AGENDA

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

April 28, 2023 12:00-1:00 PM

Join ZoomGov Meeting https://www.zoomgov.com/j/1616889251?pwd=YXQyS2RmZEFId0JnTUJMazF5MGIwQT09

Meeting ID: 161 688 9251 Passcode: 157025 (669) 254-5252

Meeting Objectives:

- Approve April 11 meeting minutes
- Review feedback from local public health authorities on communicable disease priority areas and indicators
- Discuss recommendations to PHAB on communicable disease priority areas and indicators, with focus on vaccine preventable diseases and seasonal and emerging respiratory pathogens
- Discuss moving toward a syndemic approach to communicable disease accountability metrics

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

PHAB's Health Equity Policy and Procedure

9:00-9:10 AM	 Welcome and introductions Approve April 11 meeting minutes Review group agreements and proceeding with metrics discussions that are person-centered 	Sara Beaudrault, Oregon Health Authority
9:10-9:50 AM	 Communicable disease priorities and indicators Discuss feedback provided by LPHAs on communicable disease priority areas Discuss recommendations for vaccine preventable diseases Discuss recommendations for seasonal and emerging respiratory pathogens Discuss moving toward a syndemic approach to communicable disease accountability metrics 	All

	 Decision: Is the subcommittee prepared to recommend communicable disease priorities and indicators to PHAB in May? If not, what additional information would the subcommittee like to discuss? 	
9:50-9:55 AM	 Subcommittee business The next meeting is scheduled for 5/9 at 9:00-10:00 	All
9:55-10:00 AM	Public comment	
10:00 AM	Adjourn	All

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 <u>publichealth.policy@dhsoha.state.or.us</u>, at least 48 hours before the meeting.

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



April 11 Subcommittee discussion and recommendations

Based on:

- Input provided by state and local communicable disease staff through the CLHO communicable disease accountability metrics workgroup
- Input provided by LPHA officials through consultation, and
- PHAB Accountability Metrics subcommittee discussions and data reviews

The PHAB Accountability Metrics subcommittee

- 1. Recommends that PHAB adopt sexually transmitted infections and three related indicators for syphilis for public health accountability metrics.
- 2. Will continue to discuss vaccine preventable diseases and seasonal and emerging respiratory pathogens as possible areas for accountability metrics.
 - The CLHO CD accountability metrics workgroup recommends vaccine preventable diseases and would like the PHAB subcommittee to discuss options for maintaining focusing on seasonal and emerging respiratory pathogens, even if not an accountability metric.
- 3. Will not continue to discuss Hepatitis C, foodborne diseases, HIV or Tuberculosis at this time.

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

Collective responsibility a	Oregon Health Authority and local public health authority accountability	
Health priorities Policy actions		Public health data, partnerships and policy
Public health assessment	Public health policy development	Public health assurance
Indicators of health outcomes	Measures of policy landscape	Measures of foundational capabilities
What are priority health issues throughout Oregon?How are policies contributing to or eliminating root causes of health inequities?Which groups experience disproportionate harm?How are policies contributing to or eliminating root causes of health inequities?		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?
Level of accountability		Level of accountability
The governmental public health system as a whole, other sectors and partners, elected officials.		OHA and individual LPHAs
Oregon's Public Health Advisory Boa	ard has a critical role to influence	
necessary policy changes.		

Framework for public health accountability metrics

Past accountability metrics	New metrics framework
Minimal context provided for disease risks and root causes of health inequities	Provides context for social determinants of health and systemic inequities resulting from systemic racism and oppression
Focus on disease outcome measures	Disease outcomes used as indicators of progress, but are secondary to process measures of public health system accountability
Focus on programmatic process measures	Focus on data and data systems; community partnerships; and policy.
Focus on LPHA accountability	Focus on governmental public health system accountability.
Minimal connection to other state and national initiatives	Direct and explicit connections to state and national initiatives.

Proposed communicable disease priority areas and indicators

The following priority areas and indicators have been developed by state and local public health authority staff. The goal is for the PHAB subcommittee to eventually narrow recommendations to 1-2 priority areas and one or more related indicators.

