

AGENDA

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

October 20, 2021
8:00-9:30 am

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1601161415?pwd=Tmd1dHhXcGppd0VHOStZY3lOKy80dz09>

Meeting ID: 160 116 1415

Passcode: 848357

(669) 254 5252

Meeting Objectives:

- Approve August and September meeting minutes
- Begin discussion on communicable disease priorities and related measures

Subcommittee members: Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Poe, Sarah Present

OHA staff: Sara Beaudrault, Kusuma Madamala; Ann Thomas, Linda Drach, Rex Larsen, Kelly McDonald

PHAB's [Health Equity Policy and Procedure](#)

8:00-8:10 am	Welcome and introductions <ul style="list-style-type: none">• Approve August and September minutes• Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
8:10-9:20 am	Communicable Disease Priorities and Measures <ul style="list-style-type: none">• Review communicable disease data and discuss community and public health priorities• Review proposed measurement areas• Discuss how metrics selection criteria can be applied to communicable disease metrics	Ann Thomas, Linda Drach, Rex Larsen, Kelly McDonald, Oregon Health Authority
9:20-9:25 am	Subcommittee business <ul style="list-style-type: none">• Select subcommittee member to provide update at 10/21 PHAB meeting• Next meeting scheduled for 11/18	All

9:25-9:30 am **Public comment**

9:30 am **Adjourn**

All

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

August 18, 2021
8:00-9:30 am

Subcommittee members present: Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Sarah Poe

Subcommittee members absent: Sarah Present, Olivia Gonzalez

OHA staff: Sara Beaudrault, Kusuma Madamala; Gabriela Goldfarb, Emily York, Ali Hamade

PHAB's [Health Equity Policy and Procedure](#)

Welcome and introductions

June and July meeting minutes approved.

Metrics selection criteria

Sara reviewed the updated metrics selection criteria with changes from last month's meeting incorporated. In this version the criteria are separated into two distinct and necessary components:

1. Criteria for metrics that represent priorities of the communities we serve, that are actionable and drive us forward in our work to eliminate health inequities, and
2. Criteria to ensure this group selects metrics for which we have or can get data, for which data are available by county and other demographic factors, and that are within the sphere of control of the public health system.

As we begin identifying metrics and using these criteria, the subcommittee can continue to refine the selection criteria.

Kusuma asked if, for feasibility of measurement, it is acceptable to have a mechanism for collecting data even if data aren't collected yet. Would a Program Element count?

Sara replied that this would be acceptable, for example, if LPHAs are required to report data to OHA as part of a Program Element requirement but data aren't collected yet.

Cristy asked about inclusion of 2020 census data. Is this something that will be incorporated?

Sara said that updated data will be incorporated.

Cristy noted that BIPOC communities now make up nearly half of the population or close to it, which is a significant change.

Kat asked about state and local public health accountability. Are there ways to include public health influence in other conversations?

Sara said this is the work of public health, to influence where are conversations are happening that are likely to have an affect on health. Public health can be at the table for discussions and decisions.

Kusuma asked how the rating occurred with previous iterations of selecting metrics.

Sara said each selection criteria was a yes/no, with some “must pass” criteria.

Environmental Health Priorities and Measures

Gabriela provided some background on Oregon’s Building Resilience Against Climate Effects (BRACE) Program, which has existed for about 11 years, and frameworks for Oregon’s nonregulatory environmental health priorities and for building environmental health resilience.

We’re focusing on rapidly accelerating climate change which intensifies environmental health threats and inequities and is why we’re prioritizing climate in environmental public health modernization. It also covers many types of hazards and allows local public health to be responsive to local priorities and needs.

Jeanne reflected on wanting to understand how local public health agencies interact with this work. The subcommittee needs to make sure that the work we’re expecting of public health entities is work they can execute and have the resources for.

Sarah Poe noted that public health is not integrated in all public health authorities and the work is not integrated. She said this brings an opportunity, but there needs to be state emphasis for better integration at the local level. She noted Umatilla County as a leader in this area. Sarah noted disparities for air quality in rural and impoverished Eastern Oregon counties. Their air quality is significantly worse than in other areas of the state and the chronic disease state is nearly 60% for adults in Malheur County. We need to have rural counties leading this work and they are the least likely to have the resources to integrate this.

Kat asked where failing infrastructure with water systems fall and water systems where wells are drying up and people don’t have access to water?

Gabriela responded that this is “health in all policies” work and this issue of water insecurity is a new focus for OHA. She references the Governor’s 100 Year Water Vision. OHA’s direct role is to regulate public water systems. But this doesn’t address domestic wells.

Cristy asked about weaving in mental health to climate priorities.

Gabriela said this is a more recent focus and a big priority.

Emily provided examples of work OHA has done with a variety of partners, including county collaborations through a mini-grant pilot project to develop climate adaptation plans. OHA has also collaborated with some Tribes and community-based organizations. She talked about development of a climate equity blueprint.

Emily provided an overview of collaborations with community partners to learn about needs and priorities, feedback provided, and how these collaborations have guided planning. She reviewed survey results from a survey of local and tribal health authorities on where authorities are engaging, and alignment with Healthier Together Oregon.

Emily also reviewed health outcome measures that have been developed by the Tri-county area. This is included in the statewide report. Measures like this can be really useful during climate events because we can see immediate changes in metrics for things like emergency department utilization. It can be difficult to see longer-term health effects of long-term stressors.

Gabriela described that the sum of all factors our body is exposed to affects our health. This cumulative effect is why it can be difficult to separate out the unique effects of environmental harms. A lot of changes in climate work are not directly within the control of the public health system. This is why it is important for public health to be at the table for decision-making groups, including to ensure decisions advance efforts toward health equity.

Kat asked if we are ready to take advantage of federal funding opportunities.

Gabriela responded that the state public health modernization resources will set us up so that when the federal funding comes through, we will be “shovel ready”. OHA has resources, people and tools to support local public health authorities and other partners.

Sarah Poe stated that funding is needed, but her county doesn't have the staff resources. She would appreciate regional opportunities and being able to use the state expertise to support work on the ground.

Sara B. noted that the outcomes on the slide that shows social and environmental determinants of health shows how broad the connections of environment are to such a wide range of indicators. Do these translate into areas where metrics could be developed?

Subcommittee business

Sarah Poe will provide the subcommittee update at the 8/19 PHAB meeting.

The next subcommittee meeting is scheduled for 9/15. Topics are likely to include continued discussion about environmental health metrics and a first discussion about communicable disease metrics.

Public comment

No public comment provided.

Adjourn

Minutes - draft

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

**September 22, 2021
8:00-9:30 am**

Subcommittee members present: Cristy Muñoz, Jeanne Savage, Olivia Gonzalez, Sarah Present, Kat Mastrangelo

Subcommittee members absent: Sarah Poe

OHA staff: Sara Beaudrault, Kusuma Madamala; Gabriela Goldfarb, Emily York

PHAB's [Health Equity Policy and Procedure](#)

Welcome and introductions

There were not enough members present at the beginning of the meeting to approve minutes. Minutes were not approved.

Sarah Present noted scheduling confusion, with a number of subcommittee members thinking the meeting was scheduled for the previous week.

Sara Beaudrault apologized for the confusion. The meeting was rescheduled in September but is usually scheduled for third Wednesdays.

Sarah Present shared that the Portland area tri-county Regional Climate and Health Monitoring Report update is almost final. The metrics haven't necessarily changed, but it is an update looking at new data in the last three years. With the National Environmental Health Association, this group looked for valid or acceptable metrics for climate change effects on mental health but did not find a metric that would appropriately capture that. The 2019 report is available at: <https://www.co.washington.or.us/HHS/News/upload/Regional-Climate-and-Health-Monitoring-Report.pdf>.

