AGENDA

PUBLIC HEALTH ADVISORY BOARD

December 14, 2023, 3:00-5:30 pm

Join ZoomGov Meeting
https://www.zoomgov.com/j/1614044266?pwd=ekpYekxaMm92SHN0dngzTW9ZeldsUT09

Meeting ID: 161 404 4266
Passcode: 938425
One tap mobile
+16692545252,,1614044266#

Meeting objectives:

- Approve November meeting minutes
- Approve Health Equity Policy and Procedure
- Approve process measures for public health accountability metrics
- Discuss Board accomplishments in 2023 and work plan priorities for 2024

3:00-3:20 pm	**Welcome, board updates, shared agreements, agenda review** • Welcome and board member introductions • Share group agreements and the Health Equity Review Policy and Procedure • Member transitions • Member recruitment and onboarding • New PHAB workgroups • OHA Director • Quorum rules • ACTION: Approve November meeting minutes	Veronica Irvin, PHAB Chair
3:20-3:35 pm	**Health Equity Policy and Procedure**	TBD, Workgroup member

	• Review updates proposed by the OHPB Health Equity Committee and PHAB Workgroup • ACTION: Approve Health Equity Policy and Procedure	
3:35-4:55 pm (Break from 4:00-4:10)	**Public health accountability metrics** • Review recommended process measures and feedback provided by local public health officials • ACTION: Approve state and local public health process measures	Sara Beaudrault, Tim Menza, Rex Larsen, Julie Sifuentes, OHA
4:30-4:50 pm	**2024 work plan priorities** • Share reflections on PHAB's accomplishments in 2023 • Discuss PHAB's priorities for its 2024 work plan	Veronica Irvin, PHAB Chair
4:50-5:00 pm	**Public comment**	Veronica Irvin, PHAB Chair
5:00 pm	**Next meeting agenda items and adjourn** • Meet new members • 2024 work plan review	Veronica Irvin, PHAB Chair

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters.
- Written materials in other languages.
- Braille.
- Large print.
- Audio and other formats.

If you need help or have questions, please contact Sara Beaudrault: at 971-645-5766, 711 TTY, or publichealth.policy@odhsoha.oregon.gov at least 48 hours before the meeting.

PHAB Public Health Modernization Funding Workgroup Group agreements

- **Learn from previous experiences and focus on moving forward**
- **Slow down to support full participation by all group members**
- 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

Oregon Health Authority

Public Health Advisory Board meeting minutes
Nov 9th, 2023, 3:00-5:30 pm

Attendance
Board members present: Bob Dannenhoffer, Veronica Irvin, Cara Biddlecom, Dean Sidelinger, Jocelyn Warren, Marie Boman-Davis, Meghan Chancey, Sarah Present, Jackie Leung
Board members excused:

OHA Staff for PHAB: Tamby Moore, Sara Beaudrault, Victoria Demchak, Rose Harding, Eugene Pak, Katelyn Niel, Nandini Deo, Nettie Tiso.

Welcome, board updates, shared agreements, and agenda review

- PHAB members, subcommittee and workgroup members and staff introduced themselves.

- Cara Biddlecom gave updates about the OHA opioid overdose and polysubstance use listening sessions.

- Cara also announced the appointment of Dr. Sejal Hathi as the new Director of the Oregon Health Authority.

- Bob Dannenhoffer asked whether there were any updates on the Public Health Director position.

- Cara answered by saying that there are plans to start the recruitment process for the Public Health Director position soon.

- Sara Beaudrault gave updates about the new members of the Oregon Health Policy Board. The Oregon Health Policy appointed two new members, Dr. Rosemarie Hemmings and Dr. Tony Germann.

- It was also noted that the Oregon Health Policy Board is currently recruiting for 2 new positions.

- Sara B. gave additional updates about the required training for board members. The two trainings required to complete are trainings about information security and harassment and discrimination.

Accountability Metrics Subcommittee updates

Presented by Sarah Present

- The Accountability Metrics Subcommittee met with the Strategic Data Plan workgroup and discussed ways that the Strategic Data Plan can will be able to inform accountability metrics through new data collection.

- It was noted that there has been a high involvement of LPHAs recommending metrics to be considered.

- Finalized indicators are continuing to be worked on and finalized process measures could be presented at the next PHAB meeting.

Health Equity Policies and Procedures updates

Presented by Veronica Irvin

- A recommendation from the Oregon Health Policy Board's Health Equity Committee was made to the draft of PHAB's Health Equity Policies and Procedures, this update being that the policies and procedures include datapoints that demonstrate the impact of systemic racism on health outcomes.

- Due to the work encompassing this recommendation, the vote on the updated PHAB's Health Equity Policies and Procedures will not occur until the next PHAB meeting in December.

Public Health Modernization Funding Workgroup updates
Presented by Cara Biddlecom

- Cara B. announced that all tasks and deliverables of the Public Health Modernization Funding Workgroup have been finalized.

- Topic 1 - Between May and August 2023, PHAB public health modernization funding workgroup members gained a baseline understanding of the current CBO Health Equity grant Program. Questions and responses were compiled and shared with all workgroup members and posted publicly.

- Topic 2 - On August 18, The PHAB Workgroup agreed to the following approaches ensure equitable distribution of public health modernization funds for CBOs through the new 2023-2025 request for Grant Applications.

    - Use LPHA public health modernization funding formula as a guide to inform equitable distribution of CBO regional and county funding.

    - Suggest a minimum biennial base funding level for CBOs so that CBOs can build staffing and infrastructure. Also establish a cap on CBO award amounts.

- Expand the list of underserved priority counties for the 2023 CBO RFGA considering both number of CBOs operating in the county and per capita investments. Ensure CBOs are funded to provide services in every county, excluding statewide CBOs.

- Begin with prioritizing CBOs that are serving locally for selection, based on the definition of local included in the RFGA. This does not preclude funding for regional or statewide CBOs overall.

- Topic 3 – On Oct 16, the workgroup agreed to the following statewide strategies to improve coordination between CBOs, LPHAs and OHA.

  - Convene a first meeting with newly funded Public Health Equity CBOs, the LPHA and OHA. From there, work to determine the most appropriate ongoing collaboration spaces for those partners, based on the work (may be an existing meeting or something new; may include breakouts for program specific coordination). Encourage periodic in-person meetings.

  - Offer memoranda of understanding (MOUs) as a tool to align CBO and LPHA work, but not require MOUs.

  - OHA staff will align with CBO and LPHA progress reporting as it makes sense to do so, and in alignment with CBO and LPHA work plan templates.

  - OHA will offer training and technical assistance opportunities for CBO, LPHA and OHA staff.

  - OHA will work with LPHA Administrators to determine if the CBO contact list can continue to be used to share CBO-specific updates.

- Topic 4 - Workgroup agreed to the following methods for LPHA involvement in CBO awardee decision-making.

    - Each CBO grant application will be reviewed by two LPHAs:
        - One from a similarly sized LPHA not located in the region.
        - One from the LPHA in the CBO is proposing to work.

    - If a LPHA cannot contribute a reviewer, then OHA will request a neighboring county, or a county also listed in the applicant's service area participate in the review.

Health Equity Framework Project updates
Presented by Nandini Deo and Katelyn Niel

- Workgroup Recruitment Status

    - The team is recruiting and confirming members by November 22nd.

    - The workgroup will include:
        - 2-4 PHAB members
        - 1-2 OHA members
        - 2-4 CBO members
        - 1-3 Tribal members
        - 1-3 LPHA members.

- Workgroup Timeline

    - Workgroup recruitment in Nov 2023; Workgroup kickoff meeting on Dec 12, 2023; Workgroup meetings will end and Deliverable 1 (Role Guidance) will be due May 2024.

