Minutes

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

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

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

Subcommittee members absent: Jocelyn Warren

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Elliott Moon, Ann Thomas, Corinna Hazard

Guest presenters: Tyra Jansson, Nadege Dubuisson, Kathleen Rees

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Welcome and introductions

August meeting minutes were approved with three approvals and two abstentions.

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

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

Sara B. described updates to the framework and tiers based on the last PHAB discussion.

- The framework still includes process measures for state and local public health authorities, and these are broken into measures of workforce and capacity, and measures of new or changed work resulting from improvements in foundational capabilities. The level of accountability is state and local public health authorities.
- Indicators are still included, looking at priority health issues of concern. The level of accountability is the public health system as a whole.
- Measures of structural determinants look at the policy landscape beyond public health policy to influence policies that contribute to or eliminate health inequities. The level of accountability could include PHAB, the public health system, other sectors, and elected officials.

Sarah P. said she likes the framework and that it separates out the do-able levels and where the accountability should be.

Kusuma asked whether the concept of tiers includes rank.

Jeanne said she thinks the tiers capture the essence of the most recent PHAB discussion and brings together public health boots-on-the-ground with systemic issues of public health with indicators, and structural determinants with the political and policy level. Jeanne said she does not see tiers as being ranked; rather it is matrixed where it all needs to be done for change to occur.

Ryan agreed that tiers don't need to be ranked. He asked whether indicators are intended to only be outcomes, and are foundational capabilities intended to only reflect services. In order for these practices to change, we need to move away from this older model of public health being about providing services. And if indicators are only about outcomes and not process, there is no way we can change structural determinants. We can track processes but outcomes will take a long time to show change.

Ryan (chat): Re: foundational capabilities and necessity of being explicit about what the status quo entails and requires in terms of antiracism:
https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.306137

Sarah P. said that workforce and capacity and foundational capabilities are two parts of public health modernization. She read services as being public health services, which includes data, evaluation and work that is not direct care. She suggested using a word other than services.

Sara B. said she doesn't think indicators need to be health outcomes only. But it may be necessary to communicate what our priorities are. We need to communicate the "why" and what are the issues that communities are experiencing that we hope to improve by changing how we hold ourselves accountable.

Sara B. said that the CLHO communicable disease workgroup proposed an indicator for being prepared to address emerging and seasonal pathogens. This could be an example of an indicator that is more process-focused and not tied to a specific disease.

Sarah P. said that among local health officers, there is a sense that outcomes are important to keep in measures so there is clear evaluation of change over time and to communicate to legislators and the public. Outcomes are important to people. Being prepared is important, but we want to show that we were prepared, and we potentially see this in outcomes. There is a lot of nuance in processes at the local level. Public health struggles to communicate what we actually do. At the last health officer discussion, there was concern about changing the accountability metrics at all.

Ryan said that people are used to seeing an orientation around outcomes, but we can't point to anything that state or local public health does that is causally related to changes in outcomes. The idea of demonstrating need and burden is used to receive funding, and then it becomes the thing that gets tracked and prioritized. But the thing that changes is people coming in and distribution of

risk factors. We need to prioritize changes to environments so exposures are modified. How do we frame the metrics to show we made a change to policy or environment that is empirically shown to improve health in the literature, understanding it will take five or ten or more years to show change? Putting outcomes in the design of metrics is faulty logic, and no one will be able to show a change that is causally related to something the LPHA did. The best way to focus on health equity and go upstream is to focus on process measures.

Jeanne said this context was very helpful, and she agreed that metrics have been used to show justification for the public health system.

Kusuma said that these systems are embedded in how things are set up federally, such as the Healthy People framework.

Cristy shared a paper from the Prevention Institute that covers, what works to improve health equity, including social determinants. She said it has been interesting to try to understand the structural drivers and how it affects PHAB's potential recommendations for metrics. The document includes indicators in line with what Ryan shared, including holistic measures that support working across sectors. Full report: https://www.preventioninstitute.org/publications/measuring-what-works-achieve-health-equity-metrics-determinants-health

Jeanne said the diagram on page four was very helpful because it shows the drivers, behaviors and exposures, and then the affect on the medical condition. It shows what Ryan is suggesting, the change is made upstream to affect downstream outcomes. There is room for this to work on all levels. This change requires maintenance of communicable disease work and emphasizing and expanding the work on structural drivers.