Emily said that OHA's 2021 Climate and Health Report will be released later this year and will feature the Portland area tri-county regional report.

Sara B. provided a review of the subcommittee's group agreements, timeline and metrics selection criteria.

Environmental Health Priorities and Measures

Sara B. reviewed the structure for accountability in the existing metrics set. Previously the metrics set included outcome measures, including by race and ethnicity and geographical breakdown. But the accountability was within the related process measures, which focused on specific bodies of work by local public health authorities. The subcommittee can use a similar structure for accountability metrics moving forward or do something different. But there seems to be agreement that accountability should reside in actions and related process measures.

Gabriela talked about why OHA has focused on metrics for climate and health. Environmental health is broader than climate and health, but not necessarily by that much. Climate and health can be tailored by local communities to what their needs are. There might be different climate impacts in one community than in another, but each can work toward climate resilience. It gives a lot of flexibility for local community choice. In addition, in coming years this work will be fueled by the investments the Legislature has made and is what OHA committed to working on in the coming years. Gabriela also noted alignment with the State Health Improvement Plan.

Gabriela reviewed goals from existing plans and how to measure progress. Health equity is at the center of climate and health.

Emily discussed the Oregon Climate and Health Collaborative, which included the OHA Environmental Health section and five local public health authorities that were funded early on to develop climate and health adaptation plans. Measures included partnerships that were created or strengthened, systems change and workplace culture change. There was also a question about health equity and whether the LPHA was able to integrate health equity into climate and health communications.

Emily discussed the Statewide Climate Resilience Plan, which has sixteen overarching strategies with related metrics. These were chosen with partners.

Emily also talked about plans for the future, which includes new five-year BRACE funding from CDC. Through this funding the Environmental Health program will be developing a new climate impact compendium, which is envisioned to be an online data tool. She also reviewed the Environmental Health Capacity Grant, which includes an annual survey to local and Tribal health directors on where they're at with utilizing environmental health data and integrating climate-related strategies into their community health assessments and action plans. This could be a tool for collecting information in the future. Emily reviewed current data projects.

Sarah Present noted that she is not very familiar with the Governor's orders for addressing carbon neutrality, and the connection to statewide law and policy and actions for implementing the policy. We need to sort through all the information to determine what is doable for communities. She supports policy, partnerships and system changes and feels that, across the state, LPHAs could find things in common. She noted differences for urban and rural areas.

Gabriela responded that partnership opportunities do look different across rural and urban areas but noted the importance of having partners at the table for planning. She gave examples of smoke risks from prescribed burns and water planning.

Cristy said that some states are mapping vulnerability via zip codes. She wondered whether the metrics around how successful efforts are could be aligned with vulnerable communities. For example, people over 65, people living in areas of food deserts, mapping whether vulnerable people are living in high hazard areas. Has Oregon done similar mapping and is this being applied to metrics?

Emily replied that this is part of an interagency climate vulnerability assessment that is in the beginning stages of being scoped. This will likely include looking at social vulnerability indices. In 2015 OHA produced a first social vulnerability assessment that included eleven different indicators. We are able to map vulnerability for those indicators. This could then be layered with environmental and climate data. There is a growing interest with other partners to bring these pieces together in the climate vulnerability assessment.

Jeanne said she loves the idea and shared that the University of Wisconsin has done an area deprivation index. She has used it to look at deprivation factors in Oregon. Jeanne said that, we know from looking at those data that if you discharge two people from the hospital to different areas, a person discharged to a deprivation area is more likely to return to the hospital. It is about poverty and food deserts.

Sarah Present said that her LPHA thinks about the effects of climate change on the food production system and access to healthy food. There is so much there that doesn't always get into the conversation. Getting healthy food to people is a huge thing that can drastically improve resilience. This gets lost in the conversation about other major climate effects.

Gabriela noted the challenge in developing public health climate metrics – air quality, water quality, water quantity or food systems - that are outside our direct control. How can we have a metric for reducing poor air quality exposures, for example. We have struggled to find a reasonable expectation for public health to be held accountable. We are starting at a low level of capacity and it seems to be reasonable and appropriate to have measures that start with capacity-building and engagement.

Emily said that metrics in the past have focused on exposures and how to reduce exposures. We want to work toward this with climate change initiatives, and this will be an uphill battle. There may be other ways to measure public health progress beyond measuring exposure. We may be able to move the needle on sensitivity to exposures by looking at how well-equipped an individual or community is to protect itself from exposures. This can happen through building resilience.

Kat asked about policies for outdoor workers. Is this the type of thing that can get incorporated into public health measures?

Gabriela said that the Governor has issued a directive to OR-OSHA jointly with OHA, requiring worker protection standards from excessive heat and smoke. There is no ability to stop the work of outdoor workers. What OR-OSHA can do is require education, training, shade protection, and plans to mitigate exposures, like flexing work schedules. We could put forward metrics of how we participate in decision-making, provide education or contribute to community response plans. But there is not a nexus for public health system accountability for how well the directive is implemented or enforced.

Cristy asked about what it could look like to have metrics related to moving the needle on better policy and actionable choices. What can cross sector policy development look like and how is equitable policy developed?

Sara asked what will be helpful for the subcommittee moving forward, to organize the work.

Jeanne commented that members can think about how to use this information to direct and change policy, and how to use this information to rectify historical racial injustices. She was impacted by the last PHAB meeting and Cristy's comments. Where is our power and where will we use that power to direct policy to make the changes needed to rectify racial injustices. How do we put this information in a context that allows for SMART goals that are actionable and measure progress?

Kat agreed and said this is the interesting nexus. How do we use metrics to impact policy? Based on the charter and what the subcommittee is charged to do, how does this fit together?

Sara suggested that OHA staff pull metrics, process measures, and priorities into a single document so that the subcommittee can discuss each area with the metrics selection criteria. OHA can also compile all the resources that have been shared to have all the resource docs in one place.

Cristy said that with smoke and wildfire at the front and center of concerns, what are the policy changes that frontline organizations are wanting to see, based on what the public sector is hearing through participatory relationships. What are the commonalities statewide?

Jeanne asked about PCUN and what policy changes they want to see.

Gabriela noted that PCUN and Oregon Law Center are both voices at the table for Oregon Administrative rule-writing.

Jeanne asked at what point CBOs will be brought into this conversation.

Sara noted there is interest in outdoor workers and policy directions.

Subcommittee business

- This subcommittee will meet again before the next PHAB meeting.
 - Next meeting scheduled for 10/20
 - Current plan is to start a conversation about communicable disease metrics in October.
-
-

Public comment

None

Adjourn

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

2021 timeline for discussions and deliverables

April	<ul style="list-style-type: none"> - Discuss charter and group agreements - Hear overview on public health modernization and accountability metrics statutory requirements
May	<ul style="list-style-type: none"> - No meeting
June	<ul style="list-style-type: none"> - Finalize charter - Discuss survey modernization findings and how to apply findings to public health accountability metrics - Discuss criteria for measure selection
July	<ul style="list-style-type: none"> - Discuss and make recommendations for public health system accountability - - Discuss <i>Healthier Together Oregon</i> and its relation to public health system accountability - Continue developing criteria for measure selection - Begin review of communicable disease and environmental health outcome measures
August	<ul style="list-style-type: none"> - Finalize criteria for measure selection (deliverable) - Continue review of measures
September	<ul style="list-style-type: none"> - Continue review of measures
October	<ul style="list-style-type: none"> - Continue review of measures
November	<ul style="list-style-type: none"> - Finalize recommendations for measures - Final PHAB approval
2022	<ul style="list-style-type: none"> - Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures. - Develop 2022 public health accountability metrics

PHAB Accountability Metrics Subcommittee

Metrics selection criteria

August 2021, draft

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

Criteria can be applied in two phases:

1. Community priorities and acceptance
2. Suitability of measurement and public health sphere of control

Phase 1: Community priorities and acceptance	
Selection criteria	Definition
Actively advances health equity and an antiracist society	Measure addresses an area where health inequities exist Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination Measure is actionable, which may include policies or community-level interventions
Community leadership and community-driven metrics	Communities have provided input and have demonstrated support Measure is of interest from a local perspective Measure is acceptable to communities represented in public health data
Transformative potential	Measure is actionable and would drive system change Opportunity exists to triangulate and integrate data across data sources Measure aligns with core public health functions in the Public Health Modernization Manual
Alignment with other strategic initiatives	Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other local health plans

Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.

