AGENDA

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

January 10, 2023
9:00-10:00 AM

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

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

Meeting Objectives:

- Approve November and December meeting minutes
- Discuss community feedback on environmental health indicators
- Discuss subcommittee expectations for measures of structural determinants for environmental health

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

PHAB's Health Equity Policy and Procedure

9:00-9:05 AM	**Welcome and introductions** • Approve November and December minutes • Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
9:05-9:50 AM	**Environmental health priorities and measures** • Review available data for proposed indicators • Hear about community feedback provided on indicators and discuss whether additional feedback is needed • Discuss expectations for the development of measures for structural determinants of health **Goals for discussion** 1. Determine the extent to which indicators meet metric selection criteria	All

	2. Determine whether community feedback provided is sufficient or if additional feedback should be requested 3. Advise on metrics development for structural determinants of health	
9:50-9:55 AM	**Subcommittee business** • Identify subcommittee member to provide update at January 12 meeting • Discuss meeting schedule for 2023	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 publichealth.policy@dhsoha.state.or.us, at least 48 hours before the meeting.

Public Health Advisory Board
Accountability Metrics Subcommittee
11/8/2022
9am – 10:30am

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

Subcommittee members absent: Cristy Muñoz, Ryan Petteway, Kat Mastrangelo

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Elliot Moon, Corinna Hazard, Amanda Spencer

Guest presenters: Kathleen Johnson, Lauralee Fernandez, Laura Daily

Public meeting, recording not posted but used for minutes

Local members here to go into CLHO metrics work

Welcome and Introductions:

- Went over agenda for the meeting.
- PHAB will be recruiting for new members for all subcommittees.
- October meeting minutes approved.

Recap of Public health accountability metrics – Measure tiers
Sara B. reviewed framework of measure tiers that were approved by subcommittee in October:

- Includes measures across three tiers/types:
    - Indicators (assessment) – Similar to health outcomes commonly used in public health. We are using these indicators to know what priority health issues really are and which communities are most affected. These indicators are separate from what is trying to be achieved which will be mostly done through process measures and policy work.
    - Public Health process measures, public health data, partnerships, and policy (assurance)
    - Structural determinants of health (policy development)
        - There will be work done to identify measures around structural determinants. This work will be focused on social and economic policies that are affecting our priories around environmental health and communicable disease.

Discussion

- Sara: The CLHO communicable disease group (which is not present at this meeting) has voiced concerns that the shift in focus to policy and structural determinants will detract from the core communicable disease program work which is more service based and not focused on policy.
    - Jeanne: There may be some unintended consequences, but that is okay. Work on the individual level will continue and will not go away and going forward we need to look at where we are spending more time and resources because we are trying to get upstream at the drivers which will require shifting focus and resources.
    - Sarah P: Stated her agreement with Jeanne and added that this framework shifts the responsibility off communicable disease staff and puts it on LPHA leadership and OHA.
    - Jocelyn: Helpful not to be too narrowly focused on policy interventions in the form of legislative measures. Structural solutions and policy changes don't necessarily have to be done through the legislative process. Communicating the importance of public

health and policy work can be difficult if there are not metrics that point to a reduction of disease.
    - Sara B: What are examples of nonpolicy interventions that can address structural determinants of health like access to care barriers?
    - Jocelyn: Structural non-policy interventions could be things like bus routes, transportation, housing, food access, and social cohesion by creating spaces that enable communities to come together (i.e., park space and community centers).
- Jocelyn: How do we draw the line from structural interventions to disease burden in communities?
    - Jeanne: It can be difficult to show the impact of public health and policy work over short periods of time when often it can take 5 to 10 years to really see the impact of public health policy. While we might except to make progress on a goal in 5 years (and should make some adjustments if we don't see any improvement) we also cannot throw everything out if we are not reaching all goals right away because long term policy interventions take long terms to measure.
        - Kusuma: It will take time to see impact of structural and policy changes, but these are core governmental public health roles.
        - Sara B: We can build our communicable disease programs while at the same time we do more policy and systems level work.
        - Sara B: The structural determinants Jocelyn discussed (housing, social cohesion, neighborhood livability, access to food, etc.) are part of the state health improvement plan and most of the community health improvement plans. Most communities also identify those priorities as important, so it is important that are priorities are reflective of these areas that communities highlight.

