is a question about whether to create a metric that we know we can't meet in order to support funding requests, or to create a metric that we can meet to demonstrate successes that can be used in funding requests. There is something to looking at what we know we cannot do if we're not at capacity to do it.

Kusuma said there has been a lot of discussion about whether workforce falls in accountability metrics or the evaluation. When she thinks about the public health system moving forward and infrastructure, nationally there is an understanding of the types of positions that are thinking of leaving public health, which will result in even bigger gaps in capacity. There is a lot of funding coming in for public health workforce through the CDC Public Health Infrastructure grant.

Kat said her clinic struggles to recruit staff who can afford housing. People who come in are quickly overwhelmed by demand, and capacity remains an issue. It goes back to what we have control over or can influence. Can we influence higher ed to encourage people to pursue careers in health care, mental health and public health?

Jeanne said there is a huge push among CCOs to develop the behavioral health workforce, and federal, state and CCO funding for behavioral health workforce. In terms of how a community member might perceive accountability metrics for workforce, Jeanne wondered whether a community member might feel that workforce measures don't concern them. From a community perspective, maintaining a workforce might be considered part of the work that needs to happen within an organization to support work with the community, but not part of accountability metrics. She sees a disconnect and would lean to not include them as measures.

Tyra noted that there are already review metrics for how quickly LPHAs respond to diseases within the regulated timeframes and looking at completeness of other data in triennial reviews. The workgroup avoided these areas since they are already being reflected elsewhere.

Lisa said that we've had measures in the past of number of interviews done, for example, and she feels that we're beyond this in communicable disease metrics. We should look at work we're doing with the community or data metrics. Analyzing our data is the key to an LPHA being able to say, here's what's happening in our community, here's policy changes that are needed.

Kat said that in COVID, LPHAs provided the backbone and organization for the whole community to come together to address issues. There is expertise in being able to do incident command that belongs with the LPHA. Because of those relationships and interactions, her organization was better prepared for a recent Monkeypox exposure, which resulted in a person being vaccinated within 20 minutes and an outbreak potentially being halted. This is a big component for safety net clinics, and there's great value in an LPHA providing the fabric in a community.

Sara B. summarized feedback provided, including the purpose of including workforce-related measures, needing to think about the "doing" in these process measures to make sure we are reflecting work that communities that can expect.

Tyra asked whether there are things members expected to see in these process measures.

Jocelyn said, with expanded capacity for foundational capabilities, how has that expansion changed or enhanced the way we deliver communicable disease services in the community? She gave an example of hiring bilingual, bicultural disease investigation specialists, and the difference it makes in the community in terms of case investigation, contact tracing, doing better investigations, and developing stronger relationships with community partners. Maybe there is something around how integrated communicable disease is within a community or being responsive to what is needed by the community. What is new or different because of modernization?

Sarah P. said the interaction between teams within a public health agency. For example, COVID resulted in communicable disease investigators and immunization staff working together. There is more internal coordination.

Kathleen provided an update on the early work of the CLHO environmental health accountability metrics workgroup. This group has met twice.

- State and local modernization funding for climate and health is new, and this is largely new work for LPHAs and a shift from regulatory environmental health work. This is, in some sense, uncharted territory.
- Initial conversations have followed the path set by the CLHO communicable disease group. The CLHO environmental health group has discussed measures for data use, accessibility and reporting. How could we develop a process measure for using data to understand the vulnerability of communities around climate risks, risks that are currently present or will be present, and then related outcomes.
- Climate and health work is naturally cross sectoral and collaborative. How could we capture in a process measure the collaborations that will happen with CBOs, other agencies, health care? Are we measuring in meetings, work products, programming that's shared?
- There is also a policy piece. Moving accountability metrics from minutiae to policy, systems and environment approaches that are needed for climate and health, and a health in all policies approach. How are we showing up in policy and decision-making spaces to elevate climate and health considerations within whatever is being developed? There are a lot of conversations happening across communities and a lot of opportunities for public health to show up and make an impact in terms of climate adaptation.
- Need to create metrics for a system in which most LPHAs are at a starting place but some LPHAs have done a great deal of climate-related work. Need to create metrics that are achievable for all.

Jeanne expressed appreciation for the flexible, mobile, adjusting, responding and preventing approach Kathleen described. We need to get to a place of the overarching goal of how we are showing up.

Subcommittee business

- Jeanne was volunteered to provide the subcommittee update at the September 8 PHAB meeting.
- Next subcommittee meeting scheduled for September 15 from 2:00-4:00

Public comment

No public comment was provided.