National or other benchmarks exist for performance on this measure

Phase 2: Suitability of measurement and public health sphere of control

Data disaggregation

Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District

When applicable, data are reportable by:

- Race and ethnicity
- Gender
- Sexual orientation
- Age
- Disability
- Income level
- Insurance status

Feasibility of measurement

Data are already collected, or a mechanism for data collection has been identified

Updated data available on an annual basis

Public health system accountability

State and local public health authorities have some control over the outcome in the measure

Measure successfully communicates what is expected of the public health system

Resourced or likely to be resourced

Funding is available or likely to be available

Local public health expertise exists

Accuracy

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



*Adapted from selection criteria used previously by the PHAB Accountability Metrics subcommittee and for selection of Healthier Together Oregon indicators and measures.

Modernized framework for governmental public health services



Communicable Disease Control *Public Health Modernization Manual*



Vision: Ensure everyone in Oregon is protected from communicable disease threats.

Communicable Disease Control *Public Health Modernization Manual*



Four functional areas:

1. Surveillance
2. Investigation
3. Intervention and control
4. Response evaluation

ACDP/Immunization/HST Proposed Accountability Metrics

Ann Thomas, MD, MPH

Acute and Communicable Disease Prevention



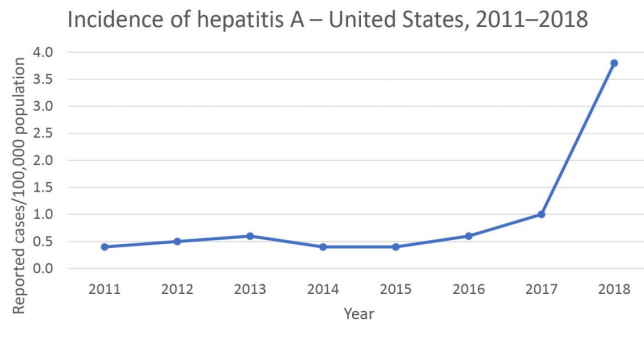
Health Disparities in Communicable Diseases: *the collision of institutional racism and social determinants of health*

- COVID-19 disproportionately impacts communities of color
- COVID-19 is more severe in persons with underlying conditions such as chronic heart and lung conditions, diabetes, obesity
- Respiratory viruses transmitted more commonly in crowded indoor settings, such as multigenerational households, congregate living facilities, correctional facilities, and work settings such as food processing plants, restaurants, bars, retail establishments
- Employees in low wage jobs tend to work while sick because they lack paid leave or job protection

Major communicable disease disparities in the pre-COVID-19 era

National

- Sharp increase in HAV in 2017
- Large outbreaks primarily affecting homeless, PWIDs, MSM, recently incarcerated, people with chronic liver disease associated with HBV/HCV
- 61% hospitalized, 1% died

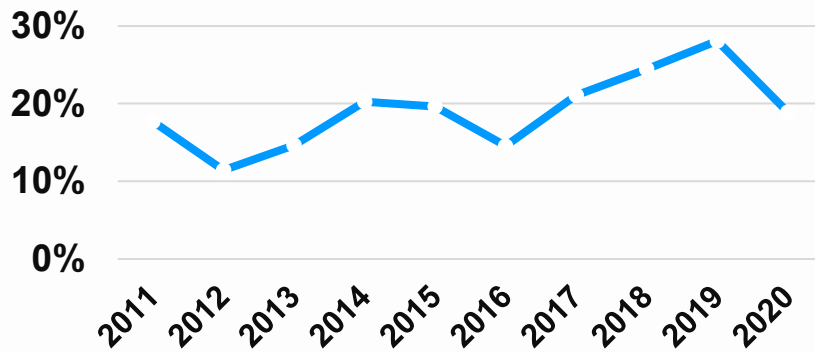


Oregon

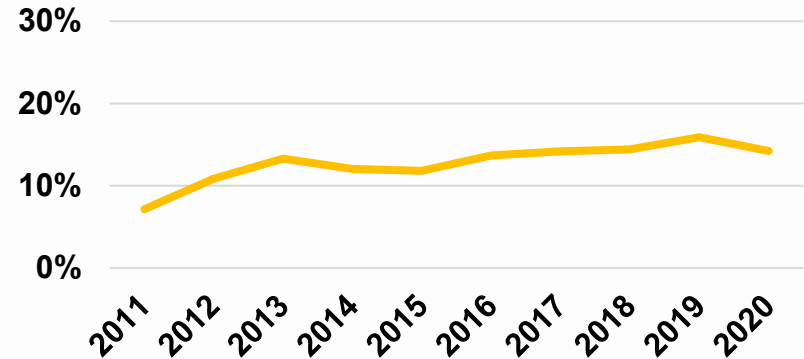
- Measles outbreaks in tri-county area among Russian-speaking immigrants
- Mumps outbreaks in Union and Multnomah counties in Pacific Islander communities
- Syndemic of opioid and methamphetamine epidemics intertwined with infectious diseases