Priority areas	Indicators
Seasonal and emerging respiratory pathogens	 All respiratory outbreaks (influenza-like illness, RSV, COVID and others) in long-term care facilities Influenza hospitalizations and mortality rates Influenza vaccination rates
Sexually transmitted infections	 Rate of congenital syphilis Rate of any stage syphilis among people who can become pregnant Rate of primary and secondary syphilis Rate of gonorrhea
HIV	 Rate of new HIV infections Proportion of people living with HIV with an undetectable viral load within three months of diagnosis Proportion of people living with HIV with an undetectable viral load in the prior year
Vaccine preventable diseases	 Rates of high impact vaccine preventable diseases (i.e. pertussis, measles), including by race, ethnicity, gender, sexual orientation, housing status (includes carceral settings), injection drug use Adolescent vaccination rates Adult vaccination rates Two-year old vaccination rates

•	School vaccination rates and non-medical exemption rates
Viral hepatitis •	 Rates of acute hepatitis, including by race and ethnicity, gender, sexual orientation, housing status (includes carceral settings), injection drug use
Foodborne diseases •	Rates of foodborne diseases, including by race, ethnicity, gender, sexual orientation, housing status (includes carceral settings), injection drug use
Tuberculosis •	Rate of active TB infection

Public Health Accountability Metrics Communicable Disease

April 4, 2023

Sara Beaudrault Kusuma Madamala, Ph.D Tim Menza, MD Ann Thomas, MD Rex Larsen



PUBLIC HEALTH DIVISION Office of the State Public Health Director

Today's agenda

- 1. Accountability metrics overview
- 2. Communicable disease priorities and indicators
 - Sexually transmitted infections
 - HIV
 - Seasonal and emerging respiratory pathogens
 - Viral hepatitis
 - Vaccine preventable diseases
 - Foodborne diseases
 - Tuberculosis
- 3. Discussion

PUBLIC HEALTH DIVISION

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Public health accountability metrics overview



Oregon Revised Statutes and Administrative Rule

- ORS 431.123: Establish accountability metrics for the purpose of evaluating the progress of OHA and LPHAs in achieving statewide public health goals.
- OAR 333-014-0540: OHA will consult with LPHAs through CLHO on proposed changes to accountability metrics. LPHAs will be notified of changes and updates when finalized by the Public Health Advisory Board.



PUBLIC HEALTH DIVISION

Office of the State Public Health Director

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Groups involved in developing and updating metrics

CLHO metrics workgroups

Work with OHA staff to develop recommendations

CLHO

• Provide LPHA leadership perspective on metrics

PHAB Accountability Metrics Subcommittee

Review and synthesize metrics recommendations; develop recommendation for PHAB

PHAB

• Formally adopt public health accountability metrics





Today's consultation

Questions we hope to answer:

- Which 1-2 priority areas and indicators do LPHAs recommend? Why?
- Which priority areas and indicators do LPHAs recommend against? What are the issues, challenges or barriers?

Ways we are collecting feedback:

- Verbal feedback provided today
- Feedback provided in the Chat today
- LPHA accountability metrics survey



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Sexually transmitted infections



Issue summary: Why is this a priority now, and which groups are experiencing disproportionate harm?

Syphilis diagnoses are higher than ever, including among people who can become pregnant, people who are pregnant, and infants. Persistent and systemic causes of inequities that impact the syphilis epidemic include poverty, housing instability, racism, stigma, the criminal justice system, substance use, and mental and behavioral health challenges.



Recommendations

If STIs is selected as a priority area, OHA recommends the following indicators:

- Rate of congenital syphilis
- Rate of syphilis (all stages) among people who can become pregnant
- Rate of primary and secondary syphilis
- Rate of gonorrhea
- Rationale
 - The three indicators together provide a more comprehensive understanding of the dramatic increase in syphilis cases, which groups are most affected and areas for intervention.
 - The rate of gonorrhea was a prior public health accountability metric



Data for indicators

Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*
Sexually transmitted inf	ections			-	
Rate of congenital syphilis	ORPHEUS	END HIV/STI Oregon	Black, Native American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander people, people who use drugs, people who are unhoused, people involved in the criminal justice system, youth, queer and trans people, people with prior STI diagnoses, people who live in rural and frontier areas	Yes	Yes
Rate of any stage of syphilis among people who can become pregnant	ORPHEUS	END HIV/STI Oregon	Same as listed above	Yes	Yes
Rate of primary and secondary syphilis	ORPHEUS	END HIV/STI Oregon	Same as listed above	Yes	Yes
Rate of gonorrhea	ORPHEUS	END HIV/STI Oregon, Healthier Together Oregon	Same as listed above	Yes	Yes