Environmental health measures

Introduction
Sara B provided overview of what CHLO members will discuss and went over selection criteria:

- CLHO committee has been meeting since July or August to identify what are the environmental health and climate health priorities across Oregon, and what possible metrics could be used.
- CLHO committee will talk through their ideas of what indicators could be, what data sources and metrics that already exist, what are their limitations, and how they align with the selection criteria.
    - Selection criteria:
        1. Advances healthy equity and an antiracist society
        2. Community leadership and community-led metrics; issue has been identified as a priority by community members
        3. Issue has been identified as a priority by public health professionals
        4. Direct and explicit connections to state and national initiatives
        5. We have data on a county/local/neighborhood level instead of just a state level – Criteria not listed on slide

Public health accountability metrics – Environmental Health: Overview
Kathleen went over metrics that the CHLO Environmental Health group came up with:

- Another factor considered for metric development was whether something can be tracked over time over several years so that there is historical context and trends over time can tracked.
- One thing that came up for CLHO committee was thinking about how local and state policy shapes build environment and access to resources that help communities adapt and/or build resilience.
- Another thing to consider is that these are statewide indicators, so it may be good to find some flexibility because local climate policies may be different for different communities which may have different priorities.
- The indicators/outcomes for extreme heat and air quality came from the Council of State and Territorial Epidemiologists.
    - These indicators have also been used in a regional health climate and monitoring report published by Multnomah, Clackamas, and Washington counties.
    - This data can be flawed (especially when trying to focus on health equity) since it leaves out many people who might have barriers to presenting to an Emergency Department.
- Water security and safety (drought, wells drying up, harmful algal blooms) can be a concern for some areas and communities, but the challenge is figuring out the connection to governmental public health as governmental public health is not always responsible for water systems.
    - Public health does have domestic well safety programs and will inspect small drinking water systems.
- OHA put out qualitive report on the impacts of climate change on youth mental health.
- State may have access to data that they can provide to LPHAs around mental health that could be used to help measure the impacts of climate change on mental health, but new measures may also need to be created.
- How does state public health support LPHAs in accessing and understanding data?
- There may also be staffing concerns as many LPHAs don't have an epidemiologist on staff and may have limited fully time employees (FTEs) for public health in general. There is also a concern about whether local public health staff are trained in climate and health and understanding climate and health data.

Discussion

- Sara B: Indicators for extreme heat and air quality strongly align with the selection criteria as there is already some data that exists, these are areas with deep health inequities, PHAB has wanted to highlight these areas, and these are areas that communities are concerned about.
    - Other areas, like water security, wildfires, and mental health effects of climate change, are priorities but there are not currently many good existing data sources or measures that can be used.
    - Local public health authorities can also be limited in their ability to talk about climate change.
- Sarah P: What is needed now is increase the ability to track those extreme heat and air quality related health outcomes which don't have to be directly linked to climate change.
    - Even if LPHAs don't have FTEs dedicated to climate and health, in many counties it is important for public health to just be at the table during conversations about climate change.
- Elliot: There is a dry well tracking within state and is managed by a state organization outside of public health. So even if some things are outside of public health, we still can have a role.
    - Private well safety could use a LOT of help and improvement across the state.
- Elliot: Responding to emergences might be another bucket as OHA and LPHAs can have a role.