Increase in infections associated with injection drug use

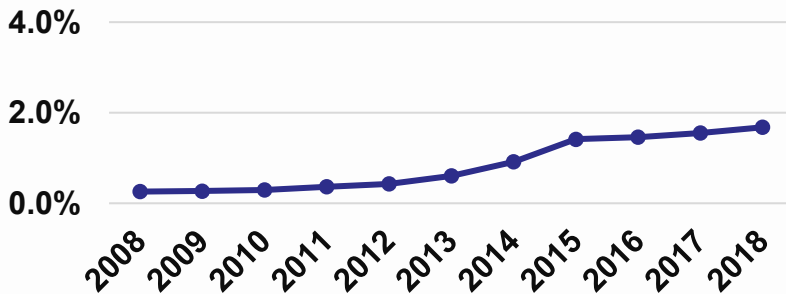
*Percent of all HIV diagnoses in PWIDs



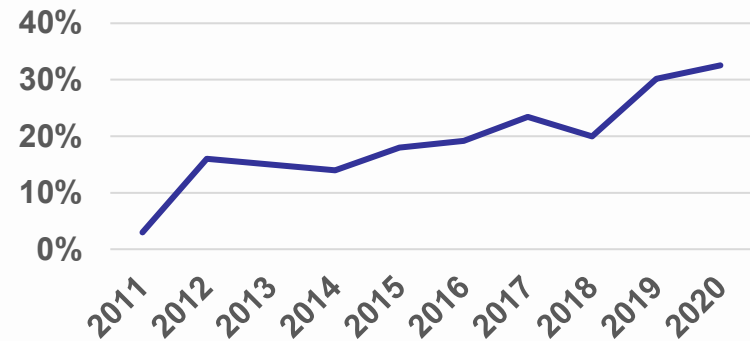
*Percent of chronic HCV cases < age 30



**Percent of all hospitalizations in PWIDs with bacterial/fungal infections

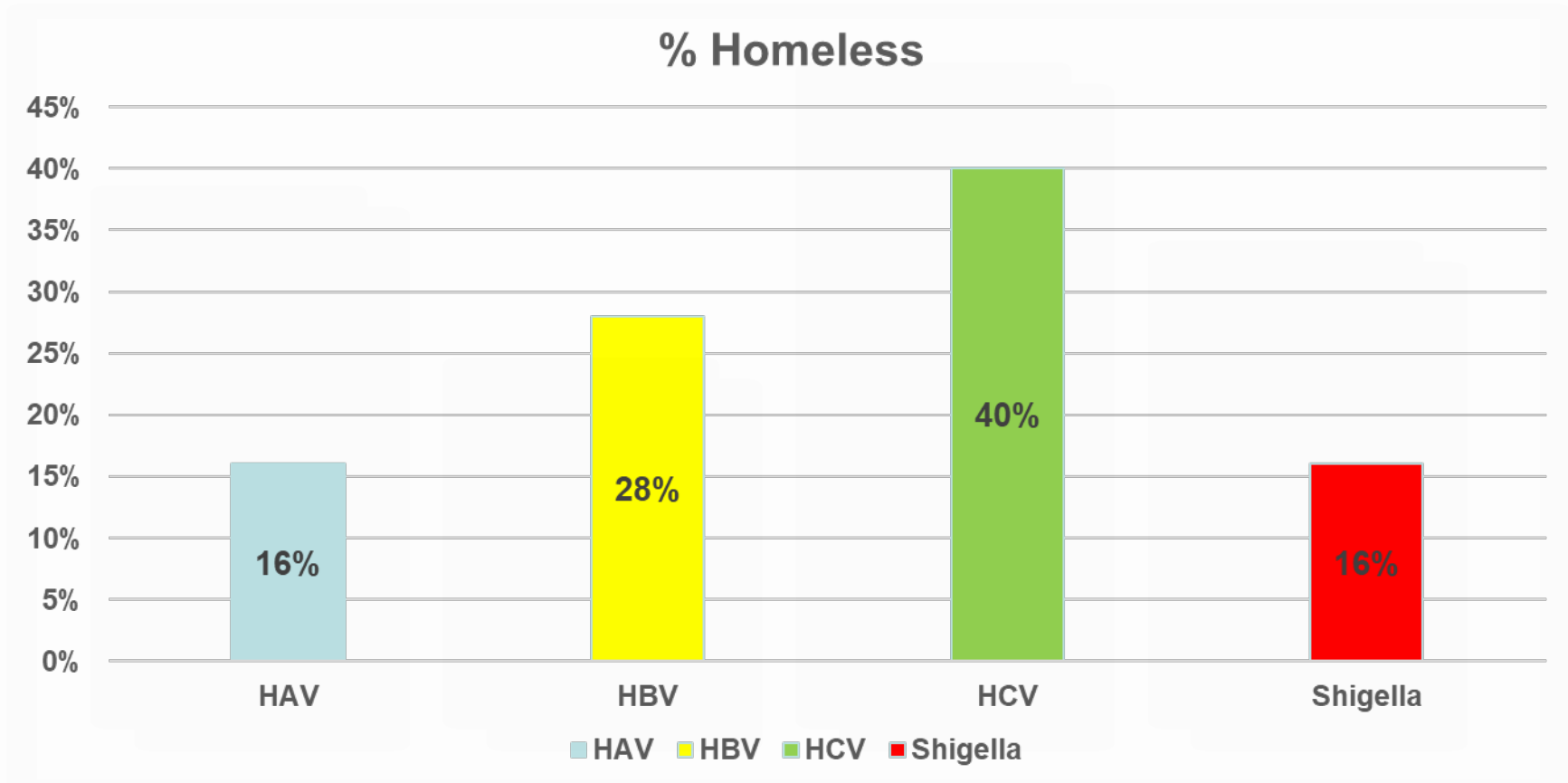


#Percent of invasive GAS cases in PWIDs



Source: * Orpheus; **OR HDD; #EIP

Percentage of cases that were homeless or unstably housed, Oregon, 2019-2020



Source: Orpheus

Racial/ethnic disparities in foodborne illnesses, Oregon, 2016-2020

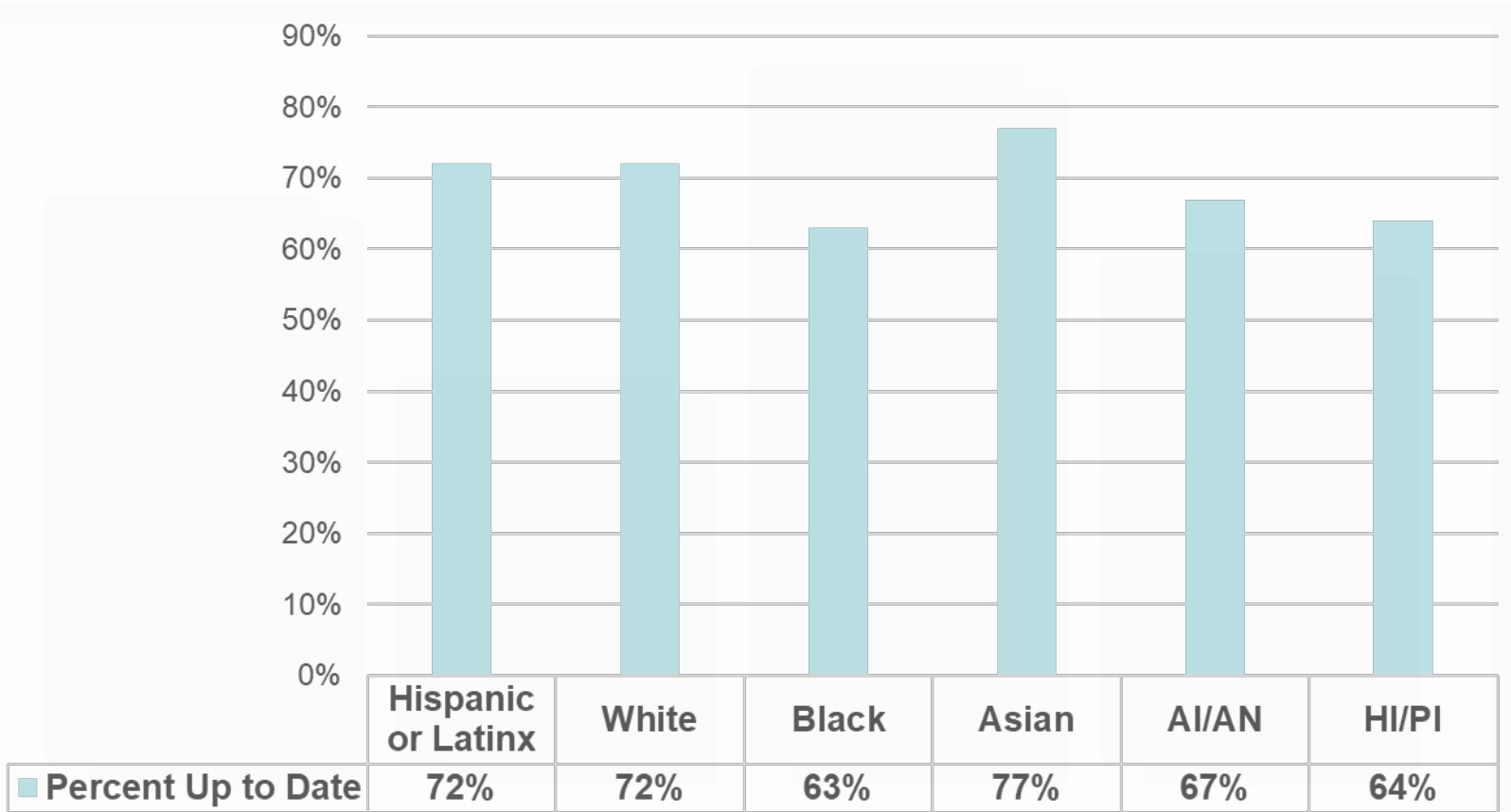
	Salmonella		Shigella		STEC	
	Rate*	RR**	Rate	RR	Rate	RR
Blacks	14.3	2.4	6.4	3.1	4.8	1.6
Asians	6.1	1.1	2.1	1.0	2.8	0.9
AI/ANs	10.3	1.8	2.6	1.3	2.6	0.9
NH/PI	13.9	2.4	11.7	5.6	-	-
Hispanic or Latinx	10.2	1.7	5.2	2.5	5.8	1.9
US rates or HP 2030 goals	HP 2030: <11.5		US rate in 2016: 3.92		HP 2030: <3.7	