Early (Infectious) syphilis diagnoses are higher than ever

Cases of primary, secondary and non-primary non-secondary (early) syphilis, 1967-2021





Since 2019, the rate of syphilis diagnoses has been increasing rapidly



Primary and Secondary (P/S) syphilis diagnoses almost tripled among people assigned female at birth between 2019 and 2021



Almost 50% of people assigned female at birth with syphilis in Oregon do not have an identifiable risk factor for infection



There were no congenital syphilis cases in 2013 and 37 cases in 2022

Cases of congenital syphilis and rate of early syphilis among people assigned female at birth,



Syphilis in Pregnancy, Oregon, 2014-

- 202 pases of syphilis in pregnancy from 2014 through 2021
 - 15 cases among 45557 pregnancies, or 3 cases per 10,000 pregnancies, in 2014
 - 86 cases among 40931 pregnancies, or 21 cases per 10,000 pregnancies, in 2021
- 96 (28%) of those pregnancies resulted in a case of congenital syphilis
 - 2/15 (13%) cases in 2014
 - 27/86 (32%) cases in 2021



Syphilis Disproportionately Affects Pregnant People of Color

• Median age 27 years (IQR: 22-31, range 16-43)

Race	People with an infant with CS, n(%)	People with a live birth, %*	* Average
American Indian/Alaska Native	5 (5%)	1%	proportio
Black/African American	5 (5%)	2%	n of live
Native Hawaiian/Pacific Islander	5 (5%)	1%	DIRTINS by
Hispanic/Latina/o/x	11 (11%)	19%	ethnicity
Multiracial, other race	1 (1%)	4%	from
Asian	1 (1%)	5%	2014-
White	66 (69%)	67%	2021



Housing Instability and Criminal Justice Involvement are Very Common

Housing

- 34/96 (35%) were houseless or unstably housed
 - Unstable housing includes incarceration, moving homes, or residing in a substance use disorder treatment facility or group residence during pregnancy
 - 32/96 (33%) were missing housing status

Criminal justice involvement (2014-2020 only)

- 42/69 (61%) had any history of criminal justice involvement
 - 17/69 (25%) had criminal justice involvement in the 12 months prior to or during pregnancy, including incarceration during pregnancy, community supervision, outstanding cases or warrants



Many Report Substance Use and Have Had Prior HIV/STI and HCV Diagnoses

Substance use

- 46/96 (48%) had a history of injection drug use
- 43/96 (45%) had a history of methamphetamine use
- 18/96 (19%) had a history of heroin/opiate use
 - 32/96 (33%) were missing data on injection drug use
 - 1/96 (1%) were missing data on meth/heroin use

HIV/STI and HCV

- Most patients reported 1 male sexual partner in the prior 12 months (max = 3)
- None were known to be living with HIV
- 43/96 (45%) had a history of either chlamydia or gonorrhea
 - 41/96 (43%) had a history of chlamydia
 - 18/96 (19%) had a history of gonorrhea
- 11/96 (11%) had chronic HCV prior to diagnosis of syphilis in pregnancy



Gonorrhea diagnoses have been increasing over time with a reduced rate of increase over time



https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/Gonorrhea_16536733712190/Story2021







Issue summary: Why is this a priority now, and which groups are experiencing disproportionate harm?

Overall, HIV diagnoses have decreased over time in Oregon. However, the decreases in HIV have largely been experienced by white cisgender gay men living in urban areas. Persistent, systemic factors of racism, homophobia, transphobia, trauma, stigma, housing instability, substance use, and mental and behavioral health continue to drive new infections among Black/African American, Indigenous, Native Hawaiian, Pacific Islander, and Latinx/o/a/e people, youth, transgender people, people who use methamphetamine, and people who live in rural areas.