- Workgroup Structure
    - Meeting cadence will be 2 times a month.
    - Meeting duration will be 2 hour each meeting, a total of 4 hours a month.
    - There will be 1 facilitator, 1 co-facilitator and 1 notetaker that will be the internal project team helping with creating and finalizing deliverables.
- Project Status
    - The project charter and the plan are currently being finalized and the internal project team is also being finalized.
- Jocelyn Warren asked what the goal of the Framework project was.
- Katelyn Niel answered by explaining that the project was in the first phase which encompasses defining roles for the public health system in reaching health equity goals set for 2030.
- Jocelyn W. asked if project would be connected to the SHIP.
- Katelyn N. answered by saying that the focus of the project right now was to get members of the workgroup are speaking to each other internally so that further connection can be made.
- Sarah P. asked how the recruitment process for the project workgroup is recruiting members.

- Nandini Deo answered by saying that invitations are being distributed to LPHAs, CBOs, and Tribal Members as well as recruitment through internal workgroups.

Public Health Workforce Workgroup Updates

Presented by Sara Beaudrault

- It was noted that recruitment for the Public Health Workforce Workgroup is currently underway.

- The first meeting for the workgroup is projected for early December.

- The first phase of the workforce project will be through a contractor that will perform a meta-analysis of existing public health workforce data and compiling reports with said data.

- The second phase of the workgroup will be development of recommendations.

- Veronica Irvin asked about what kinds of organizations were being recruited for this workgroup.

- Sara B. answered that the workgroup was recruiting for LPHAs, CBOs, Tribal Members, and potentially members of Academia.

October Meeting Minutes Approval

- Bob D. motioned to approve the meeting minutes for the October PHAB meeting and Marie Boman-Davis seconded this motion.

- The meeting minutes were approved with a single abstention from Meghan Chancey.

PHAB Strategic Data Plan Vote Presentation

Presented by Veronica Irvin, Victoria Demchak, Dean Sidelinger, and Marie Boman-Davis

- Purpose of the Strategic Data Plan Subcommittee
    - Engage with content and recommendations from Oregon culturally specific reviews of public health survey data.
    - Develop a set of strategies and activities to improve accessibility, accuracy, and usability of data.
    - Support ongoing accountability.
    - Deliverable: Recommendations to OHA PHD for strategic data initiatives (aka “Strategic Data Plan”)
- Timeline of Strategic Data Plan Sub-Committee
    - 2021: Committee convened to develop recommendations on a governmental PH strategic data plan.
    - 2022: Committee receives guidance from community specific survey modernization reports and presentation.
    - 2023: Developed definitions and recommendations for the strategic plan.
- Deliverable

- Recommendations for strategic data initiatives to support OHA PHD's ongoing implementation of strategies toward data equity, data justice and community engagement:
  - Definitions developed with community partners and public health leaders.
  - Priorities for OHA PHD's anticipated data investments.
  - Practices for data collection, use and analysis.
  - Report progress to PHAB

- How would OHA PHD use these recommendations?

  - Periodically report to PHAB and SDP subcommittee on OHA PHS efforts to use strategic data plan to advance adopted priorities.

  - Share in other internal spaces across PHD/external partner spaces where there is opportunity and interest in alignment in planning, implementation and reporting on data activities.

  - Periodically report to PHAB and SDP subcommittee on OHA PHS efforts to use strategic data plan to advance adopted priorities.

  - Share strategic data plan to Science and Epidemiology Council
    - Comprised of leadership from across all PHD centers, plus E&I.

- What does these mean for PHAB - Marie Boman Davis

  - Receive biannual update of PHD's progress including the following:
    - How is OHA engaging or investing time and resources in community participatory research, qualitative research, or community engagement.
    - What are the existing and prospective opportunities for collaboration with statewide and regional data collection and analysis systems, including health care?

  - Review process measures developed by OHA PHD staff.

  - Reflect on PHAB's progress towards data equity and data justice.

- PHAB Health Equity Policy and Procedure:

    - What health inequities exist among which groups? Which health inequities does the work product, report, or deliverable aim to eliminate?
        - The Strategic Data Plan does not address specific health inequities among specific groups. Rather, it provides recommendations to address inequities exacerbated by current and historical harmful practices through data justice, data equity, and community engagement principles.

    - How does the work product, report or deliverable engage other sectors for solutions outside of health care system, such as in the transportation or housing sectors?
        - The plan does not directly engage other sectors but supports the public health system's role; to establish cross sector partnerships for policy change. Implementation of the Strategic Data Plan recommendations will position public health agencies and diverse community partners to align data practices and cross sectoral policy initiatives with data justice and equity principles.

    - How was the community engaged in the work product, report or deliverable policy or decision? How does the work product, report or deliverable impact the community?
        - Strategic Data Plan recommendations are informed by the survey modernization work conducted in 2019-2020 by culturally specific project teams with community members, leaders, researchers and organizations.
        - Survey modernization is one example of efforts occurring across OHA to improve disaggregated data on community and to develop categories that better define individuals as they define themselves.
        - Communities will benefit as Strategic Data Plan recommendations are implemented because they will have access to more robust and representative data provided by

OHA and because OHA will have more accurate and complete data to inform how resources are allocated to communities.

- Request to PHAB and Voting
    - Request: Accept the Strategic Data Plan that includes recommendations for strategic data initiatives and regular progress updates to PHAB.
    - Voting members and their votes:
        - Sarah Present – Yes
        - Jackie Leung – Yes
        - Bob Dannenhoffer – Yes
        - Meghan Chancey – Yes
        - Marie Boman-Davis – Yes
        - Jocelyn Warren – Yes
        - Veronica Irvin – Yes
    - The Strategic Data Plan was passed.

New Member recruitment, member onboarding, and member discussion

- Veronica I. announced that the PHAB are recruiting for new members and asked members to potentially help with recruitment for 5 open positions.
- It is expected to fill these positions by January.
- Bob D. asked whether the new member appointment will push the quorum requirement to 17 since there will be 5 new positions being added to the current number of subcommittee members.
- Sara B. said that she would investigate this and confirm the quorum status.

- Veronica I. moved the discussion forward and asked members questions about member onboarding.
    - What do you wish you had known or had when you joined PHAB?
    - What are your suggestions for successful onboarding?
    - How can we build connections among members?
- She noted that for herself, she felt that understanding how the PHAB is associated with the Oregon Health Policy Board was helpful and that explaining this association to potential members would help with member onboarding,
- Sarah P. mentioned that educating potential members on the level of responsibility that PHAB have within the scope of public health (namely governmental public health) could help with onboarding. She also noted that educating members on the difference of Public Health Modernization and the State Health Improvement Plan and their respective processes would be important.
- Bob D. added that educating potential members on the exact functions of the PHAB would be important as miscommunication of what the board is capable of, especially the capabilities as an advisory board, is possible. He also mentioned that educating potential members on the acronyms used by members would be helpful.
- Jocelyn W. asked what potential members would be told about Public Health Modernization. She mentioned that the definitions and processes behind Public Health Modernization have changed considerably since it's inception and wondered what information about Public Health Modernization would be transferred.

- Jackie Leung suggested that new members be assigned a partner from the PHAB to help with onboarding members.

- Sara B. answered Jocelyn W. by saying that the information that will likely be explained to new members about Public Health Modernization would be information about the process in the current biennium.

- Marie Boman-Davis suggested in person time would be helpful for new members to get associated with each other.

- Veronica I. commented that a retreat would be possible.

- Meghan C. asked whether this potential retreat would only take place in the Portland Metro Area.

- Sara B. answered that the retreat is not fixed to the Portland Metro Area and could potentially be elsewhere.

- Sarah P. suggested that in-person time could be had at the OrEpi conference if members were already attending that conference.

- Marie Boman-Davis mentioned that it would be advisable to draft some options and go over them when the new members are confirmed as not to potentially predetermine the retreat prior to new member considerations.