Ryan agreed. He suggested that this may be in the best interest of state and local public health departments. Without this, they are being asked to improve outcomes without the social, political and environmental context and changes.

Tyra said that local communicable disease programs are service-based and don't have the resources to provide the necessary services like reaching out to every syphilis case, ensuring partners are treated. We would love to be able to work upstream, but it is outside of the scope of what communicable disease programs are able to do. Sometimes health policy sits in a different area of a health department, so it might make more sense to work with teams responsible for policy.

Ann appreciated the comments made today. She said there are some things that are fundamentally different about communicable disease programs. For example, tobacco prevention programs focus on prevention and policy, but they don't reach every person. Communicable disease programs provide direct services at the same time they are collecting data and making sure that contacts are appropriately monitored and treated. Communicable disease programs are preventing additional disease through these actions. Ann said there are gaps in the ability to reach everyone, especially among certain populations, such as people who are homeless. She would like to see communicable disease programs held responsible for reaching more people and for doing more community engagement, as we did during the pandemic.

Sarah P. said she thinks about the foundational programs and capabilities, and how we do programmatic work. We are moving toward upstream, policy-focused foundational capabilities, at the detriment of program work. LPHAs struggle to meet statutory needs when the funding comes in for upstream, policy work. There is a disconnect with focusing on policy when the basic workforce and capacity for statutorily required programmatic work isn't there.

Tyra agreed with what Sarah P shared. With upstream work, the work needs to be data-driven. Assessment and epidemiology is a foundational capability that many LPHAs don't have sufficient resources for.

Ryan asked what percentage of LPHA budgets are tied to communicable disease programs.

Tyra responded that it varies by county and described some of the funding mechanisms.

Ryan said that funding is an accountability question. It is a recurring discussion that LPHAs are understaffed and under-resourced. If the budgets aren't adequate, there needs to be a metric that shows this, for example LPHA reports that show percentage of budgets for infectious disease programs compared with local funding for policing. There is power and money being allocated. We won't change the outcomes without changing the political, economic and environmental context. Communicable disease programs are nuanced but if we address structural aspects like housing we are more able to intervene and control infectious disease. This tier structure feels inevitable and necessary. We need to show we're doing the things we need to do with limited resources, and we need to ask questions about why resources are perpetually limited.

Sara B. noted the OHA webpage for state population health indicators which includes YPLL, leading causes of death and other indicators.

Kat asked, is there a corresponding housing accountability metrics workgroup? So these conversations are happening here and not with agencies that have funding for housing?

Ann noted the new Medicaid waiver and wondered whether there is an opportunity for alignment and for public health to support what is measured.

Jeanne said she believes the work of this subcommittee should be informing how that benefit works in every CCO. CCO leaders need to have the same discussion with the same ideas and consistency across issues for where funds go. Jeanne said, regarding collection of more data, at some level we don't need more data. She can tell by looking at geography, factors of poverty, food deserts, she has the data that show the conditions in which poor health outcomes are occurring. We need to focus on movement toward changes and not so much on collection of data.

Cristy said this resonates. From a CBO perspective, data and research are important. But how can metrics help us increase relationships and community engagement as a level of accountability. She is at other tables with other sectors for housing. With large buckets of money coming in she is not seeing that sectors are talking to each other, and she believes public health equity should be a focal

point for all bureaus. Governmental entities don't have to do it alone. CBOs are community engagement experts; they know and reflect the community. Instead of trying to increase community engagement capacities within governmental entities, instead they could invest more in local organizations that already have those relationships with community. Cristy agreed with less push for data and more push for community engagement and relationships across sectors and with community partners.

Tyra agreed with Cristy's comments and said that during COVID with better data, LPHAs knew where to focus outreach and which partners to work with to reach those communities.