Recommendations

If HIV is selected as a priority area, OHA recommends all three of the following indicators:

- Rate of new HIV infections
- Proportion of people living with HIV with an undetectable viral load within three months of diagnosis
- Proportion of people living with HIV with an undetectable viral load in the prior year
- Rationale
 - The three indicators together provide a comprehensive understanding of HIV in Oregon and areas for intervention from HIV transmission to rapid care linkage and initiation of antiretrovirals to the impact of effective long term treatment.
 - These indicators align with End HIV/STI Oregon



Data for indicators

Proposed indicators HIV Rate of new HIV infections	Data source	Other Oregon plans that use these measures (if any) END HIV/STI Oregon	Populations that experience a disproportionate burden of illness, death or risks Black, Native	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*
HIV Rate of new HIV infections	ORPHEUS	END HIV/STI Oregon	Black, Native	Yes	
Rate of new HIV infections	ORPHEUS	END HIV/STI Oregon	Black, Native	Yes	
			American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander people, people who use drugs, people who are unhoused, people involved in the criminal justice system, youth, queer and trans people, people with prior STI diagnoses, people who live in rural and frontier areas		res
Proportion of PLWH with an undetectable viral load within 3 months of diagnosis	ORPHEUS	Same as above	Same as above	Yes	Yes
Proportion of PLWH with an undetectable viral load in the prior year	ORPHEUS	Same as above	Same as above	Yes	Yes
					Tealth

HIV incidence in Oregon has been declining over time




Viral suppression at last lab draw and within 3 months of diagnosis have been increasing



https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/EndHIV

HIV-related health inequities by race and ethnicity persist in Oregon

Black, Native Hawaiian Native Oregonians had Multiracial, White and	n/Pacific Islander, Latinx, and American Indian/Alaska I higher rates of new HIV diagnoses compared to Asian Oregonians (New HIV cases per 100,000), 2017-	Viral suppression at th American Indian/Alask Oregonians, 2021 (High	ne last collection date was lower than 75% among a Native, Multiracial and Black/African American ner is better, 2022 goal = 90%)
2021		American Indian/Alaska Native	68.0%
Black/African American		Multiracial	69.0%
Native Hawallan/Pacific Islander Hispanic/Latiny		Black/African American	72.9%
American Indian/Alaska	8.2	Native Hawaiian/Pacific	75.0%
Native	* * * * * * * 7.8	Hispanic/Latiny	76 2%
White	4.4		
white	▲ ▲ ▲ 3.9	Asian	77.0%
Asian	▲ ▲ 2.6	White	77.2% -

https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/EndHIV



Seasonal and emerging respiratory infections



Issue summary: Why is this a priority now, and which groups are experiencing disproportionate harm?

	Influenza	COVID-19			
CDC burden of disease estimates	Oct 2022 to March 2023 39 million illnesses 46,000 hospitalizations 37,000 deaths	Feb 2020 to Sept 2021 124 million illnesses 7.5 million hospitalizations 921,000 deaths			
Population at risk	Elderly; people who live in congregate settings; Black people, Indigenous, Hispanic/Latino/a people, and Native Hawaiian/Pacific Islander people; pregnant people, individuals with comorbid health conditions such as heart disease, lung disease, immunocompromising conditions				



Recommendations

If Seasonal and Emerging Pathogens is selected as a priority area, OHA recommends the following indicators:

- All respiratory outbreaks (influenza-like illness, RSV, COVID and others) in longterm care facilities
- COVID Hospitalizations and deaths
- Influenza hospitalization and mortality rates
- Influenza vaccination rates
- COVID vaccination rates
- Rationale
 - The selected indicators reflect multiple facets of public health responses to seasonal and emerging pathogens, including responding to outbreaks as well as ongoing prevention work
 - LPHAs historically have responded to and provided control measures formation to any provided control measures for any provided control measures