Public comment

- Laura Daily with the Coalition of Local Health Officials advised that for the member onboarding process for the PHAB that directing new members to a webinar about the capabilities of the Oregon Public Health system, that was produced in collaboration with OHA, OHSU, and CLHO, would be helpful.

- She inquired about whether the Workforce Development Plan Workgroup would have spaces to collaborate with organization such as CLHO and Oregon Center for Nursing as organization like this have large system overviews of the Public Health workforce. She also suggested appointment of a county commissioner would also be beneficial for the workgroup.

Adjourn

- Meeting adjourned at 4:30 pm.

Public Health Advisory Board
Health equity policy and procedure
December 2023

Purpose

The purpose of the Public Health Advisory Board (PHAB) Health Equity Policy and Procedure is to ensure PHAB is making decisions that facilitate elimination of health inequities and uphold a commitment on behalf of the public health system to lead with racial equity.

The public health system leads with race because communities of color and tribal communities have been intentionally excluded from power and decision-making.

Definition of health equity[1]

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

PHAB also adopts the following definitions:

Racism as defined by Dr. Camara Jones is *"a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities,*

[1] Oregon Health Policy Board, Health Equity Committee. (2019). Available at https://www.oregon.gov/oha/EI/Pages/Health-Equity-Committee.aspx.

unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[2] Racism "*refers not only to social attitudes towards non-dominant ethnic and racial groups but also to social structures and actions that oppress, exclude, limit and discriminate against such individuals and groups. Such social attitudes originate in and rationalize discriminatory treatment*".[3]

Structural racism *"refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."*[4]

Social determinants of health are *"the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*[5] Social determinants of health include access to quality education, employment, housing, health care, all of which have a direct impact on health.

Leading with racial equity

Health inequities exist and persist on historical, structural, cultural and interpersonal levels. PHAB acknowledges historic and contemporary racial injustice and commits to eradicating racial injustice through systemic and structural approaches. PHAB acknowledges the pervasive racist and white supremacist history of Oregon, including in its constitution; in the theft of land from Indigenous communities; the use of stolen labor and the laws that have perpetuated unjust outcomes among communities of color and tribal communities.

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[2]Jones, C. (n.d.) Racism and health. American Public Health Association. Available at www.apha.org/racism.
[3]Calgary Anti-Racism Education Collective. (2021). Available at https://www.aclrc.com/racism.
[4]Bailey, Z., Krieger, N., Agénor, M., Graves, J. Linos, N. & Bassett. M. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *Lancet*, *389*(10077), 1453-1463. https://doi.org/10.1016/S0140-6736(17)30569-X
[5]Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Systemic racism has devastating impacts on health outcomes in Oregon.[6]

- In 2020 and 2021, Black/African American and American Indian/Alaska Native people have the highest death rates from opioid overdose, despite similar rates of use across all races/ethnicities.
- In 2021 and 2022, Black/African American, American Indian/Alaska Native, Hispanic/Latino/a/x individuals experienced nearly double the proportion of heat-related deaths in Oregon.
- Between 2017-2021, infant mortality rates were more than double for Black/African American, American Indian/Alaska Native and Pacific Islander babies.

As a partner to the Oregon Health Policy Board Health Equity Committee, PHAB uplifts the Health Equity Committee's statement that historical and current institutional and individualized acts of racism and colonization have created disadvantages for communities that are real, unjust and unacceptable. Until populations and communities most harmed by long standing social injustice and inequities share decision-making authority in our state, systems will favor the dominant culture, reinforcing institutional bias and contributing to health inequities and unjust, unfair and avoidable inequities in health outcomes.

Because of Oregon's history of racism, the public health system, as described in the Health Equity Guide, chooses to "lead explicitly — though not exclusively — with race because racial inequities persist in every system [across Oregon], including health, education, criminal justice and employment. Racism is embedded in the creation and ongoing policies of our government and institutions, and unless otherwise countered, racism operates at individual, institutional, and structural levels and is present in every system we examine."[7]

The public health system leads with race as described by the Government Alliance on Race and Equity: "Within other identities — income, gender, sexuality, education, ability, age, citizenship and geography — there are inequities based on race. Knowing this helps the [public health system] take an intersectional

[6] Oregon Health Authority. (2023).
[7] Human Impact Partners. (2023). Why lead with race. Available at https://healthequityguide.org/about/why-lead-with-race/.

approach, while always naming the role that race plays in people's experiences and outcomes."[8]

To have maximum impact, focus and specificity are necessary. Strategies to achieve racial equity differ from those to achieve equity in other areas. "One-size-fits all" strategies are rarely successful.

A racial equity framework that is clear about the differences between individual, institutional and structural racism, as well as the history and current reality of inequities, has applications for other marginalized groups.

Leading with racial equity recognizes the inter-connected ways in which systems of oppression operate and facilitates greater unity across communities.

PHAB acknowledges that geography also has a significant impact on individual and community health outcomes. For example, rural residents in areas with long-standing systematic lack of investment in resources (e.g., education, employment) and services (e.g., healthcare) experience health inequities. Within rural populations, there also are wide disparities in health outcomes among socioeconomic groups. Across varied geographies, profound disadvantages occur by both place and race.[10]

How health equity is attained

Achieving health equity requires meaningful, intersectional representation within the field of public health at all levels and authentic engagement leading to co-creation of policies, programs and decisions with the community in order to ensure the equitable distribution of resources and power. At the foundation, attaining health equity requires trust. This level of community engagement results in the elimination of gaps in health outcomes between and within different social groups.

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[8] Local and Regional Government Alliance on Race and Equity. (2023). Why lead with race? Available at https://www.racialequityalliance.org/about/our-approach/race/.

[10] Braveman P, Acker J, Arkin E, Badger K, Holm N. (2022). Advancing health equity in rural America. *Robert Wood Johnson Foundation*. Available at https://www.rwjf.org/en/insights/our-research/2022/06/advancing-health-equity-in-rural-america.html.

Identifying and implementing effective solutions to advance health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities due to racism.
- Engagement of a wide range of partners representing diverse constituencies and points of view.
- Direct involvement of affected communities as partners and leaders in change efforts.

Health equity also requires that individuals who work in public health look for solutions for the social[21] and structural[22] determinants of health outside of the health system. This may include working with transportation, justice or housing sectors and through the distribution of power and resources, to improve health with communities. By redirecting resources that further the damage caused by white supremacy and oppression into services and programs that uplift communities and repair past harms, equity can be achieved.

Policy

PHAB demonstrates its commitment to leading with race and to advancing health equity by implementing an equity review process for all formally adopted work products, reports and deliverables. Board members will participate in an equity analysis prior to making any motions. In addition, all presenters to PHAB will be expected to specifically address how the topic being discussed is expected to affect health equity. The purpose of this policy is to ensure all PHAB guidance and decision-making will advance health equity and reduce the potential for unintended consequences that may perpetuate inequities.

Procedure

[21] World Health Organization. (n.d.). Social determinants of health. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
[22] The Praxis Project. (n.d.). Social determinants of health. Available at https://www.thepraxisproject.org/social-determinants-of-health.

Board practices to facilitate equity, diversity, inclusion, justice and belonging

As adapted from the Oregon Health Policy Board Health Equity Committee and the Othering and Belonging institute, PHAB practices equity, diversity, inclusion, justice and belonging by committing to:[23, 24]

- Developing or using a tool that advances honest, direct and inclusive dialogue, such as group agreements.
- Sharing responsibility for helping each other to learn and grow together.
- Supporting one another through connectedness, mutual respect and relationship.
- Fostering agency and inclusive co-creation.
- Intentionally focusing on health for all people in Oregon, elevating needs of those we represent and using tools to co-create equitable policies.
- Creating and maintaining a safe(r) environment for open and honest conversation.
- Recognizing, celebrating and valuing our group's diversity, wisdom, and expertise. PHAB recognizes that we may need to facilitate different kinds of support to create an equitable place of belonging.