- Jeanne: When thinking about health indicators, are we picking one or two? Which one are we picking? Is that for us to decide?
    - Sara: This could be a narrowing down opportunity. CHLO has given this broad list of health indicators, not all of which currently have data or measures. Would recommend choosing one or two of the indicators (likely Extreme heat and/or air quality) as even just one of those areas will be a lot of measures.
    - Kusuma: One thing to consider which might help the process is where are there existing measures that align with each indicator.
- Kathleen: Can LPHAs pick one indicator, or is it one indicator one for all LPHAs? How is progress measured? Is it compared to progress within county itself over time, or to other LPHAs? Is helpful to have just one indicator, or maybe three that each LPHA could decide which indicator they want to track?
    - Jeanne: Agreed with Kathleen's question about how flexible we want to be.
    - Kathleen: OHA is not dictating what is put in LPHA's local and climate adaptation plans. So, it would make sense for LPHAs to choose how they are being measured based on what they are including in their plans.
    - Sara B: Selecting an indicator may not necessarily require LPHAs to do specific work. Part of public health modernization is resourcing LPHAs to be able to address their local priorities.
    - Sarah P: Our statute for PHAB has flexibility around recommendations to make metrics. Modernization has a lot of flexibility.
- Kusama: Important to consider how to make a story for when sharing results. How will that flexibility allow us to share a story within a report.
- Lauralee: Thinking back to different indicators in the buckets. Different counties have different priorities. Emphasizing standards and easy access to data for LPHAs so they can choose what is relevant to them.
- Sarah P: Numbers seem to be less impactful with people and policy makers than personal stories (i.e., How OHA reached underserved communities with covid vaccination).
- Sara B: Can Jeanne talk more about the focus areas of CCOs, what their roles will be and how that will be measured?
    - Jeanne: Due to recent Medicaid waiver, CCOs can provide housing and food benefits that can come directly out of Medicaid funds. There is also an environmental aspect of that which allows people to qualify to receive things like air conditioners or air purifiers.
        - This allows a lot of partnership opportunities for the state, LPHAs, CCOs, and CBOs.
        - It is important to make sure that public health doesn't duplicate work of CCOs, but instead tries to complement that work.
- Kathleen: Washington county would probably select something like extreme heat and air quality as priorities for the first five years, but then at the same time would probably start background work for understanding water security/quality concerns that they should be anticipating.
- Sara B: We can select areas like extreme heat or air quality, but then LPHAs can decide how to do that work in ways that make the most sense for them in their communities.
- Sara B: In communicable disease, they might consider a domain to be preventing communicable disease among those who are homeless. Local public health could tailor what that looks like based on their data and the needs in their communities.
- Jeanne: Is it necessary to build a system to responding to extreme climate events? In most regions, at the LPHA level, is there a protocol and response for extreme climate events?

    - Sarah P: At the local level, response to extreme events is usually housed disaster management or emergency response and not public health.
    - Joslyn: Some places it would be in public health, but it differs greatly from county to county. In Lane County, when public health is involved, it often is in a capacity of providing warning, preparation, and prevention instead of responding when disasters happen.
- Kusuma: Is communications a public health role across all these areas?
    - Sarah B: Communicating health information generally is a public health role, but how that information gets implemented may or may not be a role for local public health depending on the county.
- Jeanne: We are dealing with the long-term impact environmental health and the intersection with public health, which does not involve emergency response.
- Jeanne: Sounds like the current basic function of public health in environmental and extreme climate work is communication, informing of what is coming, tracking, planning, and cohesion building of partnerships. Is that right, is there anything else?
    - Sara B: Would also include bring data and policy experience. Being at the table where policy conversations are happening, and policy decisions are being made.
- Jeanne: How do we take lenses of health equity and put it into coordination of response, planning and communication? Do we say going forward do we break down data into various demographics and look at impact based on that and then communicate that data to our partners to inform decisions around extreme climate events? Is that what we are doing or working towards?
    - Kathleen: In Washington county, that is what they are headed and where they are going. There can be flaws in data. Also try to collect data about where people were when an event happened (Were they outside? Were they unhoused?) to get an idea of what happen when people are presenting with health outcomes like heat related illnesses. There can be some missing pieces as it is based on if providers documenting the data (it is not imputed by patients) and there can be barriers for presenting at ED.
        - We go to community partners with that and try to understand what might be missing.
        - We also work closely with emergency management to develop plans and messages that center health equity. Like understanding best placement for emergency shelters, understanding that many people prefer to shelter at home, and making sure that commutations around extreme climate events go out in many languages.
    - Jeanne: Are all LPHAs doing this work or is this an ideal state that we should measure and try to get all LPHAs to?
        - Sara B: Washington County is ahead of many LPHAs, but many LPHAs are working towards this goal.
        - Jeanne: Do we want to put this kind of process into the metrics and track if LPHAs are setting up their systems to an ideal state, or do we want to focus on something outside of public health process.
        - Jocelyn: What would be the metric around planning? Do we have characteristics around planning? It seems not to focus much on health outcomes.
        - Sarah P: Don't want to lose sight of improving the well safety program even if not in modernization.