*Rate in cases /100,000

**RR=Relative risk compared to Oregon average

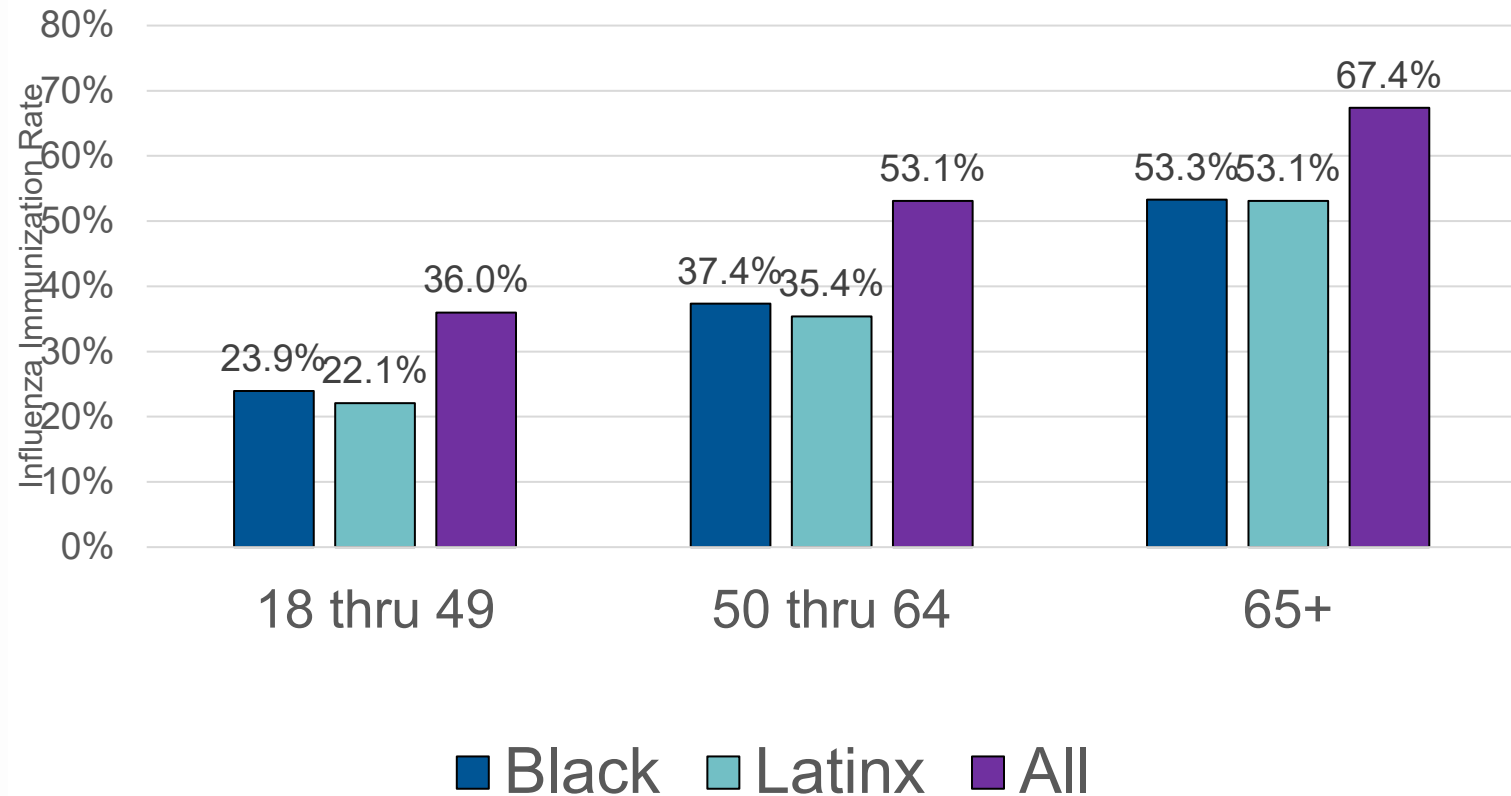
Source: Orpheus, OHA

Two-year-old up-to-date rates Oregon, 2020



Source: Oregon ALERT Immunization Information System

Oregon Adult Influenza Immunization Disparities (2019-20)



ACDP approach: Start with key vulnerable populations

I. Persons who inject drugs (PWIDs)

- Increase access to harm reduction services to reduce infections related to injection drug use

II. Homeless

- Decrease infections related to poor sanitation and lack of vaccination

III. BIPOC, immigrant, refugee, migrant and seasonal farmworkers (MSFWs)

- Increase cultural competence and level of community engagement that LPHAs have with marginalized communities to reduce foodborne and vaccine preventable diseases, particularly when related to vaccine hesitancy

How the metrics will work

- **Disease Outcomes**

- For each population, several infections could be mitigated through community-based interventions
- Counties or coalitions that adopt this measure could choose which diseases they want to focus on, based on the local burden of disease and community priorities

- **Process Indicators**

- Proposed process measures based on public health modernization foundational capabilities: health equity and cultural responsiveness, community partnership, assessment and epidemiology, policy and planning, and communications

I. Injection Drug User Health: Disease Outcomes

County level rates of:

- HIV; congenital syphilis; acute hep A/B/C; with proportion occurring among PWID; chronic cases of HCV under the age of 30 years (Orpheus);
- Invasive rates of group A streptococcus (EIP data, tricounty only)
- County level rates of hospitalizations for skin and soft tissue infections, septicemia/bloodstream infection, osteomyelitis, endocarditis in persons with substance use disorder (Oregon Hospital Discharge Dataset)
- For chronic HBV/HCV, estimates of hospitalizations for complications of chronic liver disease related to viral hepatitis (Oregon Hospital Discharge Dataset); cases of liver cancer associated with HBV/HCV (cross-match with OSCaR); rates of death related to chronic HBV, HCV (Center for Health Statistics)

I. Injection Drug User Health: Process Metrics

*County-level data on

- Syringe access and reuse estimates by SSP, pharmacy, syringe dispensing machines.
- Harm reduction supply access estimates
 - Locations: By county and organization type
 - Type and volume of supplies: safer injection, safer smoking, naloxone and wound care
 - Number of program hours per month
- Distance to access syringes
 - Average travel time to SSP distribution sites
 - Percentage of county residents within 50 miles of at least one SSP distribution site in their county

***Metrics will be tracked by LPHA or agency that supports SSP**

I. Injection Drug User Health: Process Metrics

County-level data on:

- *Access to medication for opioid use disorder (MOUD)
 - Number of SUD treatment referrals made by programs.
 - Number of medical care referrals made by programs.
- **Access to immunizations at harm reduction program locations
 - Evaluation of capacity of county or partners to offer Hepatitis A and B vaccination services at SSP and other harm reduction service locations
 - Percent of days per month that Hepatitis A and B vaccination is provided at SSP locations

***Metrics will be tracked by LPHA or agency that supports SSP**

****Metrics to be tracked by LPHA in collaboration with Oregon Immunization Program**

I. Injection Drug User Health: alignment with state and national priorities

- National goals (CDC, SAMHSA) to reduce viral hepatitis morbidity, mortality, and disparities
- Healthy People 2030 goals to reduce the incidence of HAV and HBV;
- End HIV Oregon;
- Save Lives Oregon, an initiative funded by Measure 110 funds based in the OHA Health Services Division that supports the distribution of harm reduction supplies through the Harm Reduction Clearinghouse
- Prime+ Programs in 20 counties using peers to promote harm reduction, HIV/HCV testing and treatment, linkage to care for substance use disorder
- ACDP will be convening stakeholders to draft a plan for elimination of HCV in Oregon by 2030 in 2022

II. Reduce Foodborne Disease and VPDs in homeless: Disease metric

County level rates of:

- Vaccine preventable diseases such as HAV, HBV, and pertussis, with proportion of cases occurring in homeless* individuals (Orpheus)
- Foodborne bacteria (Salmonella, Shigella, STEC), with proportion of cases occurring in homeless individuals (Orpheus)

* Collected routinely as part of case investigations since 2019

II. Reduce Foodborne Disease and VPDs in homeless: Process metrics

County level data on:

- *Volume of supplies dispensed (soap, disinfectant wipes, alcohol-based sanitizer)
- *Distance to public restrooms or availability of portable toilets to homeless camps, availability of handwashing stations, garbage disposal stations, and clean water
- **Capacity of LPHA or partners to provide Hepatitis A and Hepatitis B vaccination services in association with LPHA hygiene programs
- **Number of Hepatitis A and Hepatitis B vaccines administered in association with LPHA hygiene programs (ALERT IIS)

***Metrics will be tracked by LPHA or agency that supports SSP**

****Metrics to be tracked by LPHA in collaboration with Oregon Immunization Program**

II. Reduce Foodborne Disease and VPDs in homeless: alignment with state and national priorities

- Existing public health modernization metric to increase rates of immunizations in two-year olds
- Healthy People 2030 goals to reduce infections caused by Salmonella and Shiga toxin-producing *E. coli* (STEC) infections;
- HP 2030 immunization goals to increase the proportion of people who get the flu vaccine every year, the proportion of adults age 19 years and older who get recommended vaccines
- Regional Health Equity Coalitions (RHECs) goals that prioritize underserved communities

III. Engagement with BIPOC, immigrant, refugee, and MSFW communities: Disease metrics

County rates of:

- Vaccine-preventable diseases (focus on acute hep A and B, pertussis, measles, mumps), stratified by race and ethnicity (Orpheus)
- Foodborne diseases (STEC, salmonella and shigella) stratified by race and ethnicity (Orpheus)

III. Engagement with BIPOC, immigrant, refugee, and MSFW communities

By county:

- Vaccination rates stratified by race (ALERT IIS)
- *Completion of cultural competency workforce training
- *Development of summary report of census tract demographic and Social Vulnerability Index (SVI) data to delineate populations at risk;
- *Establishment of links to CBOs and faith-based groups providing services to identified groups; identification of trusted messengers for each identified community;
- *Capacity to create plain language information flyers on health topics and provide in appropriate languages and alternate formats
- *Development of mechanisms for community feedback such as advisory boards and community driven needs assessments

***LPHAs to track**

III. Engagement with BIPOC, immigrant, refugee, and MSFW communities: alignment with state and national priorities

- OHA's commitment to reduce health disparities by 2030
- Existing public health modernization metric to increase rates of immunizations in two-year olds
- Public health modernization foundational capacities
- HP 2030 immunization goals to increase the proportion of people who get the flu vaccine every year, the proportion of adults age 19 years and older who get recommended vaccines
- Healthy People 2030 goals to reduce infections caused by Salmonella and Shiga toxin-producing *E. coli* (STEC) infections;
- Reducing cases of STEC is a state health improvement indicator
- Regional Health Equity Coalitions (RHECs) prioritize these underserved communities

Contact information

Ann Thomas

Acute & Communicable Disease Prevention

Public Health Physician

Viral Hepatitis Program Director

ann.r.thomas@dhsoha.state.or.us

Acute and Communicable Disease Prevention (ACDP) Proposal for Equity-Based Metrics

As we have seen in the pandemic, communicable diseases often disproportionately impact marginalized communities. ACDP has oriented its proposed metrics around three particularly vulnerable populations affected by a wide range of communicable diseases: 1) persons who inject drugs (PWIDs); 2) the homeless; and 3) BIPOC, immigrant, refugee, and seasonal and migrant farmworker communities. For each of these groups, several different infections could be reduced through community-based interventions. We have proposed several infections that counties or regional health equity coalitions could choose to track.

For each population, we additionally propose process-based measures that reflect several foundational capabilities outlined in the framework for public health modernization: health equity and cultural responsiveness, community partnership development, assessment and epidemiology, policy and planning, and communications.

Given the range of diseases and proposed activities, ACDP plans to work very closely with our partners in Immunization and HST to develop these metrics in collaboration with affected communities, provide a broad range of technical assistance to LPHAs and regional coalitions that want to work towards these goals, and collect and analyze data to produce annual assessments.

Proposed Metrics

1) Increase access to harm reduction services like syringe service programs (SSPs), wound care supplies, and medication for opioid use disorder (MOUD) to reduce infections related to injection drug use

- **Disease Metrics**

- County level rates of HIV; syphilis; acute hep A/B/C syphilis with proportion occurring among PWID; chronic cases of HCV under the age of 30 years (Orpheus);
- Invasive rates of group A streptococcus (Emerging Infections Program [EIP] data, tricounty only)
- County level rates of hospitalizations for skin and soft tissue infections, septicemia/bloodstream infection, osteomyelitis,

- endocarditis in persons with substance use disorder (Oregon Hospital Discharge Dataset)
- For chronic HBV/HCV, estimates of hospitalizations for complications of chronic liver disease related to viral hepatitis (Oregon Hospital Discharge Dataset); cases of liver cancer associated with HBV/HCV (cross-match with the Oregon State Cancer Registry); rates of death related to chronic HBV, HCV (Center for Health Statistics)
- **Process Metrics**
 - County-specific¹ data on
 1. Syringe access and reuse estimates by
 - a. Outlet type: Syringe Service Program, pharmacy, syringe dispensing machines.
 - b. Level: primary, secondary
 2. Syringe reuse estimate: An estimate of the (mid-point, upper and lower) proportion of injections that are covered by sterile syringe access among “unique” PWID participants of SSPs that track with unique ID.
 3. Harm reduction supply access estimates
 - a. Locations: By county and organization type
 - b. What purchases supplies are used to support: safer injection, safer smoking, naloxone and wound care
 - c. Distribution volume of specific supplies: syringes, smoking pipes, smoking foil
 - d. Number of program hours per month
 4. Distance to access syringes
 - a. Average travel time to SSP distribution sites
 - b. Percentage of county residents within 50 miles of at least one SSP distribution site in their county
 5. Access to MOUD
 - a. Number of SUD treatment referrals made by programs.
 - b. Number of medical care referrals made by programs.
 6. Access to immunizations at harm reduction program locations