Board work products, reports and deliverables

The questions in the tool below are designed to ensure that decisions made by PHAB advance health equity. The questions below may not be able to be answered for every policy or decision brought before PHAB but serve as a platform for further discussion throughout the development of PHAB work products and prior to the adoption of any motion.

Subcommittees and board members will consistently consider the questions in the health equity assessment tool while developing work products and deliverables to bring to the full board, and upon any formal board action.

[23] Oregon Health Policy Board, Health Equity Committee. (April 2023). Health Equity Committee charter. Available at https://www.oregon.gov/oha/EI/HECMeetingDocs/HEC%20Charter%20APPROVED%204.17.2023.pdf.
[24] Othering and Belonging Institute. (August 2023). Belonging design principles. Available at: https://belonging.berkeley.edu/belongingdesignprinciples?emci=07bfaa71-753c-ee11-a3f1-00224832eb73&emdi=dff58124-0f3d-ee11-a3f1-00224832eb73&ceid=13607753#6.

Upon review of a subcommittee deliverable, PHAB members may return the deliverable to the subcommittee if the product does not have the ability to address health equity through further discussion about the equity assessment questions.

Health Equity Assessment Tool[25][26]

1. Which health inequit(ies) does the work product, report or deliverable aim to eliminate, and for which groups?
2. What data sources have been used to identify health inequities?
3. How was the community engaged in the work product, report or deliverable policy or decision?
4. How does the work product, report or deliverable advance health equity, lead with race and impact the community?
5. Will any groups or communities benefit from the direction or redirection of resources with this decision? Are they the people who are facing inequities?
6. What are short and long-term strategies tied to this work product, report or deliverable that will impact racial equity?
   What data will be used to monitor the impact of this work product, report or deliverable over time?

Presentations to the Board

OHA staff will work with presenters prior to PHAB meetings to ensure that presenters specifically address health inequities and strategies to promote equity in their presentations to the board, following on PHAB's commitment to equity.

Policy and procedure review

[25] Questions adapted from Big Cities Health Coalition (2021). Equity Lens Tool for Health Departments. Available at: https://www.bigcitieshealth.org/health-equity-tool/.

[26] Questions adapted from the Minnesota Department of Health (2018). Advancing Health Equity: Key Questions for Assessing Policy, Processes and Assumptions. Available at: https://www.health.mn.gov/communities/practice/resources/publications/docs/1811advancingHEkeyQs.pdf.

The PHAB health equity policy and procedure will be reviewed and updated biennially by a workgroup of the Board. This workgroup will also propose changes to the PHAB charter and bylaws in order to center the charter and bylaws in equity. Board members will discuss whether the policy and procedure has had the intended effect of mitigating injustice, reducing inequities or improving health equity to determine whether changes are needed to the policy and procedure.

Public Health Advisory Board
Health Equity Policy and Procedure
December 2023

Health Equity Assessment Tool

1. **Which health inequity(ies) does the work product, report or deliverable aim to eliminate, and for which groups?**

   The PHAB Health Equity Policy and Procedure (P&P) ensures that Board decisions facilitate the elimination of health inequities and uphold PHAB's commitment on behalf of the public health system to lead with racial equity. In this way, the P&P serves communities of color, Tribal communities and groups with intersecting identities who have been excluded from power and decision-making.

   The P&P provides practices PHAB can use to eliminate health inequities, in alignment with its charter and bylaws.

2. **What data sources have been used to identify health inequities?**

   The P&P does not use data to identify specific health inequities.

3. **How was the community engaged in the work product, report or deliverable policy or decision?**

   The community was not directly engaged in developing this P&P. The P&P references and aligns with existing resources, including those provided through the OHPB Health Equity Committee.

4. **How does the work product, report or deliverable advance health equity, lead with race and impact the community?**

   The P&P is grounded in practices to advance health equity by leading with race. The P&P applies a racial equity framework that differentiates between individual, institutional and structural racism and the inter-connectedness across systems of oppression. Application of this P&P is intended to shift

power and resources to communities that experience racism and oppression through Board work products and deliverables.

5. **Will any groups or communities benefit from the direction or redirection of resources with this decision? Are they the people who are facing inequities?**

   All groups that experience inequities based on race and ethnicity, income, gender, sexuality, education, ability, age, citizenship and geography, while recognizing that within these groups there are inequities based on race.

6. **What are short- and long-term strategies tied to this work product, report or deliverable that will impact racial equity?**

   All PHAB work products, deliverables and decisions will be made using the questions in this P&P throughout the development process and prior to decision-making.

7. **What data will be used to monitor the impact of this work product, report or deliverable over time?**

   This P&P will be reviewed biennially by a workgroup of PHAB. This workgroup will also regularly review PHAB's charter and bylaws to ensure alignment and action toward racial equity.

PHAB vote

- Do members approve adopting the updated PHAB Health Equity Policy and Procedure?

Public Health Accountability Metrics

Communicable disease and environmental health process measures

Sara Beaudrault
Tim Menza, MD, PhD
Rex Larsen
Julie Sifuentes

PUBLIC HEALTH DIVISION
Office of the State Public Health Director

Today's agenda

1. Overview
2. Communicable disease process measures
3. Environmental health process measures
4. PHAB Health Equity Policy and Procedure
5. PHAB vote

Overview

Public health system metrics

The following set of metrics brings attention to health priorities in Oregon.

These metrics provide a framework to bring together governmental public health authorities, other sectors and partners, and state and local health officials to collectively change policies to create health for everyone.

These metrics also demonstrate improvements in Oregon Health Authority and local public health authorities' core system functions through public health modernization

<table>
<tr><th colspan="2">Collective responsibility across sectors and partners</th><th>Oregon Health Authority and local public health authority accountability</th></tr>
<tr><th>Health priorities</th><th>Policy actions</th><th>Public health data, partnerships and policy</th></tr>
<tr><td>Public health assessment</td><td>Public health policy development</td><td>Public health assurance</td></tr>
<tr><td>Indicators of health outcomes

What are priority health issues throughout Oregon?

Which groups experience disproportionate harm?</td><td>Measures of policy landscape

How are policies contributing to or eliminating root causes of health inequities?</td><td>Measures of foundational capabilities

Are public health authorities increasing capacity and expertise needed to address priority health issues?

Are public health authorities better able to provide core public health functions within their community?</td></tr>
<tr><td colspan="2">Level of accountability

The governmental public health system as a whole, other sectors and partners, elected officials.