Sarah P. agreed that there is a lot of data. COVID has also shown us that we also need to work on engagement between public health communicable disease programs and health care delivery systems including insurers, health care and behavioral health providers. The idea of modernization was to put some direct services back in the health care system, but the coordination of services is a barrier to doing public health work and leaves public health scrambling to fill gaps. We need to figure out what the gaps are and how to address them.

Ryan wrote in chat that data is always a part of discourses of power and politics in public health, but only as *potential* tools/instruments of persuasion--always reliant upon action and advocacy to render real. And that's where the accountability part comes in.

Ann agreed and would support measures to improve interview rates. We're not reaching people from populations of concern, like communities of color, people who are houseless or using drugs, people whose primary language is other than English. When we reach people through interviews, we are able to connect people to care and resources. It's not necessarily more data, but reaching more people and making sure we're using data.

Kat raised the CCO quality improvement measure around ER utilization for clients with SPMI. In her community the initial discussion was about who was responsible and how to impact the measure. But they ended up realizing that it required all groups working together to make a difference. Was that a successful CCO measure and did we see the needle move?

Jeanne did not know the answer to that but can look into it.

Cristy asked in chat if LPHAs have forums for community engagement in geographically diverse locations to engage with culturally diverse communities.

Sara B. said the mechanisms for community input are different in different counties, but it is a part of accreditation and all aspects of public health modernization funding. Sara also noted that there is a need to bring a Medicaid 1115 waiver discussion to PHAB. Sara also noted PHAB's responsibilities toward the State Health Improvement Plan, Healthier Together Oregon and its five priorities. There are connections between these accountability metrics and other areas that PHAB has prioritized.

Sara B. recommended changing the framework with measure tiers to take the indicators out of the middle of the graphic. It should be on the lefthand side if indicators are used for assessing priorities,

or on the right-hand side if indicators are used to reflect long-term changes in outcomes. It sounds like there is agreement that the framework should describe work at a spectrum of levels, from programmatic work reflected in process measures to systemic policy work reflected in structural determinants.

Ryan said this is a useful place to start in terms of accountability and equity. Some of the things we're looking at are answerable with the data we have. One issue with equity is when priorities are determined before we look at the data or get community input. Ryan suggested the group workshop one outcome across measure types.

Sara B. proposed the group try this with congenital syphilis.

Ann provided an overview of congenital syphilis. Ten years ago we had 0-1 cases per year, and now it is up to 15-20. While sexually transmitted, much of the increase is driven by increased drug use. There are a lot of behavioral risk factors and social determinants involved.

Sarah P. said that 20 years ago we thought that syphilis was nearly gone in the U.S. but there has been a huge resurgence with behavior changes around sexual activity. The rate of cases among females of child-bearing age, lack of access to reproductive health services, lack of access to appropriate and timely prenatal care, increased use of methamphetamines that correlates with increased sexual behavior risk taking, houselessness and exchanging sex for safety needs like housing and money.

Sara B. noted that both Ann and Sarah talked about drug use, access to health care and behavioral health care, access to prenatal care. There are connections to structural determinants and factors like community wellbeing. If there were an indicator for congenital syphilis, could we demonstrate the core public health work for case investigation, contact tracing, partner treatment, epi trends and use of data in decisions making, community partnerships, etc. Is there a possibility for process measures that would resonate with the subcommittee?

Jeanne said she would defer to public health partners doing the work. They need to feel like they have the ability to make an impact now or potentially in the future. Should the subcommittee be attempting to advance the work with these accountability measures?

Sara B. said it is the role of the CLHO workgroups to come up with what the process measures are or could be, and to bring to the subcommittee for discussion and a recommendation. Sara said these measures should, to some degree, influence the work that happens locally and at the state level, but they also reflect the core work that we want to see in every county in the state. If LPHAs don't have the capacity then we would want to see them building the capacity.