        - Sara B: LPHAs are currently working on developing plans. There are ways to look at those plans and look to see if they have certain metrics. It might not resonate though to spend funding on and then to have the only result be plans. There should be a connection to health outcomes.
- Sara: There is a through line from helping LPHAs to helping people during heat events or events related to air/water quality.

Subcommittee business

- Jocelyn volunteered to provide the subcommittee update at the next PHAB meeting.
- Next meeting is focus on environmental health again, and then start conversations on communicable diseases in the beginning of 2023.
- Subcommittee members provided availability and Sara B. will schedule next meeting.
- No public comment.

Meeting was adjourned

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD
Accountability Metrics Subcommittee

December 13, 2022
9:00-10:00 am

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

OHA staff: Sara Beaudrault, Kusuma Madamala, Diane Leiva, Elliot Moon, Ann Thomas, Amanda Spencer

Guest presenters: Kathleen Rees, Lauralee Fernandez, Kathleen Johnson

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Welcome and introductions
Sara B

- Participants introduced themselves.
- Went over agenda for the meeting.
- Went over subcommittee deliverables:
    1. Recommendations for updates to public health accountability metrics framing and use, including to eliminate health inequities.
    2. Recommendations For updates to communicable disease and environmental health metrics.
    3. Recommendations on engagement with partners and key stakeholders as needed.
    4. Recommendations for developing new metrics, as needed.
    5. Recommendations for sharing information with communities.
- November meeting minutes provided in email, will vote on them during January 2023 meeting.
- Went over subcommittee calendar.

Agenda for Environmental Health Measures:
Sara B

- Hear CLHO accountability metrics recommendations for environmental health priorities and indicators.
- Hear update on work to develop state and local process measures for foundational capabilities.
- Discuss expectations for the development of measures for structural determinants of health.

- Brief review of metrics selection criteria for indicators:
    - Advances healthy equity and an antiracist society
    - Community leadership and community-led metrics; issue has been identified as a priority by community members
    - Issue has been identified as a priority by public health professionals
    - Direct and explicit connections to state and national initiatives

PH Accountability metrics – Environmental Health – State:
Elliot

- All indicators for extreme heat and air quality are tracked and reported in different formats by the state, so question for state is how to report out that information and in what format.
- LPHA workforce capacity: A needs assessment could be completed to determine the statewide workforce capacity to use heat related health data (and policy air quality data).
- Assessment and Epidemiology: Number of technical assistance resources and trainings given related to health even data sources.
- Policy and Planning: Number of interventions and amount spent on home based extreme heat adaptations through the Healthy Homes Grant Program.
- Community Partnership Development: Number of CBOs and amount of funding given by OHA Modernizations that have heat related programing in their workplans.
- Communication: Number of outreach events and education materials produced related to new workplace heat rules (Executive Order 20-04).

Discussion:

Sara B: When it comes to indicators, as Elliot mentioned, the state already collects this data, so it is just a matter of making the data available. The metro counties have already presented this data in their regional monitoring report. Could Kathleen J or Lauralee go over that report? Also, would like to discuss Jeanne's questions in chat about how these indicators can be broken down, and how we know these issues are priorities for communities?

Kathleen J: In terms of race and ethnicity data, the report shows extreme heat indicators and includes all three indicators (ED visits, hospitalizations, and deaths). This report did not break down data by race and ethnicity. But next iteration will break down data by race and ethnicity where it is possible to do that. One challenge is that race and ethnicity data is reported by the provider and not the individuals presenting. Also, ED visits don't adequately capture everyone who experiences adverse health outcomes due to heat events or air quality due to various barriers in the health care system that can make it difficult for some to present to the ED. For hospitalizations and deaths there can be small number ethical issues when attempting to report based on race and ethnicity, so it might not be possible to break data down in that way in some communities.

Kathleen J: In Portland Metro, we have heard from community partners that health impacts related to extreme heat and air quality are important, there was especially a lot of concern during the heat dome event in 2021. There may be other areas of equal or greater importance to community partners (like water safety/security and mental health impacts of climate events), but currently we

don't have a lot of data sources to be able to track changes over time. However, those are developmental areas that we hope to be able to look at for accountability metrics in the future.