Oregon's Public Health Advisory Board has a critical role to influence necessary policy changes.</td><td>Level of accountability

OHA and individual LPHAs</td></tr>
</table>

Steps and timeline to finalize accountability metrics

October 2023

Develop framework for public health accountability metrics - Framework shifts - Metrics selection criteria - PHAB vote	April 2021 – June 2022
Finalize health outcome indicators - CLHO metrics workgroups - LPHA consultation - PHAB vote	March 2022 – June 2023
Finalize process measures - CLHO metrics workgroups - LPHA consultation - CBO engagement - PHAB vote	October – December 2023
Establish benchmarks and measurement strategy - Indicators and process measures - Strategy to measure reduction of inequities - Strategy to measure improvement in process measures	October – December 2023
Develop data collection methods, timelines and standards - Develop process measure guides - Develop data collection instruments where there isn't an existing data source - Standardize indicator data to the extent possible	October 2023-February 2024
LPHA, CBO and OHA implementation - LPHA, CBO and OHA work plans - LPHAs select process measures to be used for incentive payment eligibility	January 2024-ongoing

Collect and report data - Collect and analyze data - Publish 2024 accountability metrics report	March – June 2024
Communicate and build alignment - PHAB opportunities to meet with related groups, such as CCO Metrics and Scoring Committee - Publish preliminary and annual metrics reports	January 2024-ongoing
Award LPHA incentive payments based on 2023-25 performance - **Review and update LPHA funding formula methodology** - Collect and analyze 2023-25 performance	January 2024-June 2025

Public health accountability metrics
Indicators and process measures
November 6, 2023

Priority area	Indicator	Indicator data source	Indicator baseline	Indicator 2030 goal	LPHA process measure	LPHA process measure data Source	LPHA process measure 2030 goal
Reduce the spread of syphilis and prevent congenital syphilis	Rate of congenital syphilis	Orpheus	93.9/100K live births (2022)	47.0/100K, 50% decrease	1. Percent of congenital syphilis cases averted (OR baseline: 60:0)	Orpheus	TBD
	Rate of syphilis (all stages) among people who can become pregnant	Orpheus	29.7/100K (2022)	26.7/100K, 10% decrease	2. Percent of cases interviewed (67.7)	Orpheus	TBD
	Rate of primary and secondary syphilis	Orpheus	26.2/100K (2022)	23.6/100K, 15% decrease	3. Percent completion of CDC core variables (84.4)	Orpheus	TBD
					4. (Percent completion of core risk variables [57.8])	Orpheus	TBD
					5. Percent of cases treated with appropriate regimen within 14 days (74.1)	Orpheus	TBD
Protect people from preventable diseases by increasing vaccination rates	Two-year old vaccination rate (4:3:1:3:3:1:4 series)	ALERT IIS	69% (2022)	80%	1. Demonstrated use of data to identify population(s) of focus (required process measure)	New data collection mechanism	TBD
	Adult influenza vaccination rate, ages 65+	ALERT IIS	59% (2022)	70%	2. Demonstrated actions to improve access to influenza vaccination for residents of LTCFs	New data collection mechanism	TBD
					3. Demonstrated actions with health care providers or pharmacists to improve access to vaccination	New data collection mechanism	TBD
					4 Increase in the percent of health care providers participating in the Immunization Quality Improvement Program (IQIP)	New data collection mechanism	TBD
					5. Demonstrated outreach and educational activities conducted with community partners	New data collection mechanism	TBD
Build community resilience for climate impacts on health: extreme heat, wildfire smoke and drinking water	Emergency department and urgent care visits due to heat	ESSENCE			1. Demonstrated use of data to identify population(s0 of interest	New data collection mechanism	TBD
	Hospitalizations due to heat	Oregon inpatient hospital discharge data from the Healthcare Cost and Utilization Project (HCUP)			2. Demonstrated actions in Communications to oimprove priority area of focus	New data collection mechanism	TBD
	Heat deaths	Oregon Vital Records, OHA Oregon death certificates			3. Demonstrated actions in Policy to improve priority ara of focus	New data collection mechanism	TBD
	Respiratory (non-infectious) emergency department and urgent care visits	ESSENCE			4. Demonstrated actions in Community Partnerships to improve priority area of focus	New data collection mechanism	TBD
	Community water system health-based violations, #/% of population affected	SDWIS database			5. Demonstrated actions to integrate climate and health into cross-sectoral or public health planning	New data collection mechanism	TBD
	Number of/type of advisories, #/% of population affected	OHA Drinking Water Services database				New data collection mechanism	TBD
	Developmental: Mental health effects of climate change	TBD				New data collection mechanism	TBD

Process measure implementation

- Each LPHA will be expected to demonstrate work toward two process measures in each of the three priority areas (six total).
- Process measures are developed as a menu so that each LPHA can choose the areas that are priorities within their agency or community.
- Some process measures are required for all LPHAs.

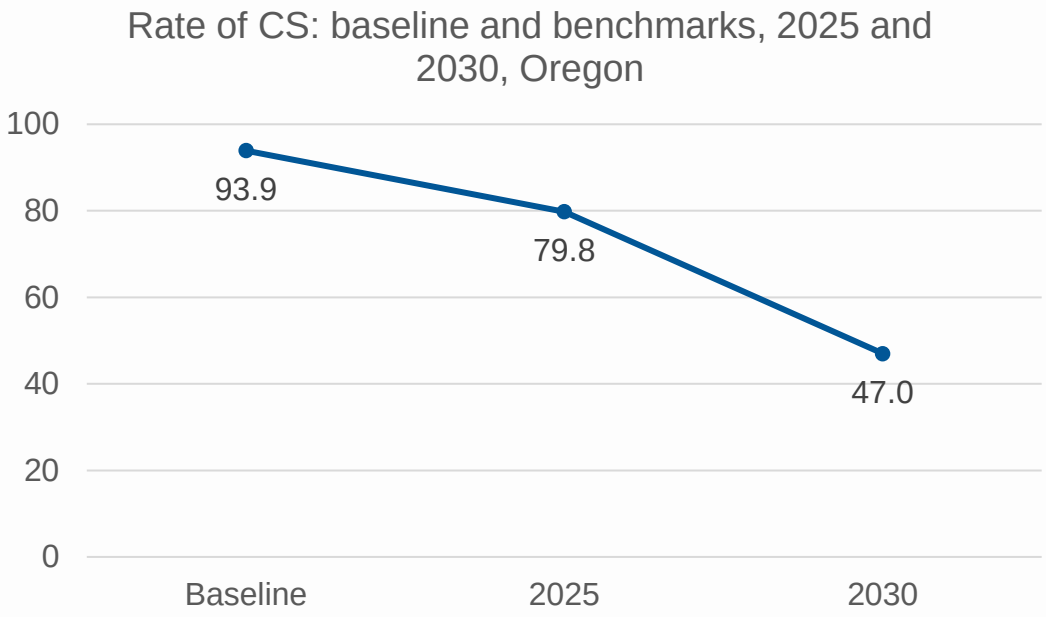
Local public health authority engagement

- Three workgroups of LPHA and OHA subject matter experts convened.
- Meetings held 11/6 and 11/13 to review process measure recommendations and share questions, feedback and concerns.
- Survey fielded 11/14-11/27.

Syphilis

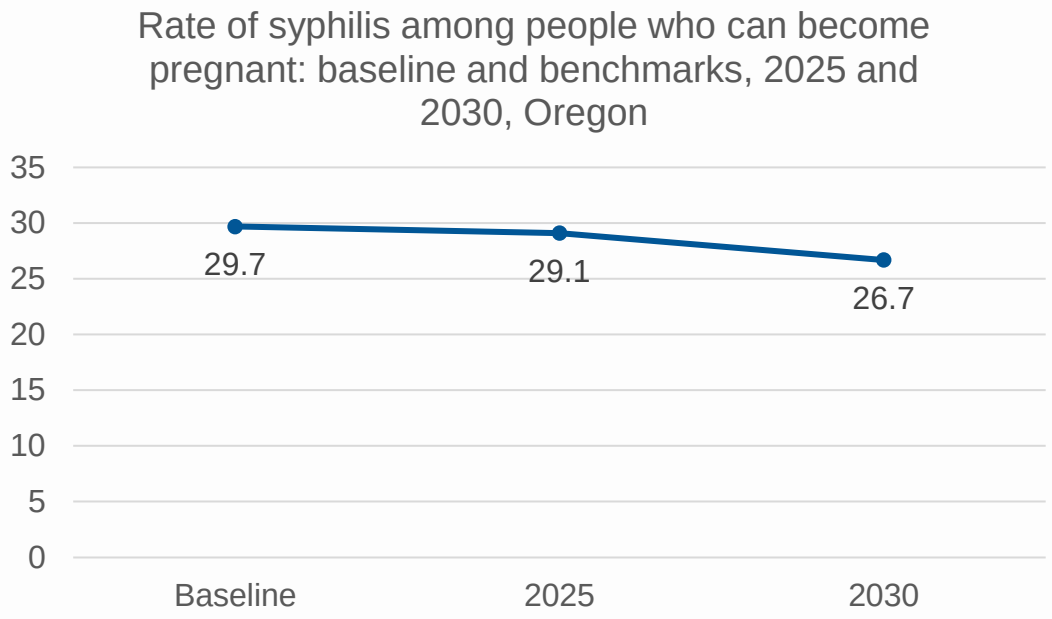
Indicators and benchmarks

- Rate of congenital syphilis
  - Baseline rate (2022): 93.9/100K live births
  - 15% decrease by 2025 (79.8)
  - 50% decrease by 2030 (47.0)



