# AGENDA

# PUBLIC HEALTH ADVISORY BOARD
# Accountability Metrics Subcommittee

**February 12, 2020**
**3:30-4:30**
Portland State Office Building, room 900

Zoom meeting link: https://zoom.us/j/555017394
Conference line: 669 900 6833
Meeting ID: 555 017 394

Please do not put your phone on hold – it is better to drop the call and rejoin if needed.

Meeting Objectives

- Review changes to layout and framing for 2020 report.

PHAB members: Muriel DeLaVergne-Brown, Eva Rippeteau, Jeanne Savage, Eli Schwarz, Teri Thalhofer, Rebecca Tiel

| | | |
|---|---|---|
| 3:30-3:40 pm | **Welcome and introductions**<br>• Approve Dec. 19, 2019 minutes | Sara Beaudrault, Oregon Health Authority |
| 3:40-4:10 pm | **2020 report changes**<br>• Provide feedback on proposed changes to the report layout and formatting<br>• Provide feedback on proposed changes to framing for accountability metrics and to other key concepts highlighted in the report introduction | Myde Boles, Program Design and Evaluation Services |
| 4:10-4:15 pm | **Subcommittee business**<br>• Decide who will provide subcommittee update at March 19 PHAB meeting<br>• Discuss schedule for meetings in April, May and June | All |
| 4:15-4:20 pm | **Public comment** | |
| 4:20 pm | **Adjourn** | |

Public Health Advisory Board (PHAB)
Accountability Metrics Subcommittee meeting minutes
December 19, 2019
2:00 p.m. – 3:30 p.m.

PHAB members present: Muriel DeLaVergne-Brown, Eva Rippeteau, Dr. Jeanne Savage**,** Teri Thalhofer, Rebecca Tiel
PHAB members absent: Dr. Eli Schwarz
Oregon Health Authority (OHA) staff: Sara Beaudrault, Dr. Myde Boles, Krasimir Karamfilov

## *Welcome and introductions*

Ms. Beaudrault introduced the meeting. She noted that Zoom web conferencing would be used during the meeting. She invited subcommittee members to introduce themselves. Subcommittee members introduced themselves.

Ms. Beaudrault remarked that one of the meeting objectives was to pick up where the subcommittee left off last April/May and discuss the purpose of the report, its usefulness, the requirements around the report, and OHA's use of the report, so that changes could be made before the publication of the 2020 report. When the PHAB approved the 2019 report, the board requested OHA to look at some of the process measures and consider making changes. She will provide an update on those changes. Last month, the Conference of Local Health Officials (CLHO) provided feedback on the proposed changes.

Ms. Beaudrault noted that in terms of minutes, the subcommittee wouldn't be able to approve the minutes, because Dr. Savage was absent. Ms. DeLaVergne-Brown and Dr. Savage were the two subcommittee members at the last meeting.

## *Subcommittee timeline and scope of work*

Ms. Beaudrault stated that as in previous years, the bulk of this subcommittee's work was going to be during the first half of 2020. In December 2019, the focus of the meeting will be on the purpose and use of the annual report, with the subcommittee recommending changes to the framing and layout of the report. There will be no need to meet in January 2020. In February 2020, the subcommittee will review the changes to the report framing and layout and provide feedback on the overall look and feel of the report, as well as some of the framing language that goes into the introduction and background portions. In April 2020, most of the data will be available and the subcommittee will discuss key findings and messages. This was pushed back a little bit to allow some of the Public Health Division programs to report 2019 data, instead of 2018 data.

Ms. Beaudrault added that in Spring 2020, the SHIP indicators will be finalized. It's hard to say if the PHAB would discuss changes to the accountability metrics report, based on the direction

that the SHIP goes. In May 2020, the final 2020 report will be completed and the PHAB will be asked to adopt it at the board's meeting in May. In June 2020, the report will be published and OHA will submit a funding report to the Legislative Fiscal Office.

## *Purpose and use of public health accountability metrics*

Dr. Boles reviewed the legislative requirements, stipulated in ORS 431, for the accountability metrics. One of the things that have been discussed from the previous report is the use of the term *accountability metrics*. Although the report is in statute about accountability metrics, it is really about public health system metrics and the value and contributions of the whole public health system. The purpose of the report is to help us identify a need or gaps. One of the ideas is to retain *accountability metrics* in the title of the report and have a two-part title that says that it is a public health system metrics report. A smaller, secondary title could say that it is an accountability metrics report. This could also be framed more specifically in the introductory section of the report.

Dr. Boles added that accountability component reflected on the link between accountability and funding, with both being primarily focused on communicable disease control. There hasn't been direct modernization funding for some of the other metrics in the report. OHA will continue to highlight the lack of funding for many of the metrics in the report.

Ms. DeLaVergne-Brown shared that she liked the idea about reframing the report. There's much more to the report than accountability and demonstrating the need and where the state is going. It's really about the system, not just every county.