¹ Metrics 1-6 will be tracked by SSPs

- a. Evaluation of capacity of county or partners to offer Hepatitis A and B vaccination services at SSP and other harm reduction service locations
 - b. Percent of days per month that Hepatitis A and B vaccination is provided at SSP locations
 - c. Number of Hepatitis A and B vaccine administered through harm reduction programs
7. Data collected by Addictions Treatment, Prevention and Response unit (Behavioral Health section of HSD) from clients accessing substance use disorder treatment using the Government Performance and Results ACT ([GPRA](#)) [questionnaire](#):
- Participant demographics (not at REAL-D level)
 - Substance and nicotine use behaviors – including last 30 days, route, use of equipment and water after someone else, overdose
 - HIV, HCV testing, use of PrEP
 - If HIV, HBV, HCV tests were reactive/positive was person linked to treatment
 - Respondent’s living conditions, arrests/criminal justice system status, insurance, health, QOL, social connectedness, child welfare status
- **Rationale for metrics**
 - Rates of HIV and congenital syphilis among PWID, cases of chronic HCV in persons under 30 (often used as a marker of injection drug use), and hospitalizations associated with bacterial and fungal infections related to injection drug use are rising in Oregon
 - Cases of chronic HCV, along with cases of liver cancer and deaths related to HCV disproportionately affect American Indians/Alaska Natives and Blacks
 - These proposed metrics align with:
 - [CDC’s 2025 strategic plan](#) to reduce new viral hepatitis infections, reduce viral hepatitis-morbidity and mortality, and reduce viral hepatitis-related disparities;

- Healthy People 2030 goals to reduce the incidence of [HAV](#) and [HBV](#);
 - A [SAMHSA advisory](#) for screening and treatment of viral hepatitis in people with substance use disorder
 - [End HIV Oregon](#);
 - [Save Lives Oregon](#), an initiative based in the OHA Health Services Division that supports the distribution of harm reduction supplies through the Harm Reduction Clearinghouse (funded by Measure 110 Funds);
 - Additionally, ACDP will be convening stakeholders to draft a plan for elimination of HCV in Oregon by 2030 in 2022
-
- These metrics also overlap with several indicators being used to evaluate the PRIME+ program, a collaboration between ACDP, Comagine, and the Addictions Treatment, Prevention and Response Unit (part of OHA's Health Services Division) that utilizes peer recovery specialists in 20 Oregon counties to connect people to care, resources and services before and after an overdose, infection, or other health issue related to substance use

2) Decrease infections related to poor sanitation and lack of vaccination among homeless

- **Disease Metrics**

- County levels of rates of vaccine preventable diseases such as HAV and HBV and various foodborne bacteria occurring in homeless (Orpheus); with proportion of cases occurring among homeless.

- **Process Metrics**

- County level of volume of supplies dispensed (soap, disinfectant wipes, alcohol-based sanitizer); distance to public restrooms or availability of portable toilets to homeless camps, availability of handwashing stations, garbage disposal stations, and clean water

- Access to immunization services
 - Capacity of LPHA or partners to provide Hepatitis A and Hepatitis B vaccination services in association with LPHA hygiene programs
 - Number of Hepatitis A and Hepatitis B vaccines administered in association with LPHA hygiene programs (ALERT IIS)
- Rationale for Metric
 - Large outbreaks of HAV across the nation since 2017 have occurred in homeless populations
 - Since ACDP began collecting data on housing status for many reportable diseases in 2019, homelessness has commonly been identified among cases of HAV, HBV, HCV, and Shigella
 - Since 2015, ACDP has investigated one cluster of HAV and three outbreaks of Shigella in the homeless
 - This metric aligns with:
 - Healthy People 2030 goals to reduce infections caused by Salmonella and Shiga toxin-producing *E. coli* (STEC) infections;
 - HP 2030 immunization goals to increase the [proportion of people who get the flu vaccine](#) every year, the [proportion of adults age 19](#) years and older who get recommended vaccines
 - Regional Health Equity Coalitions (RHECs) goals that prioritize underserved communities

3) Increase cultural competence and level of community engagement/outreach that LPHAs have with marginalized communities (such as BIPOC populations, immigrants, refugees, migrant and seasonal

farmworkers) to improve prevention and control of vaccine preventable diseases, particularly when associated with vaccine hesitancy

- **Disease Metrics**

- Rates of vaccine-preventable diseases (focus on acute hep A and B, pertussis, measles, mumps) stratified by race (Orpheus)

- **Process Metrics**

- Vaccination rates stratified by race
- Completion of cultural competency workforce training
- Development of summary report of census tract demographic and Social Vulnerability Index (SVI) data to delineate populations at risk;
- Establishment of links to CBOs and faith-based groups providing services to identified groups; identification of trusted messengers for each identified community;
- Capacity to create plain language information flyers on health topics and provide in appropriate languages and alternate formats
- Development of mechanisms for community feedback such as advisory boards and community driven needs assessments

- **Rationale for Metric**

- Several large outbreaks of vaccine preventable diseases such as measles and mumps in recent years have involved under-vaccinated immigrant communities
- Rates of pertussis among Hispanics are twice the Oregon average
- This aligns with:
 - OHA's commitment to reduce health disparities by 2030
 - Existing public health modernization metric to increase rates of immunizations in two-year olds
 - Public health modernization foundational capacities

- HP 2030 immunization goals to increase the proportion of people who get the flu vaccine every year, the proportion of adults age 19 years and older who get recommended vaccines
- Regional Health Equity Coalitions (RHECs) prioritize underserved communities

4) Increase cultural competence and level of community engagement/outreach that LPHAs have with marginalized communities (such as BIPOC populations, immigrants, refugees, migrant and seasonal farmworkers) to improve prevention and control of foodborne diseases

- **Disease Metrics**

- Rates of foodborne diseases (STEC, salmonella and shigella) stratified by race (Orpheus)

- **Process Metrics**

- Completion of cultural competency workforce training
- Development of summary report of census tract demographic and Social Vulnerability Index (SVI) data to delineate populations at risk;
- Establishment of links to CBOs and faith-based groups providing services to identified groups; identification of trusted messengers for each identified community;
- Capacity to create plain language information flyers on health topics and provide in appropriate languages and alternate formats
- Development of mechanisms for community feedback such as advisory boards and community driven needs assessments

- **Rationale for metrics**

- Higher rates than the Oregon average of STEC, Salmonella and Shigella in Hispanics and Blacks; elevated rates of Salmonella

among American Indians and Alaska Natives; elevated rates of Salmonella and Shigella in Pacific Islanders and Native Hawaiians

- This metric aligns with:
 - OHA's commitment to reduce health disparities by 2030
 - Healthy People 2030 goals to reduce infections caused by [Salmonella](#) and [Shiga toxin-producing *E. coli* \(STEC\)](#) infections;
 - Reducing cases of STEC is a [state health improvement indicator](#)
 - Regional Health Equity Coalitions (RHECs) prioritize underserved communities

Background:

State and local HIV and STI services are guided by End HIV Oregon, Oregon's comprehensive strategy to end new HIV transmissions in Oregon. End HIV Oregon, launched on World AIDS Day 2016, was developed under the guidance of Oregon's statewide planning group. Members and partners of the statewide planning group include state and local public health, CBOs, and community members living with HIV/STI and vulnerable to HIV/STI. End HIV Oregon includes specific metrics that align with the national HIV and STI Strategies, and which include community-developed local measures and activities. The proposed PHAB measures align with End HIV Oregon. *(Note: Community planning for End HIV Oregon is ongoing, and a new 5-year plan is currently in development. Suggested updates to these measures may be offered as they are presented by the HIV/STI community planning group.)*

Proposed METRICS:

Outcome: Proportion of people newly diagnosed with HIV who achieve viral suppression within 90 days of diagnosis.