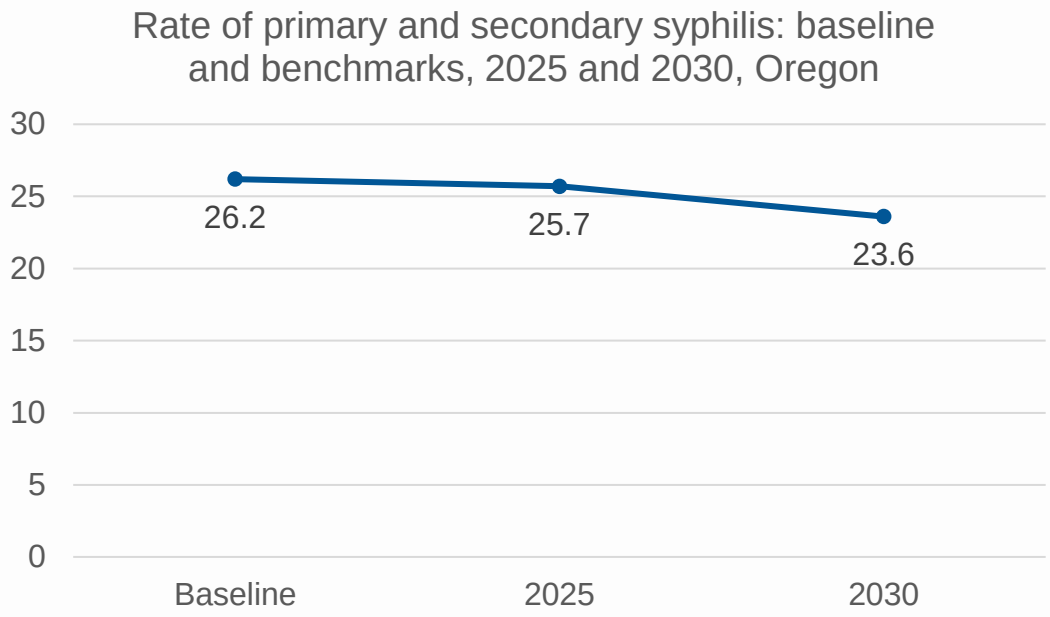
Indicators and benchmarks

- Rate of syphilis (all stages) among people who can become pregnant
  - Baseline rate (2022): 29.7 per 100K population
  - 2% decrease by 2025 (29.1)
  - 10% decrease by 2030 (26.7)



Indicators and benchmarks

- Rate of primary and secondary syphilis per 100K population
  - Baseline (2022): 26.2 per 100K population
  - 2% decrease by 2025 (25.7)
  - 10% decrease by 2030 (23.6)



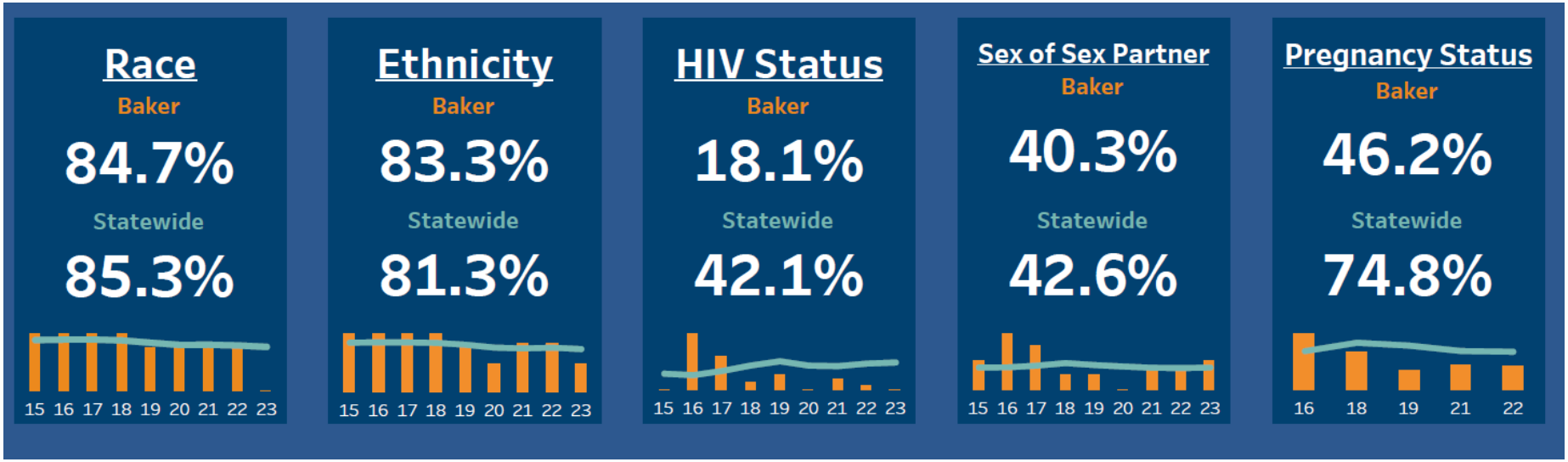
CLHO CD syphilis process measures workgroup

- **Met 5 times** between Aug 14 and Sept 25
- **LPHA participants:** Bailey Burkhalter (Jackson); Rachel Posnick (Marion); Zachary Hale (NCPHD); Jonathan Geertsen (Washington); Carrie Shuler (Washington); Tanya Philips (Jackson); Tessa Robinson (Washington); Jeffrey Gander (Clackamas); Laura Turpen (Douglas); David Cuevas (Multnomah); Miriam Morehart (Multnomah); Nadine Campbell-Davis (Clatsop); Carolina Guerrero-Lara (Clatsop); Mary Shaughnessy (Benton); Abby Gray (Yamhill); Joseline Montes (Yamhill); Jessie Hunsaker (Deschutes); Michelle Mattison (Clackamas)
- **OHA participants:** Tim Menza, Yuritzy Gonzalez-Pena, Cedric Cicognani

Recommended LPHA process measures

Goal: 10% increase in measures by 2030

- Percent of congenital syphilis cases averted (OR baseline: 60.0)
- Percent of cases interviewed (67.7)
- Percent completion of CDC core variables (84.4)
- (Percent completion of core risk variables [57.8])
- Percent of cases treated with appropriate regimen within 14 days (74.1)



Percent of CS cases averted

- Partner with organizations and services that provide touchpoints for pregnant people, especially pregnant people experiencing poverty, housing instability, criminal justice involvement, and substance use
- Advocate for low barrier prenatal care services
- Educate community providers that substance use in pregnancy is **NOT** subject to mandatory reporting
- Educate community providers on syphilis screening at three time points during pregnancy
- Educate community providers on appropriate syphilis treatment for stage and the importance of timely treatment
- Consult and partner with community providers to discuss appropriate, timely treatment for syphilis as cases arise
- Treat patients with syphilis (if LPHA offers clinical services)
- Provide Bicillin to community providers through the OHA Bicillin Access Program (if LPHA does not offer clinical services and community provider does not stock Bicillin)