Ms. Tiel said that she liked the framing focused on the public health system, but the subcommittee shouldn't lose sight of accountability. That's what is in the statute and it is important to the system. She was unsure what problem the title change would solve.

Dr. Boles answered that in past meetings, LPHAs have been concerned about the term *accountability* when there was no incentive funding, or funding to support efforts related to the metrics. The point is not to remove the word *accountability*, but downplay it, and emphasize the overarching public health system component.

Ms. Tiel noted that what made the modernization initiative innovative was that the public health system was holding itself to something collectively. *Accountability* is what makes Oregon so unique in its approach.

Ms. Thalhofer agreed that the way the report has been framed was that LPHAs were held accountable for meeting something without holding the OHA accountable for meeting something. The report doesn't show that the system is working together. The way it is framed now is still state against local. A new way is needed to express that this is not what the state is trying to do.

Ms. Rippeteau reminded the subcommittee that it was hard to hold people accountable when they didn't have funding to do the work. It's not about removing accountability or the focus on it, but recognizing that all parties involved, whether it is the legislature as the funder, or the state, or LPHAs that do the work, are in this together. Doing the work without being funded properly puts the onus back on the legislature. Accountability should be more about the relationship between the parties, rather than an expectation. The people working in public health are already accountable to the people in the state to do their best and prevent communicable disease and other diseases. Without getting funding to do the work, one can be accountable to only so much.

Dr. Boles stated that the report was organized by the modernization foundational programs: communicable disease control, prevention and health promotion, environmental public health, and access to clinical preventive services. The importance of health equity is highlighted in the report. There is race and ethnicity reporting for the overall health outcome measures. The report also includes the outcome measures and the process measures. She asked the subcommittee members how they used the report and if they knew others who were using the report.

Ms. DeLaVergne-Brown shared that in Crook County, the staff used the report when they were creating operational plans. The LPHA is in the process of starting a new strategic plan and the reports is included as one of the data points.

Dr. Boles asked if the Crook County team was pulling the data points that they needed from the report.

Ms. DeLaVergne-Brown answered that in addition to that, the report was used to gauge where Crook County was for each measure and what work was needed to do. Funding was lacking in some cases, but the question was how to still move forward based on operational plans.

Ms. Thalhofer remarked that she shared the report with the North Central Public Health District board and the local public health advisory councils. The sharing is in print format.

Ms. Tiel added that she used the report to prepare the annual PHAB presentation to the Oregon Health Policy Board. She found the slide deck format more helpful for sharing the information in the report with other stakeholders. The downside of a slide deck is that the footnotes in the report don't end up on the slide.

Dr. Savage pointed out that as an outsider to public health, the report was used for education with legislators. When the subcommittee looked at it, the discussion revolved around ease of understanding, and readability, and a way of modeling what public health was looking at and doing, and also, when accountability is discussed, being accountable for outcomes resulting from funding. That is, showing people what public health does with the funding that it gets, whether it's big or small, and showing the impact the work has with whatever funding public

health receives. The report was also used at QHOC, where all CCOs met and discussed what projects public health was doing to create a connection with the CCO and work on similar projects together.

Dr. Boles stated that the OHA team has been thinking about streamlining the report this year. Some of the introductory material will be removed. Instead of a lot of textual narrative in the introduction, the section will include short blocks of text and bullet points. The key elements will include the outcome measures, statewide data by race and ethnicity and by county, and the local public health process measures by county. The new report will have less text and more white space. It will still include an executive summary, introductory key points, and metrics pages. A longer technical document with narrative, notes, and data tables will be available online. The format may not be a slide deck format, but something that is briefer and can be used easily.

Dr. Boles added that the map format would be retained. Some horizontal information could be presented vertically. The process measures will have three time points instead of two and will be presented in a timeline-oriented way as spark lines, because there is a lot of data. Most of the information in boxes and notes will be transferred to the technical document, except the most key contextual information that needs to be included on the page.

Ms. Rippeteau reiterated her suggestion that accountability didn't only mean being accountable to providing services, but the legislature was accountable to public health to fund it. Often the questions are *What are we buying? What are the services? What's the FTE that's associated with this?* Maybe the detailed report should include some sort of indicator that shows the dedicated staff for the work and the FTE, or an indicator that shows why a benchmark was or was not met.

Dr. Boles answered that this information is not currently collected statewide. It's information that each LPHA must have, but it's not available on the state level. Local public health staff have the general contextual information and know the connection between resources, staffing, and funding, and what can and cannot be accomplished.

Ms. Thalhofer remarked that LPHAs braided and blended funds to such an extent that people worked in multiple programs. Losing funding from what seems to be a small thing hits an LPHA's capacity in a huge way.

Ms. Beaudrault pointed out that in addition to the accountability metrics report, OHA did an evaluation report that focused more directly on the legislative investments. This conversation has come up with the evaluation planning group as well. How do we talk about improvements with a $15 million investment within the broader context when some LPHAs are at a net loss, not a gain?