Elliot: Through modernization funding that is being given out at the state level, there are CBOs across the state doing heat related adaptation planning and work and there were organizations not funded that wanted to do heat and air quality related work, so that would suggest that address heat and air quality concerns is a need for their communities.

Jeanne: From what Kathleen J said, it seems that the report doesn't include a breakdown of race and ethnicity data on local level due in part to concerns that reporting small numbers could reveal people. The report did include national data about unequal impact. We could do the same thing but with state level data to explain impact.

Jeanne: Looking at the selection criteria, how do we know these indicators around extreme heat and air quality are priorities of communities? Are those indicators tracked and broken down by race and ethnicity?

Sara: Both Kathleen J and Elliot have given examples of how we know these are priorities. Another example is with our state health improvement plan, Healthier Together Oregon (HTO). From community feedback gathered in 2019, the community asked for an overarching priority on climate across that entire state plan. We can look at this several different ways and say that we have heard this feedback from communities, but that approach may not meet this subcommittee's expectations.

Jeanne: It makes sense to look at work done in 2019 for the HTO and the feedback from communities that put environmental health as an overarching goal, and then we liberties to look at environmental health impacts that CLHO has indicated that these are good focus areas to look at. Do we have anyone on this subcommittee from CBO or a community member that we can run this by?

Kat: I don't think looking at monthly data is helpful, looking at daily information when there is a heat event is going to be more revelatory. Obviously heat deaths are going to go up in the summer months and down in the winter months. Looking at daily highs and lows on daily basis as well can be helpful during heat events. In addition to tracking hospitalizations and ED visits, it would be good to track urgent care visits as well.

Kathleen J: ED data in report includes urgent care visits. Also, not every LPHA has the capacity to look at and track data daily. Modernization is pushing public health to have a great focus on planning/preparing and prevention and not just emergency response. We should focus on how we are using data to plan policy and community action, so we are preventing these illness and deaths from showing up during emergencies.

Sara B: Before next meeting we can compile where state and local public health have received feedback from communities indicating how they have expressed priorities in this area and what those different sources are. Christy will be back by then and can provide further information.

Sara B: For race and ethnicity data, it sounds like we can show that for the state, large counties, and possibly by regions. OHA can work to improve race and ethnicity data coming in from the hospital systems.

Kathleen J: Are we headed more towards a menu option where LPHAs can pick and choose which indicators and metrics they want to track, or will they all be accountable to all of them? Some communities heat as much as a concern so it may want to choose heat as an indicator. What is the comparison, are we comparing a health department to itself over time or to similar size health departments?

Sara B: OHA will be producing report and will look at and track extreme heat and air quality indicators across the state. Then each LPHA will choose which indicators are most significant in their communities and then will choose what process measures (likely one or two) that they will focus on which is more where the menu comes into play.

Sarah P: We need to be able to track heat and air quality related data across the state, but then there is flexibility in what LPHAs choose to do with that data.

Jocelyn: From a local perspective, we need to be able to see change over time in our counties. Another challenge for some large counties is that there can be variability within counties.

Sarah P: When looking at process measures, we get into providing options for heating and cooling which is not under LPHA control, but their partners might be. In Clackamas County, CCOs provide air conditioners based on PCP recommendation and LPHA is not involved other than insuring information about heat related illness and how it impacts our communities gets to our partners. Accountably metrics in assurance and capability areas are less specific that we can't hold LPHAs to them in the way that we can hold OHA to collecting data.

Kusuma: Is there anything of consistency across LPHA that is captured in these foundational capabilities? Sounds like partnership Development and Communications seem to be bigger buckets that are across LPHAs.

Sarah P: LPHAs don't need to run or develop partnerships if they are at the table and participating in partnerships. Technical assistance is provided by the state, but LPHAs could be held accountable for getting/requesting technical assistance when needed. Policy and planning are difficult to be consistent across jurisdictions.

Kat: Is it reasonable to ask that county or region health improvement plans include something about these measures? That could be something easier for smaller counties to achieve and be held accountable for.

Jocelyn: Community health plans are meant to be drive by the community so if we start mandating what should be in those plans from state or systems perspective, it could open door for those plans

to be more driven by the state rather than communities. It makes since for public health not to be too directive in these community plans.