Percent of cases interviewed

- Offer a variety of forms of communication to reach clients, including text, Facebook messenger, Instagram direct messaging, geospatial networking apps, field visits
- Train staff in motivational interviewing to engage clients in the case interview
- Train staff in trauma-informed approaches to collecting information on a highly stigmatized STI
- Hire staff that reflect the community served by the CD team
- Offer incentives for the completion of case interviews

Percent of CDC core and Orpheus risk variables completed

- Use a variety of resources to capture key information, including case interview, chart review, provider outreach, social media accounts (if permitted)
- Offer a variety of forms of communication to reach clients, including text, Facebook messenger, Instagram direct messaging, geospatial networking apps, field visits
- Train staff in motivational interviewing to engage clients in the case interview
- Train staff in trauma-informed approaches to collecting information on a highly stigmatized STI
- Hire staff that reflect the community served by the CD team
- Offer incentives for the completion of case interviews

Percent of cases who receive appropriate treatment within 14 days

- Educate community providers on appropriate syphilis treatment for stage and the importance of timely treatment
- Consult and partner with community providers to discuss appropriate, timely treatment for syphilis as cases arise
- Treat patients with syphilis (if LPHA offers clinical services)
- Provide Bicillin to community providers through the OHA Bicillin Access Program (if LPHA does not offer clinical services and community provider does not stock Bicillin)

OHA process measures

- Cases of congenital syphilis averted at the state level
  - 60% baseline → 75%
- Percentage of prenatal care providers who report screening pregnant people routinely in the early third trimester
  - 69% baseline → 80%
- Adoption of metrics for syphilis screening at three time points in pregnancy by CCOs
  - No baseline → Yes

OHA activities to support state process measures

- Maintain a dashboard of indicators and process measures
- Collect data on touchpoints accessed by pregnant people with syphilis
- Develop methods to track syphilis screening in pregnancy
- Prenatal care provider survey on screening practices
- Conduct provider trainings on syphilis
- Promote low barrier care models for pregnant people
- Advocate for CCO/OHP metrics for syphilis screening
- Develop EMR-based interventions to increase syphilis screening
- Partner with emergency departments, correctional facilities, and substance use disorder clinics to increase HIV, STI, and hepatitis testing

Immunizations

Indicators and benchmarks

Two-year-old vaccination rates

- Baseline rate (2022): 69%, 4:3:1:3:3:1:4 series
- Oregon benchmark:
  - 74% by 2025
  - 80% by 2030
  - Additional benchmarks will be established for each race and ethnicity, with the goal of eliminating immunization rate disparities by 2030 by reducing the initial year disparity by 12.5 % each year.

Data: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Documents/county/Oregon.pdf

Indicators and benchmarks

Influenza vaccination rates for adults aged 65+

- Baseline rate (2022/23 flu season): 59%
- Oregon benchmark:
  - 64% by 2025
  - 70% by 2030
  - Additional benchmarks will be established for each race and ethnicity, with the goal of eliminating immunization rate disparities by 2030 by reducing the initial year disparity by 12.5 % each year.

Data: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Documents/county/Oregon.pdf

CLHO CD immunization process measures workgroup

- **Met 9 times** between Aug 10 and Oct 12
- **LPHA participants:** Bailey Burkhalter (Jackson); Kathleen Rees (Washington); Alicia Barmettler (Multnomah); Jamiel Brown (Multnomah); Krista Klingensmith (Jackson); Cindy D'Angiolillo (Benton); April Johnson (Clatsop); Stephanie Fox (Yamhill); Abby Gray (Yamhill); Michelle Mattison (Clackamas); Kevin Staley (Clackamas); Jessica Winegar (Grant)
- **OHA participants:** Rex Larsen; Kelly McDonald; Becca Pierce

Immunization process measures

- Will require a new data collection mechanism.
- Each LPHA will select their indicator of focus (adult influenza vaccination rates, two-year old vaccination rates, or both), which will determine their process measure options.
- Benchmark measurement strategy still in development.

Recommended process measures

1. Demonstrated use of data to identify population(s) of focus.	Required for all LPHAs
2. Demonstrated actions to improve access to influenza vaccination for residents of LTCFs.	Only available to LPHAs focused on adult flu
3. Demonstrated actions with health care providers or pharmacists to improve access to vaccination	Available to all LPHAs
4. Increase in the percent of health care providers participating in the Immunization Quality Improvement Program (IQIP)	Only available to LPHAs focused on two-year-old imms
5. Demonstrated outreach and educational activities conducted with community partners	Available to all LPHAs

1. Demonstrated use of data to identify population(s) of focus.

- **This is a required process measure.**

- **Sub-question:** What data did you use to identify population(s) of focus? Select all that apply.

  Example response options

  - Standard state data set, provided by OHA Immunization Program

  - Local data set, not provided by OHA Immunization Program

  - National data set

- **Sub-question:** Which priority population(s) were identified by the data to address disparities in vaccination rates? Select all that apply.

  Example response options

  - Disparities for racial and ethnic groups

  - Geographic disparities

  - VFC/insurance status

2. Demonstrated actions to improve access to influenza vaccination for residents of LTCFs.

- **This process measure is only available to LPHAs that selected "Adult influenza vaccination rate" in Q1.**

- **Sub-question:** Select which actions your LPHA took to improve access. Select all that apply.

  Example response options

  - Held vaccination clinic at LTCFs (# clinics, # vaccines administered)

  - Worked with vaccinating partners to provide vaccines (partner type, # vaccines administered)

  - Provided education and technical assistance to LTCF staff to provide vaccines (briefly described education or TA provided)

3. Demonstrated actions with health care providers or pharmacists to improve access to vaccination

- **This process measure is available to all LPHAs.**

- **Sub-question:** What types of actions did you conduct? Select all that apply.

  Example response options

  - Worked with hospitals to offer adult influenza vaccine to patients prior to discharge (briefly describe, including any known changes)

  - Worked with health care providers to improve immunization access and reduce barriers (briefly describe, including any known changes)

  - Worked with Eds and urgent cares to offer adult influenza vaccine (briefly describe)

- **Sub-question:** What type(s) of organizations did you work with? Select all that apply.

  Example response options

  - Pharmacy

  - Hospital

  - Private health care provider

4. Increase in the percent of health care providers participating in the Immunization Quality Improvement Program (IQIP)

- **This process measure is only available to LPHAs that selected "two year old vaccination rates" in Q1.**

- **Sub-question:** Percent of health care providers that participated in an IQIP meeting within the past year. (Data provided by the OHA Immunization Program. Benchmark 25%.)

- **Sub-question:** Which actions did your LPHA take to engage health care providers in IQIP? Select all that apply.

  Example response options

  - Trained LPHA staff to conduct IQIP sessions with health care providers (briefly describe)

  - Convened health care provider community meeting to discuss strategies to increase vaccination rates (briefly describe)

  - Recruited providers to participate in IQIP and worked with OHA to conduct sessions (briefly describe)

5. Demonstrated outreach and educational activities conducted with community partners

- **This process measure is available to all LPHAs.**

- **Sub-question:** What type of Organization did you work with? Select all that apply

  Example response options

  - CBOs

  - Shelters or houseless/homeless serving orgs

  - Health care provider or health system

- **Sub-question:** Which actions did your LPHA take with community partners? Select all that apply

  Example response options

  - Vaccination clinic or off-site event (briefly describe)

  - Promotional campaign or event (briefly describe)

  - Development of culturally specific communication materials (briefly describe)

OHA process measures

- Develop and maintain data for indicators
  - Ensure dashboards are available at the state and county level
  - Additional data and assistance with using data provided to counties
- Implement the Immunization Quality Improvement for Providers Program
  - Report the percent of VFC clinics that received an IQIP visit at the state and county level in the prior year
- Provide data to CCOs to meet immunization incentive measures and partner with CCOS on QI program implementation
- Assure vaccine supply and monitor the state's vaccine finance model to ensure it is sustainable, equitable, and adequately funds vaccination programs
  - Make policy recommendations for improvements as needed