Meeting was adjourned

Framework, measure tiers and metrics selection criteria

Come to subcommittee agreement

- Do the measure tiers accurately reflect PHAB discussions? Do they demonstrate a progression from public health capacity to policy influencing structural determinants of health?
- Do the metrics selection criteria accurately reflect PHAB discussions?
- What changes are needed so that these can be finalized?

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**.

Public health accountability metrics

Public health process measures
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

Indicators
Communicable disease control and environmental health

- Bring attention to priority issues that affect health and wellbeing.
- Provide context 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 Measure tiers			
Public health process measures Public health data, partnerships and policy		Indicators	Structural determinants of health
LPHA workforce and capacity *Do public health authorities have the capacity and expertise needed to address priority health issues?*	Foundational capabilities *Are public health authorities better able to provide services within their community?*	Health outcomes and reduced differences among populations *What are priority health issues that are of concern to communities throughout Oregon?*	Policy landscape and interventions *How are policies contributing to or eliminating root causes of health inequities?*
Level of accountability: OHA and LPHAs	Level of accountability: OHA and LPHAs	Level of accountability: Public health system	Level of accountability: PHAB, public health system, other sectors and state/local elected officials

Public health accountability metrics Environmental Health			
Public health process measures Public health data, partnerships and policy		Indicators	Structural determinants of health
LPHA workforce and capacity	Foundational capabilities	Health outcomes and reduced differences among populations	Policy landscape and interventions
# LPHA staff trained in using climate and health-related data	# Collaborations with other agencies for data and monitoring efforts # LPHAs that have a climate adaptation plan, or an integrated plan across disciplines # LPHAs working with partners to identify community exposures # policy papers or policy recommendations	# local jurisdictional plans that include heating and cooling interventions at individual and community level Heat-related emergency department and urgent care visits Extreme weather-related hospitalizations/deaths Urban heat mapping and tree canopies Mental health impacts of climate change Holistic measures of cumulative exposures	Policy mapping Policy supports for renters, MSFW and others for accessing and using cooling options in homes Climate ready homes and affordable housing MSFW protections Air quality ordinances

Public health accountability metrics Communicable disease control			
Public health process measures Public health data, partnerships and policy		Indicators	Structural determinants of health
LPHA workforce and capacity	Foundational capabilities	Health outcomes and reduced differences among populations	Policy landscape and interventions
# of state-level dashboards that include housing status. # of state-level data sets available to LPHAs that include housing status Completeness of housing status data across communicable diseases when a case interview is initiated.	Partnerships in place to provide Hep A and B vaccines to people who are homeless. # LPHAs demonstrating use of housing status and CD data for decision-making Culturally and linguistically responsive standards of care	County levels of rates of hepatitis A and B occurring in people who are homeless. Rates of vaccine preventable diseases among seasonal workers. Syphilis and congenital syphilis Rates of communicable disease within injection drug users Ability to respond to novel and seasonal pathogens	Policy mapping Access to culturally appropriate health care Homeownership among people of color Housing cost burden among renters

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.

Commented [BS1]: By both state and local health?

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 (Process measures and indicators)**	Measure aligns with State Health Indicators or priorities in community health improvement plans and the state health improvement plan, *Healthier Together Oregon*

Commented [BS2]: Sphere of control needs to be present for both process measures and indicators.

Does sphere of control include influence?

PHAB may have levers that state and local public health authorities may not.

	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.

Measure selection for communicable disease control and environmental health

- What direction can subcommittee members provide to CLHO workgroups?
- Is there an opportunity to align with Healthier Together Oregon indicators?
- What process would the subcommittee like to use to review proposed measures?

Foundational program/capability	HTO strategy	Key indicator	Short term measure
Communicable Disease	Improve access to sexual and reproductive health services.	Childhood Immunizations	
Environmental Health	• Provide safe, accessible and high-quality community gathering places, such as parks and community buildings. • Build climate resilience among priority populations. • Center BIPOC-AI/AN communities in decision making about land use planning and zoning in an effort to create safer, more accessible, affordable, and healthy neighborhoods. • Increase affordable housing that is co-located with active transportation options. • Build a resilient food system that provides access to healthy, affordable and culturally appropriate food for all communities.		• % of population with a park within a 10-minute walk from their home • # of Community Based Organizations that have meaningfully partnered with PHD, tribal and local public health authorities to build community resilience • % of full-voting representation of BIPOC-AI/AN on state rule making and grants advisory committees • % of people who use active transportation to get to work • Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).