Data for indicators

Proposed indicators Data source Differ Delight pairs in the set these measures (if any) County level or other geographic breakdowns Deta can be stratified* Seasonal and emerging respiratory pathogens Elderly, people who live in congregate settings, Black, Native American/Alaska Native, Latinx, Native Hawaiian/Pacific Islander REALD/SOGI unavailable, but age, gender, census and insurance data are people, pregnant people, people with comorbid health conditions such as heard disease, lung disease, influenza-like liness, RSV, COVID and others) in long- term care facilities Native Hawaiian/Pacific Islander people, pregnant people, people with comorbid health conditions such as heard disease, lung disease, influenza-like liness, RSV, COVID and others) in long- term care facilities No individual level data care, staff likely to be embers of marginalized populations (low noome, low educational attainment) No individual level data collected, typically track collected, typically track program COVID-Net care, staff likely to be ambers of marginalized populational attainment) No individual level data collected, typically track collected, typically track program COVID-Net data, Center for Health Statistics Influenza hospitalization and motality rates Emerging Inflections Program COVID-Net data, Center for Health Statistics Elderly, people who live in congregate settings, Black, Native American/Alaska Native, Latinx, native Hawaiian/Pacific Islander people, pregnant people, comorbid health conditions such as heat disease, lung disease, people with munuccompromising conditions Statewide Statewide and insurance data are available for hospitalizations health Key Performance Measure St			Other Oregon plans that us	Populations that experience a	Data are reportable at a	
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congregate settings, Black, Native age, sex, race and ethniicty, American/Alaska Native. Latinx.	COVID vaccination	ALERT IIS		Flderly, people who live in		Data can be stratified by
American/Alaska Native, Latinx.				congregate settings, Black, Native		age, sex, race and ethniicty.
				American/Alaska Native, Latinx.		and geographic area down
Native Hawaijan/Pacific Islander to zip code.				Native Hawaijan/Pacific Islander		to zip code.
people, pregnant people, with				people, pregnant people, people with		
comorbid health conditions such as				comorbid health conditions such as		
heart disease				heart disease lung disease		
immunocompromising conditions				immunocompromising conditions		

Outbreaks of influenza in LTCFS

Typical year (2018-19) in pre-pandemic era

Influenza Outbreaks: There were 0 influenza outbreaks reported during Week 18, 2019. There have been a total of 156 influenza outbreaks reported to the Oregon Health Authority in the 2018–2019 flu season, 109 of which have occurred in long-term care facilities, 35 of which have occurred in schools, and 3 of which occurred in a hospital.



Figure 4. Number of Influenza Outbreaks in Oregon by Setting, 2018-2019 Season

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Outbreaks of COVID-19 in LTCFs, 2020-2023 (as of March 9, 2023)



Number of Outbreaks

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Seasonal Respiratory Virus Vaccination COVID-19 Vaccination by Age



Seasonal Respiratory Virus Vaccination COVID-19 Vaccination by Race and Ethnicity





Seasonal Respiratory Virus Vaccination

Influenza Vaccination by Season





Seasonal Respiratory Virus Vaccination

Influenza Vaccination by Season



Seasonal Respiratory Virus Vaccination

Adult Influenza Vaccination Statewide and by County

Oregon: Adult Immunization Rates

	2016-2017	2017-2018	2018-2019	2019-2020
Influenza Vaccination Rates ^{a,b}				
Female				
18 to 49 years	32.4%	33.6%	38.2%	41.6%
50 to 64 years	49.7%	52.0%	53.7%	57.2%
≥65 years	63.6%	66.1%	69.4%	69.8%
Male				
18 to 49 years	20.8%	22.3%	25.7%	29.6%
50 to 64 years	42.6%	44.5%	45.9%	48.6%
≥65 years	60.1%	62.6%	65.4%	64.5%
All adults				
18 to 49 years	27.0%	28.3%	32.4%	36.0%
50 to 64 years	46.4%	48.5%	50.0%	53.1%
≥65 years	62.0%	64.5%	67.6%	67.4%



Vaccine preventable diseases



Issue summary: Why is this a priority now, and which groups are experiencing disproportionate harm?

An unintended consequence of the response to COVID-19 was a sharp reduction in routine immunization of children, adolescents and adults, leaving groups at higher risk of diseases that are preventable. Public health can improve vaccination rates by addressing access barriers, providing culturally relevant outreach and education and working with health care and other partners.