Extreme heat, wildfire smoke and drinking water

Indicator benchmarks

Baseline: analyses in progress to standardize data based on heat

Benchmarks: reducing disparate impacts

CLHO EH process measures workgroup

- **Met 8 times** between Sept 13-Nov 9
- **LPHA participants:** Kathleen Johnson (Washington); Lauralee Fernandez (Washington); Nadege Dubuisson (Multnomah); Jaraj Singh (Multnomah); Teresa Roark (Lane); Leah Swanson (Josephine); Michael Keuler (Marion); John Pegg (Benton); Michael Derossett (Josephine); Jiancheng Huang (Clatsop); Lucas Marshall (Clatsop); Andy Mitsch (Umatilla); Katharine Carvelli (Lane); Renae Johnson (Yamhill); Sarah Worthington (Deschutes); Ian Stromquist (Hood River); Edward Colson (Tillamook); Leah Fisher (Clackamas)
- **OHA participants:** Carol Trenga, Julie Sifuentes, Jen Seamans, Cordelia Schimpf, Kim Tham, Pradnya Garud

Extreme heat, wildfire smoke and drinking water process measures

- Will require a new data collection mechanism.
- Each LPHA will select their indicator of focus (extreme heat, wildfire smoke and drinking water) which will determine their process measure options.
- There is one required process measure for all LPHAs.
- Benchmark measurement strategy still in development.

Recommended process measures

1. Demonstrated use of data to identify population(s) of focus.	Required for all LPHAs
2.Demonstrated actions in Communications to improve priority area of focus	Available to all LPHAs
3. Demonstrated actions in Policy to improve priority area of focus.	Available to all LPHAs
4. Demonstrated actions in Community Partnerships to improve priority area of focus	Available to all LPHAs
5. Demonstrated actions to integrate climate and health into cross-sectoral or public health planning	Available to all LPHAs
6. Developmental: Mental health effects of climate change	Required for all LPHAs?

1. Demonstrated use of data to identify population(s) of focus.

- **This is a required process measure.**

- **Sub-question:** What data did you use to identify population(s) of focus? Select all that apply.

  Example response options

  - Standard state data set, provided by OHA EH Program

  - Local data set, not provided by OHA EH Program

  - National data set

- **Sub-question:** Which priority population(s) were identified by the data to address disparities in environmental health indicator rates? Select all that apply.

  Example response options

  - Disparities for racial and ethnic groups

  - Geographic disparities

2. Demonstrated actions in Communications to improve priority area of focus

- **This process measure is available to LPHAs for the priority area selected.**

- **Sub-question:** Select which actions your LPHA took to improve communications. Select all that apply.

  Example response options

  - Partnered with culturally specific organizations to develop locally tailored communications. (briefly describe)

  - Demonstrated application of a communications plan or SOP during an extreme heat event. (briefly describe)

3. Demonstrated actions in Policy to improve priority area of focus

- **This process measure is available to LPHAs for the priority area selected.**

- **Sub-question:** Select which actions your LPHA took to improve Policy. Select all that apply.

  Example response options

  - Local ordinance passed (briefly describe)

  - Assisted in development of policies within other organizations or sectors (i.e. schools, parks)

  - Published briefs or white papers on policy issues

- **Sub-question:** Select the types of partners engaged in policy-related activities

  Example response options

  - Other city or county government partners

  - Community organizations

4. Demonstrated actions in Community Partnerships to improve priority area of focus

- **This process measure is available to LPHAs for the priority area selected.**

- **Sub-question:** Select which actions your LPHA took to improve Community Partnerships. Select all that apply.

  Example response options

  - Increased number of organizations who agree to be listed as cooling centers

  - Established systems/strategies to check on high risk people who live alone during heat events

  - Participation in OHP Climate Benefit implementation

5. Demonstrated actions to integrate climate and health into cross-sectoral or public health planning

- **This process measure is available to LPHAs for the priority area selected.**

- **Sub-question:** Select which actions your LPHA took to improve integration of climate and health into cross-sectoral or public health planning. Select all that apply.

  Response options

  - Integrated climate/environmental health data and recommendations into local/regional cross-sectorial assessments, planning, decision-making (select assessment type)

  - Integrate climate and health data and considerations into other public health program development, planning, training and communications (list PH program area)

6. Developmental: Mental health effects of climate change

- **OHA would like to collect information from LPHAs to inform a future accountability metric.**

- **Sub-question:** Is the LPHA currently taking action to address the mental health effects of climate change within their jurisdiction? (yes/no)

- **Sub-question:** If yes, briefly describe

OHA process measures

- Ensure access to environmental health data for LPHA's
- Provide technical support and trainings that meets the range of LPHA needs
- Make available culturally-specific climate and health education resources
- Integrate climate and environmental health into state decision-making and prioritization
- Strengthen connections between LPHA, CBO and State partners
- Build capacity of public health system to assess and address emerging climate and health issues
  - Water insecurity
  - Mental health and climate change

Public Health Advisory Board
Public Health Accountability Metrics, Process Measures
December 2023

Health Equity Assessment Tool

1. **Which health inequity(ies) does the work product, report or deliverable aim to eliminate, and for which groups?**

   Inequities exist for all indicators that have been adopted by PHAB, and the process measures are intended to measure core public health work to eliminate health inequities.

2. **What data sources have been used to identify health inequities?**

   Data for public health accountability metrics are provide through multiple OHA Public Health Division data and reporting systems.

3. **How was the community engaged in the work product, report or deliverable policy or decision?**

   The PHAB Accountability Metrics subcommittee has not directly engaged communities in the selection of priority areas, indicators or process measures. The subcommittee has looked to previous engagement and existing community-developed and -informed plans to understand community priorities.

4. **How does the work product, report or deliverable advance health equity, lead with race and impact the community?**

   Accountability Metrics process measures reflect core work of LPHAs and OHA to identify and eliminate health inequities. For every priority area, process measures are included that demonstrate that public health authorities are using data from a variety of sources to understand existing health inequities and are implementing activities and strategies with partners to eliminate health inequities. The measurement strategy for indicators includes reduction of gaps in rates across racial and ethnic groups.

5. **Will any groups or communities benefit from the direction or redirection of resources with this decision? Are they the people who are facing inequities?**

   Groups experiencing health inequities are expected to benefit from improvements to core governmental public health work that is reflected in the process measures.

6. **What are short- and long-term strategies tied to this work product, report or deliverable that will impact racial equity?**

   Process measures reflect an LPHA's capacity for public health foundational capabilities, specifically assessment and epidemiology, community partnership development, communications, and policy and planning. Sufficient capacity and expertise within the foundational capabilities are essential for impacting racial equity.

7. **What data will be used to monitor the impact of this work product, report or deliverable over time?**

   Public health accountability metrics data will be collected, analyzed and reported annually. A portion of public health modernization funding to local public health authorities is tied to performance on these process measures.

PHAB vote

- Do members approve adopting the recommended process measures for 2023-25?

2024 work plan priorities

Priorities from 2023 work plan. Are these right for 2024, or are changes needed?

1. Public health system commitment to health equity
2. Public health system improvements and funding
3. Statewide population health priorities and policies
4. PHAB structure, business and member support

Required and anticipated work in 2024

- Update public health modernization funding formula for local public health authorities
- Approve the 2024 Public Health Modernization Funding Report
- Make recommendations related to future public health modernization investments
- Approve Public Health Equity Framework
- Approve Public Health System Workforce recommendations
- Approve Public Health Accountability Metrics Report, and use of accountability metrics
- Inform 2023-25 public health modernization evaluation
- Update charter and bylaws
- Elect a Chair for a two-year term