Ryan wondered if it is such a small number, is there enough data to make a determination about a pattern to reveal something about structural processes. If there is a pattern of risks, then we're able to start unpacking the structural things, and they will probably be the same things as for many other outcomes. Hence the significance of focusing on structural determinants.

Sarah P. said when we think about what we do at the local level for congenital syphilis, we have increased funding for case management and incentives for pregnant women. The incentives are not large enough for these individuals to overcome the barriers to getting appropriate care, including drug use and housing. The larger public health system needs to have resources to for the case manager to be able to move the needle.

Ann described the Oregon Nurture program. Twenty-four counties have Prime+ programs with peers with lived experience.

Sarah P. said these programs are critical on the individual level. Ideally, we are also trying to increase screening and treatment at a population so we can prevent disease in general and in people who are pregnant. Public health is struggling to get information out and screening rates when indicated are still low. This is another systems-level place we could improve upon. The LPHA can only do so much in ensuring that providers are screening and have appropriate treatments available.

Tyra said even just having testing and treatment available is a challenge. This is a place where there are disparities among counties. Some provide the services whereas others work through partnerships.

Jeanne said it was helpful to walk through this process to look at a condition at different levels of where work is done and can be held accountable. Will the subcommittee come up with the top things we're working on and come up with measures across them?

Sara B. said yes.

Jeanne asked if other members are on board and whether this will need to go to the Oregon Health Policy Board (OHPB) for approval.

Sara B. said OHPB does not need to approve PHAB metrics, but they are very interested in PHAB's metrics work and how PHAB may use its levers

Jeanne said there is appetite at all levels to have this format, and this could be modeled for metrics happening within the CCO metrics. This is parallel work. Jeanne recommended taking this to the CCO metrics committee and encourage them to use this to hold other groups accountable at the same levels. Jeanne asked whether the next phase is hashing out the priority areas and measures.

Sara B. quickly reviewed the measure areas drafted by the CLHO environmental health work group, including focus on heat-related measures.

Ryan said this is a good example of an outcome, but the reason people seek urgent care vary by reasons public health has no control over. There are interpersonal and community supports to mediate heat impacts. To have a sense of accountability, it would need to work back up to what the state health department and legislators are doing. What's missing is what the measure would look like at the structural determinant level.

Sara B. asked whether subcommittee members are on board with the general direction for measure tiers or if there are concerns. Jeanne noted that the framework and ideas will need to be socialized for how these changes can affect public health. Sarah P. said these are the conversations and movement that should be happening in PHAB. Sarah P. said it will be important to keep an understanding of what local public health can do and be accountable for.

Kat, Ryan and Cristy voiced support.

Sara B. asked how subcommittee members want to move forward with identifying measures. Sara proposed that the CLHO workgroups could develop proposals for priority issues and have some conversations with the subcommittee about process measures and structural determinants.

Sarah P. said the CLHO workgroups have already brought things to the subcommittee, and this could be a starting place within the context provided by PHAB.

Sara B. agreed and said the committees are well-prepared to bring proposals to the subcommittee.

Ryan said he doesn't know the process for CLHO workgroups to determine priorities. This work is not separate from other commitments to equity, antiracism and social justice. Whatever the outcomes or priorities, they need to be arrived at through a process that considers equity, antiracism and social justice.

Subcommittee business

- Jeanne volunteered to provide the subcommittee update at the October 21 PHAB meeting.
- Next subcommittee meeting scheduled for October 21 from 12:00-2:00. Most, but not all, members are available to attend.

Public comment

Carissa Bishop with Access Care Anywhere. She brought attention to her comments in the chat. She encourages use of the social ecological model in terms of identifying levers. She sees an opportunity for alignment with CCO metrics and encourages PHAB to find ways to align with other committees and boards.

Carissa provided the following links.
https://pubmed.ncbi.nlm.nih.gov/26082170/
https://www.cdc.gov/nccdphp/dnpao/health-equity/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnccdphp%2Fdnpao%2Fstate-local-programs%2Fhealth-equity%2Fframing-the-issue.html
https://www.frontiersin.org/articles/10.3389/fpubh.2020.00131/full

Meeting was adjourned