Recommendations

If vaccine preventable diseases are selected as a priority area, OHA recommends any combination of the following indicators:

- Rates of high impact vaccine preventable diseases (pertussis, measles), including by race, ethnicity, gender, sexual orientation, housing status (includes carceral setting), injection drug use.
- Adolescent vaccination rates/HPV rates
- Adult vaccination rates
- Two year old vaccination rates
- School vaccination rates and Non-medical exemption rate



		Other Oregon plans	Populations that experience a	Data are reportable at	
Proposed indicators	Data course	that use these	disproportionate burden of	a county level or other	Data can be stratified*
Proposed indicators	Data source		disproportionate builden of	geographic	Data can be stratilled
		measures (if any)	illness, death or risks	breakdowns	
Vaccine preventable di	iseases	_!	•	<u>I</u>	!
Rates of high impact					
vaccine preventable					
diseases (pertussis.					
measles)					
Adolescent vaccination	ALERT IIS	Existing CCO	Elderly, infants and young		Data can be stratified
rates		incentitve measure for	children, people who live in		by age, sex, race and
		HEDIS adolescent	congregate settings. Black.		ethnicity. Medicaid and
		combo 2	Native American/Alaska		Vaccines for Children
			Native, Latinx, Native		Program participation
			Hawaijan/Pacific Islander		and deographic area
			people pregnant people		down to zin code
			people with comorbid health		
			conditions such as heart		
			disease lung disease		
			immunocompromising		
			conditions		
Adult vaccination rates			Elderly infants and young		Data can be stratified
			children, neonle who live in		by and say race and
			congregate settings Black		ethnicity Oregon
			Nativo Amorican/Alaska		Vaccino Accoss
			Native Latinx Nativo		Program Participation
			Hawaijan/Pacific Islandor		for uningurod adulte
			navaliari/Facilic Islander		
			people, pregnant people,		down to zin oodo
			people with comorbid health		down to zip code.
			diagona lung diagona		
			disease, lung disease,		
			Immunocompromising		
T					Data and ha stratified
i wo year old vaccination	ALERIIIS		Elderly, infants and young		Data can be stratified
ales		measure for HEDIS	children, people who live in		by age, sex, race and
		childhood combo 3	congregate settings, Black,		ethnicity, Medicaid and
			Native American/Alaska		VAccines for Children
		Existing PH	Native, Latinx, Native		Program participation
		modernization goal to	Hawaiian/Pacific Islander		and geographic area
43		increase rates of	people, pregnant people,		down to zip code.
		vaccinations in 2 year	people with comorbid health		

Incidence of pertussis (cases per 100,000) in Oregon vs US, 2001-2020



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Incidence of pertussis by age and sex, Oregon, 2020



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Incidence of pertussis by race and ethnicity, Oregon, 2011-2020





Note: Rates based on small case counts might be unstable.



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Routine Vaccination 2 Year-Old-Vaccination Rates

	2014	2015	2016	2017	2018	2019	2020	2021
Two-Year-Olds ^a Up-to-Date Rate ^b								
4:3:1:3:3:1:4 ^c	60%	64%	66%	68%	69%	71%	71%	71%
4 doses DTaP	76%	77%	78%	80%	80%	81%	81%	80%
3 doses IPV	87%	88%	89%	89%	89%	90%	90%	89%
1 dose MMR	87%	89%	88%	88%	88%	91%	90%	88%
3 doses Hib	87%	87%	88%	88%	88%	89%	89%	88%
3 doses HepB	82%	83%	85%	85%	85%	87%	87%	87%
1 dose Varicella	85%	86%	86%	87%	86%	88%	88%	87%
4 doses PCV	72%	75%	76%	77%	77%	78%	79%	78%
1 dose HepA	86%	87%	87%	87%	87%	88%	88%	87%
2-3 doses Rotavirus	65%	67%	68%	70%	71%	72%	74%	75%
1 dose Flu (in most recent season)	55%	52%	54%	55%	57%	61%	64%	58%
One or more VFC vaccines ^{d,e}	60%	64%	65%	66%	66%	69%	68%	68%
No VFC vaccines ^{d,e}	59%	<mark>63</mark> %	67%	71%	73%	75%	76%	76%
Hispanic ^{d,f}	63%	<mark>68</mark> %	70%	69%	72%	74%	72%	72%
White ^{d,f}	60%	64%	67%	69%	70%	72%	72%	72%
African American ^{d,f}	55%	59%	60%	62%	61%	61%	63%	63%
Asian ^{d,f}	64%	68%	69%	73%	73%	76%	77%	77%
American Indian and Alaskan Native ^{d,f}	60%	63%	65%	66%	66%	69%	67%	66%
Hawaiian/Pacific Islander ^{d,f}	54%	59%	61%	62%	61%	65%	64%	64%

2021 2 Year-Old-Vaccination Rates



*Rates not displayed for populations of fewer than 50 people.