Sara B: When we start putting requirements on community health plans, we start moving away from them being community owned and led. But by collecting some of this information at the state level, this work becomes a data source and a source for strategy that local groups can look to when they are coming up with community health assessments and plans as well as setting strategies in their communities.

Jeanne: Would be good to summarize what we accomplished today, what do we need to accomplish at our next meeting, and what decisions do we need to make.

Sara B: For next meeting we want to collect some information about where we have received input from communities about environmental health priories, so we have that to guide our work moving forward. Sounds like we might also want to bring clearly documented pieces that explain the differences that LPHAs might be held accountable to. How are they all held accountable to doing work in these foundational capability areas while understanding that work might look different for each LPHA? Lastly, getting into structural determinates and having a conversation about what it means to have measures around structural determinates that holds PHAB, elected officials, other sectors, and the whole public health system accountable and not just individual LPHAs.

Subcommittee business

Sara B

- Subcommittee will meet again before PHAB meets, so don't need someone to present at the upcoming PHAB meeting.
- Next subcommittee meeting scheduled for 1/10/2023 from 9am to 10am.

Public comment

No public comment.

Meeting was adjourned

PHAB Accountability Metrics
Group agreements

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

PHAB Accountability Metrics subcommittee deliverables

1. Recommendations for updates to public health accountability metrics framing and use, including to eliminate health inequities.
2. Recommendations for updates to communicable disease and environmental health metrics.
3. Recommendations on engagement with partners and key stakeholders, as needed.
4. Recommendations for developing new metrics, as needed.
5. Recommendations for sharing information with communities.

PHAB Accountability Metrics subcommittee

Timeline for discussions and deliverables (Updated June 2022)

	Topics	Work products
April-November 2021	- Public health modernization and accountability metrics statutory requirements - Survey modernization findings and connections to public health accountability metrics - *Healthier Together Oregon* and its relation to public health system accountability - Communicable disease and environmental health outcome measures - Alignment with national initiatives (RWJF *Charting a Couse Toward an Equity-Centered Data System*, data modernization, accreditation)	- Charter - Group agreements - Metrics selection criteria
February-June 2022	- Develop framework for public health accountability metrics - Finalize metrics selection criteria - Begin discussions on communicable disease and environmental health indicators	- Metrics framework - Metrics selection criteria
July-December 2022	- Identify and discuss communicable disease and environmental health indicators - Review recommendations from Coalition of Local Health Official (CLHO) committees -	- Metrics recommendations for PHAB approval

January-May	- Develop 2022 accountability metrics report - Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures.	- 2022 Metrics Report

Environmental health indicators

Subcommittee activity: Determine the extent to which indicators meet metrics selection criteria

- Document on excel file where indicators do and do not meet criteria

Community input on environmental health indicators

Subcommittee discussion: Do the following sources of feedback demonstrate sufficient community input? If not, what actions would the subcommittee propose taking?

- State Health Improvement Plan (2018)
- Oregon Climate and Health Resilience Plan (2017)
- Oregon Climate Change and Youth Mental Health Report (2021)
- Public health equity program funding to community-based organizations (2021)
- Connections to Oregon 1115 Medicaid waiver and legislative actions to invest in climate and health interventions

Metrics for structural determinants of health

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

Climate and Health in Oregon, 2020 Report

https://www.oregon.gov/oha/PH/HEALTHYENVIRONMENTS/CLIMATECHANGE/Documents/2020/Climate%20and%20Health%20in%20Oregon%202020%20-%20Full%20Report.pdf

Table 1. Examples of social and environmental determinants of health

Social stressors	Job safety and stability	Food security	Safe housing	Geographic vulnerabilities	Access to health-promoting assets
Interpersonal and systemic racism; other discrimination Toxic stress, trauma Social isolation	Employment Income Worker protections Sick leave	Hunger Access to healthy options	Affordable housing and utilities Clean indoor air quality Weatherization	Near sources of air pollution Urban heat islands Flood plains Near fire-prone landscapes	Parks, nature Transportation options Culturally relevant healthcare Community connectedness

Health outcomes:
Life expectancy, injuries, illnesses, functional limitations, medical expenses, etc.