Process: Proportion of people newly diagnosed with HIV enrolled in Early Intervention Services (EIS).

Number of formal funded partnerships between OHA/LPHAs and CBOs related to STI/HIV.

Percent increase in LPHA and Oregon State Public Health Lab billing revenue for HIV/STI services.

Number of FQHCs and CBOs serving undocumented persons who receive information about CAREAssist, other HIV treatment services, and Cover All People as it relates to HIV/STI.

Number of rural health providers educated about rapid start antiretroviral therapy and the best practice clinic processes needed to implement it.

Rationale for Metric:

- Viral suppression indicates effective treatment for HIV. People living with HIV who are virally suppressed have zero chance of transmitting HIV to sexual partners and have the best chance for optimal health and longevity.
- A key pillar of End HIV Oregon is ending disparities by ensuring equal access to HIV treatments.
- Viral suppression within 90 days indicates quick linkage to care/access to treatment.
- Although new diagnoses represent a small number of people each year, this metric measures the overall health of the public health system related to HIV/STI treatment, partner services, access to care, and coordination between public and private medical and social support systems.

Data sources:

- ORPHEUS/eHARS (valid, reliable, easily accessed, consistent, stable)
- OHA/LPHA program data (EIS, Ryan White HIV/AIDS Program Services, OHA/HMA billing assessment)

Outcome: Proportion of people in Oregon with a PrEP prescription.

Process: Proportion of HIV-negative EISO clients (people with syphilis or rectal gonorrhea) who receive a PrEP referral.

Number of medical providers enrolled in the PrEP Directory.

Number of pharmacists trained to dispense PrEP and PEP under Oregon's new pharmacist-delivered PrEP/PEP law.

Increased proportion of Chime In participants (especially PWID, low-income women, and low income men who identify as heterosexual) who are aware of PrEP.

Rationale:

- Pre-exposure prophylaxis (PrEP) is a pill that is 99% effective in preventing HIV infection.

- Currently, PrEP is underutilized in Oregon. It is a resource disproportionately used by white MSM in urban areas (e.g., there are disparities by race/ethnicity, gender, and geography).
- Data from Chime In (a survey of populations vulnerable to HIV, conducted in the Portland metro area) found that while most MSM were aware of PrEP and 1 in 5 HIV-negative MSM had taken PrEP in the past 12 months, PrEP awareness was low (and use extremely low) among people who inject drugs and low-income heterosexuals.

Data sources: AIDS Vu, ORPHEUS, Chime In (National HIV Behavioral Surveillance System), OHA/LPHA Program Data (easily accessed, consistent, stable. Fairly valid and reliable.)

(Note: Although PrEP prescription data can be accessed through All Payer/All Claims data, the delay in accessing those data make AIDS Vu a more reliable source for tracking metrics.)

Alternate Upstream Outcome Measures:

Percentage of population age 12+ with a substance use disorder in past year.

(source: SAMHSA; this is a Healthier Together Oregon metric)

Percentage of population that is food insecure. (source: Feeding America; Healthier Together Oregon metric)

Percent of population that lacks transportation. (source: U.S. Census; predictive measure from Oregon Vulnerability to Injection Drug-Related Outbreak Assessment)

EXISTING PHAB METRICS:

Outcome: Gonorrhea incidence rate per 100,000 population

Process: Percent of gonorrhea cases that had at least one contact that received treatment
Percent of gonorrhea case reports with complete priority fields

Communicable Disease Control *Public Health Modernization Manual*



- What additional information would you like from today's presenters?
- What resonates, and how does the information shared today align with your community's priorities?
- Which areas would the subcommittee like to continue to explore?

Health areas and measures	Measure source/related plan	Indicator/outcome measure or Accountability metric/process measure	Data source	Notes	Phase 1 Selection Criteria: Community priorities and acceptance					Phase 2 Selection Criteria: Suitability of Measurement and Public Health Sphere of Control				
					Actively advances health equity and an antiracist society	Community leadership and community-driven metrics	Transformative potential	Alignment with other strategic initiatives	Feasibility of measurement	Data disaggregation	Feasibility of measurement	Public health system accountability	Resourced or likely to be resourced	Accuracy
Public health modernization priority: Environmental health														
Percent of commuters who walk, bike, or use public transportation to get to work	Current public health accountability metric (PHAB)	Indicator/outcome												
Local public health authority participation in leadership or planning initiatives relates to active transportation, parks and recreation, or land use	Current public health accountability metric (PHAB)	Acct. metric/process												
Percent of community water systems meeting health-based standards	Current public health accountability metric (PHAB)	Indicator/outcome												
Percent of water systems surveys completed	Current public health accountability metric (PHAB)	Acct. metric/process												
Percent of water quality alert responses	Current public health accountability metric (PHAB)	Acct. metric/process												
Percent of priority non-compliers resolved	Current public health accountability metric (PHAB)	Acct. metric/process												
# of CBOs that T+LPHAs have partnered with to build climate resilience	Healthier Together Oregon/ EH Capacity program baseline	Acct. metric/process												
# of T+LPHAs that have integrated EPH/climate data into their CHAs	EH Capacity program baseline measure	Acct. metric/process												
# of T+LPHAs that have integrated climate related strategies into their CHIPs.	EH Capacity program baseline measure	Acct. metric/process												
% of T+LPHAs that have begun to engage in climate change conversations	EH Capacity program baseline measure	Acct. metric/process												
% of T+LPHAs that have begun to assess climate and health risks	EH Capacity program baseline measure	Acct. metric/process												
% of T+LPHAs that have begun to implement climate-related interventions	EH Capacity program baseline measure	Acct. metric/process												
INSERT BRACE program measures for enhance and expand community partnerships; compile evidence and best practices implement adaptation actions;		Acct. metric/process												
Outdoor worker protections														
Communicable disease control														
Percent of two-year olds who received recommended vaccines	Current public health accountability metric (PHAB); Healthier Together Oregon	Indicator/outcome												
Percent of Vaccines for Children clinics participating in IQIP	Current public health accountability metric (PHAB)	Acct. metric/process												
Gonorrhea incidence rate per 100,000 population	Current public health accountability metric (PHAB)	Indicator/outcome												
Percent of gonorrhea cases that had at least one contact that received treatment	Current public health accountability metric (PHAB)	Acct. metric/process												
Percent of gonorrhea case reports with completed data priority fields	Current public health accountability metric (PHAB)	Acct. metric/process												
Proportion of people newly diagnosed with HIV who achieve viral suppression within 90 days of diagnosis.	End HIV Oregon	Indicator/outcome												
Proportion of people newly diagnosed with HIV enrolled in Early Intervention Services (EIS).	End HIV Oregon	Acct. metric/process												
Number of formal funded partnerships between OHA/LPHAs and CBOs related to STI/HIV.	End HIV Oregon	Acct. metric/process												
Percent increase in LPHA and Oregon State Public Health Lab billing revenue for HIV/STI services.	End HIV Oregon	Acct. metric/process												
Number of FQHCs and CBOs serving undocumented persons who receive information about CAREAssist, other HIV treatment services,	End HIV Oregon	Acct. metric/process												
Number of rural health providers educated about rapid start antiretroviral therapy and the best practice clinic processes needed to implement it.	End HIV Oregon	Acct. metric/process												
Proportion of people in Oregon with a PrEP prescription.	End HIV Oregon	Indicator/outcome												