Routine Vaccination Adolescent Vaccination Rates

Oregon: Adolescent Immunization Rates

	2017	2018	2019	2020	2021	2022
Thirteen- to Seventeen-Year-Old ^{a,b} Vaccination Rates						
Tdap (1 dose)	93%	93%	93%	92%	90%	91%
Meningococcal A,C,W,Y (1 dose)	75%	77%	80%	81%	81%	81%
Flu (1 dose in most recent complete season)	25%	28%	30%	32%	33%	25%
HPV initiation (1+ dose)	65%	67%	70%	73%	71%	73%
HPV completion (2-3 doses) ^c	44%	46%	51%	55%	55%	53%
HPV completion ^c by race/ethnicity ^d						
Hispanic ^d	56%	56%	60%	62%	65%	64%
White ^d	46%	49%	53%	56%	57%	58%
Black/African American ^d	53%	54%	57%	59%	58%	58%
Asian ^d	53%	56%	59%	62%	62%	64%
American Indian and Alaskan Native ^d	56%	59%	64%	67%	67%	66%
Native Hawaiian/Pacific Islander ^d		53%	57%	60%	59%	59%
Thirteen-Year-Old ^{e,f} Vaccination Rates ^g						
Tdap (1 dose)	80%	82%	84%	81%	84%	83%
Meningococcal A,C,W,Y (1 dose)	66%	67%	71%	69%	73%	72%
HPV initiation (1+ dose)	52%	56%	65%	57%	61%	63%
HPV ^c completion (2 doses)	33%	32%	33%	30%	34%	35%
Teen series ^h	30%	30%	31%	28%	33%	33%

May 2022 Adolescent Vaccination Rates

2022 HPV Completion Rates, 13- to 17-year-olds



Hepatitis C virus (HCV)



Issue summary:

Why is this a priority now, and which groups are experiencing disproportionate harm?

- Oregon has the second highest HCV-related mortality rate in the country, and the third highest prevalence of HCV
- New cases (acute) of HCV are most common in persons 20-29 years, and the proportion of chronic cases of HCV occurring in this age group has tripled in the past 3 years
- The most common route of transmission is injection drug use
 - People who use drugs are a heavily stigmatized population with mental and behavioral health issues and high rates houselessness
- Although APAC data shows a trend of increasing testing in this age group between 2010-2019, treatment of HCV patients in their 20s lags behind
- Rates of HCV mortality are highest in Black and Indigenous people
- Access to harm reduction services and treatment particularly difficult in rural Oregon
 Oregon

Recommendations

If viral hepatitis is selected as a priority area, OHA recommends the following indicator:

- Rates of acute HCV, including by race, ethnicity, gender, sexual orientation, housing status (includes carceral setting), injection drug use
- Rates of chronic HCV cases occurring in persons < 30 years
- Rationale
 - Most new cases occur in young people who inject drugs, so to interrupt transmission of disease, critical need is to focus efforts on harm reduction programs and promotion screening/linkage to treatment for young adults
 - Oregon has goal to eliminate HCV by 2030



Data for indicators

Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*		
Viral hepatitis	2	•					
Rates of acute hepatitis C, including by race, ethnicity, gender, sexual orientation, housing status (includes carceral setting), injection drug use.	ORPHEUS	Oregon HCV Elimination Plan	Black and Indigenous people, people who inject drugs, houseless populations, carceral settings, rural populations		REALD/SOGI data available, along with age and risk factors.		
Rates of chronic HCV in persons under 30 years of age	Same	Same	Same		Age, gender, county		
UBLIC HEALTH DIVISION							
Office of the State Pub	Office of the State Public Health Director						

Age group of cases of acute hepatitis, 2016-2020, Oregon





Figure 2. Proportion of chronic HCV cases in persons aged 20-29 years, Oregon, 2010-2019





Race and ethnicity of cases of acute hepatitis, 2016-2020, Oregon

Race	HAV	HBV	HCV	Population of Oregon
AI/AN	1%	1%	3%	2%
Asian	5%	5%	3%	5%
Black	1%	1%	5%	2%
Pacific Is.	2%	4%	0%	0.5%
White	76%	74%	72%	75%
Multiple	4%	1%	3%	4%
Other/Unk	12%	15%	16%	-
Ethnicity				
Latinx	12%	7%	7%	13%



Characteristics of persons screened for HCV, Oregon 2010-2019





Gender	%
Male	41%
Female	59%



Characteristics of persons initiating treatment for HCV, Oregon 2010-2019



Foodborne diseases



Issue summary:

Why is this a priority now, and which groups are experiencing disproportionate harm?