Structural determinants of health measures

Subcommittee discussion: What are the expectations for measures of structural determinants of health?

- Provide guidance to OHA and LPHA staff

Accountability metrics selection criteria

Framework	Metrics selection criteria
Advances health equity and an antiracist society **(Indicators and process measures)**	Measure addresses an area where health inequities exist Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination Measure is actionable by state and local public health, through policy change and community-level interventions
Community leadership and community-led metrics **(Indicators and process measures)**	Communities have provided input and have demonstrated support
Provides context for **social determinants of health, systemic inequities resulting from systemic racism and oppression (Indicators)**	Information is available to provide the community, societal, systemic, and political context that creates and upholds inequities. Opportunity exists to triangulate and integrate data across data sources
Disease outcomes used as **indicators of progress.** These are **secondary to** process measures of **public health system accountability (Indicators)**	Issue has been identified as a population health priority by community members and/or public health professionals Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District Updated data are routinely available to ensure that the public health system does not rely on data that are old, outdated or no longer relevant. May include data from other sectors.

	When applicable, data are reportable by race and ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data.
Focus on **governmental public health system accountability (Process measures and Indicators)** Focus on **data** and data systems, community **partnerships**, and **policy (Process measures)**	State and local public health authorities have control over the measure, which includes influence. Measure successfully communicates what is expected of the governmental public health system, specifically state and local public health authorities. Measure aligns with core system functions in the Public Health Modernization Manual Allows for each public health authority to tailor how work toward achieving the metric is implemented in order to be responsive to local context and priorities. Context provided shows how locally tailored metrics are working toward common goals. Data are already collected, or a mechanism for data collection has been identified, which could include establishing data sharing agreements with other sectors. Updated data available on an annual basis Funding is available or likely to be available Local and state public health expertise exists Changes in public health system performance will be visible in the measure Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years

Direct and explicit **connections to state and national initiatives (Process measures and indicators)**	Measure aligns with State Health Indicators or priorities in community health improvement plans and the state health improvement plan, *Healthier Together Oregon* Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures. Measure aligns with national Public Health Accreditation Board standards and measures.

Public health accountability metrics Environmental Health			
Indicators **(assessment)**	**Public health process measures (public health data, partnerships and policy)** **(assurance)**		**Structural determinants of health** **(policy development)**
Health outcomes and reduced differences among populations	LPHA workforce and capacity	Foundational capabilities	Policy landscape and interventions
Extreme heat **Summer heat-related morbidity and mortality (CSTE).** 1. Heat deaths 2. Hospitalizations due to heat 3. ED visits due to heat	LPHA: # FTE dedicated to climate and health planning and policy (per population size) LPHA: # FTE assigned and trained to use/incorporate heat related health data into climate programming (per population size) State: Needs assessment completed of statewide workforce capacity to use heat related health data in climate programming	**Assessment and Epidemiology** State: Number of technical assistance resources and trainings given related to heat-related health event data sources including ESSENCE, EPHT, CDC Heat Tracking Portal, Vital Records, etc. **Policy & Planning** State: Number of interventions and amount spent on home based extreme heat adapatations through the Healthy Homes Grant Program. LPHA: # local jurisdictional plans that include heating and cooling interventions at individual and community level **Community Partnership Development** LPHA: Documented development and maintenance of partnerships with cross-sector workgroups/ committees for decision-making and enhanced response capacity (e.g., ability to respond to early warnings) related to climate-sensitive exposures and health outcomes (Yes/No) State: Number of Community Based Organizations and amount of funding given by OHA Modernization that have heat related programming in their workplans. **Communications** LPHA: Communication plans for seasonal climate hazards (i.e. extreme heat, wildfires and wildfire smoke) events that includes appropriate communication formats and languages (Yes/No) State: Number of outreach events and education materials produced related to new workplace heat rules (Executive Order 20-04)	State/local policies affecting proximity to/transportation to cooling centers Policies that ensure renters, MSFWs and others access to cooling options in homes. Climate ready homes
Air quality **Asthma and allergenic disease morbidity (CSTE):** 1. asthma and allergic disease related hospital admissions 2. asthma and allergic disease related ED visits			
Developmental metrics Water security Mental health effects of climate change			