- CDC estimates 48 million people get sick, 128,000 are hospitalized, and 3,000 die from foodborne disease each year in US
 - Over 400 cases of Salmonella are reported each year in OR
 - Although less common, E. coli 0157 and other Shiga toxin-producing E. coli (STEC) infections cause painful bloody diarrhea
 - Children and elderly have a 2%-7% risk of developing hemolytic uremic syndrome, higher in OR than rest of US
- Disparities
 - Children (especially daycare outbreaks)
 - In 2020 a large outbreak occurred of Shigella primarily in houseless populations or people working with houseless populations
 - Shigella common in MSM
 - Racial and ethnic disparities for Salmonella, Shigella, STEC in Oregon



Recommendations

If foodborne diseases are selected as a priority area, OHA recommends the following indicator:

- Rates of Salmonella, Shigella and STEC, including by race, ethnicity, gender, sexual orientation, housing status (includes carceral setting), injection drug use.
- Rationale
 - LPHAs in Oregon routinely investigate cases and outbreaks of foodborne illness
 - Opportunities for prevention include education about handwashing, proper handling of raw foods, avoidance of certain food items (unpasteurized milk), prompt investigation and implementation of control measures


Data for indicators

Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*
Foodborne diseases	6				
Rates of foodborne illness, including by race, ethnicity, gender, sexual orientation, housing status .	Orpheus		Children, elderly, people living in congregate settings, Black, NH/PI, Hispanic or Latino/a people, MSM	Yes	Yes



Rates of STEC in Oregon vs US, 2001-2020

Incidence of STEC infection: Oregon vs. nationwide, 2001–2020



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

	Salmonella		Shigella		STEC	
	Rate*	RR**	Rate	RR	Rate	RR
Black	14.3	2.4	6.4	3.1	4.8	1.6
Asian	6.1	1.1	2.1	1.0	2.8	0.9
AI/AN	10.3	1.8	2.6	1.3	2.6	0.9
NH/PI	13.9	2.4	(11.7)	5.6	Ō	-
Hispanic or Latino/a	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



65 Source: Orpheus, OHA

Tuberculosis



Issue summary: Why is this a priority now, and which groups are experiencing disproportionate harm?

 Active TB infection has been stable over time in Oregon. However, the rate of active TB has increased dramatically among Pacific Islanders and continues to affect those involved in the criminal justice system, people who experience housing instability, and new arrivals to Oregon from other countries.



Recommendations

If Tuberculosis is selected as a priority area, OHA recommends the following indicator:

- Rate of active TB infection
- Rationale
 - TB elimination is a key public health priority
 - This measure is consistent with the CDC TB Elimination Plan



Data for indicators

Proposed indicators	Data source	Other Oregon plans that use these measures (if any)	Populations that experience a disproportionate burden of illness, death or risks	Data are reportable at a county level or other geographic breakdowns	Data can be stratified*			
Tuberculosis								
Rate of active TB infection	ORPHEUS	National TB Elimination Plan	Pacific Islanders, people who are unhoused, people involved in the criminal justice system, new arrivals to the US from other countries	Yes	Yes			



The rate of active TB in Oregon has held steady over time



https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/Tuberc ulosisAnnualProfile/1-Main?publish=yes



Discussion

 Which of the priority areas discussed today <u>should be prioritized</u> as a statewide area of focus for public health accountability metrics? Why would you prioritize this area/these areas?

2. Which of the priority areas discussed today <u>should not be</u> <u>prioritized</u> as a statewide area of focus for public health accountability metrics? Why would you recommend against selecting this area/these areas?



Wrap up and next steps

PUBLIC HEALTH DIVISION

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