Ms. Tiel agreed that Ms. Rippeteau's comments fit in an evaluation bucket. It should be clear that public health is buying staffing. It takes people and systems to run a public health system. It should be very clear in the report that the public health system is run by FTE and requires sophisticated data systems, which are very different than the investment the legislature might make in the education system or other systems. In the evaluation report, there can be a more specific breakdown of what happens when there are gains and losses in specific programs. When the investment is bigger, there is more money in the system, but that doesn't necessarily mean that specific areas of the state or programs are seeing gains. It's helpful to have two reports.

Ms. Rippeteau added that if the legislature wanted to know what it was paying for and expected public health to be accountable by moving the marker on things, public health staff could show what it takes for public health to do this work. The legislature won't give public health another $5 million or $15 million without fully understanding what the funding does and whether or not it moves the marker.

Dr. Boles noted that the discussion was beyond the scope of the report. Talking about it in the context of modernization evaluation is appropriate. The two things are linked. One is more on the result, while the other is more on the process and the investment. The modernization evaluation is focused on communicable disease control because that's where the money has gone. All the rest doesn't make a connection in the report, in terms of modernization funding.

Ms. Rippeteau commented that maybe it should be noted in the report that there hadn't been any modernization money focused on most metric in the accountability report and LPHAs hadn't been able to fund any additional staffing to focus on this work, but the LPHAs were still accountable to their communities in these areas.

Dr. Boles summarized the discussion around the importance of retaining the context around the funding and the resources available to do the work. The feedback supported the pairing down of the report and making it cleaner and less busy, resulting in a brief report with a reference to a technical document online.

Ms. Beaudrault suggested to use the couple of sentences and bullet points at the top of each page to highlight the problem that was being solved, what the state public health system did to address that problem or should be doing, and something about the funding.

Dr. Boles acknowledged the suggestion and thanked the subcommittee members for their feedback. The OHA team has started collecting the data and will present a draft layout of the report at the subcommittee meeting in February.

## *Measure set updates*

Ms. Beaudrault reminded the subcommittee that the PHAB asked OHA to look into a few of the process measures for the 2020 report. The OHA team has been working on that with OHA program staff, as well as talking with CLHO and CLHO committees to get their feedback. The first two measures—*dental visits for children 0-5*, *prescription opioid mortality*—are outcome measures, not process measures. PHAB voted on both measures in August. For process measure *percent of top opioid prescribers enrolled in PDMP*, both OHA and CLHO recommended to remove the measure from the 2020 report. OHA will work with CLHO to identify a new process measure that will tie to opioid mortality in 2020.

Ms. Thalhofer asked whether somebody kept track of where the wins were. The law change for prescribing opioids was a public health win. It's a mistake to say that it isn't applicable anymore. Somebody should keep track of the wins, because with policy systems and environmental change, there was a policy change through advocacy that fixed the problem.

Ms. Tiel agreed with Ms. Thalhofer and wondered where that might be listed in the report. The prescription opioid law was a huge win and there is regulation in place now. That happened because public health worked toward that big goal. It would be good to see the wins over time.

Dr. Boles answered that this information can be noted in the executive summary of the report.

Ms. Rippeteau suggested to include a table in the report, maybe at the end of it, that listed measures that had been removed from the report over the last five years along with explanations for their removal. This way, people could see that the public health system was able to accomplish much more when it started making modernization efforts and having better funding.

Ms. Beaudrault reviewed the changes for process measure *percent of population reached by tobacco-free county properties policies*. The PHAB recommendation was to differentiate comprehensive and partial policies. OHA proposed a change, but CHLO was not supportive of it.

Ms. DeLaVergne-Brown remarked that there were county commissioners in the state who advised LPHAs to not talk about tobacco policy. It has to be taken into consideration what the counties and the LPHA directors are dealing with locally with their policy makers.

Ms. Thalhofer added that this was one of those things where the system must be discussed. It hasn't been that long since the state adopted tobacco-free properties. For a long time that was one of the deliverables in the tobacco program at North Central Public Health District, but state properties were not tobacco-free. The frustrating thing is that the effort is not strength-based. The discussion is not about how the process is moving forward, but about what is lacking. One of the conversations that was brought up by the locals was that sometimes the cities are more progressive and they are making great strides with city government, but the county government isn't ready to switch. It's the same with the state's message to LPHAs to turn the counties tobacco-free, but sometimes the work has to be done city-to-city. The OHA proposal

didn't recognize all the local work that was happening. Maybe the initiative needs more narrative.

Ms. DeLaVergne-Brown agreed with Ms. Thalhofer and stated that in Crook County, they went department by department. A lot of questions came up that people had gotten approval for the parks and other health care organizations in their area and it wasn't just county property. Maybe the wording of this measure is confusing.

Ms. Tiel shared that she would love to see if ten cities in a county had passed such policies, even if the county building facilities were not tobacco-free. It's a very important process measure where it can be shown that county health departments and public health are leaders in policy change and in bringing people together around complex issues. The process measure shouldn't be removed. It is maybe a framing issue and how the data is presented visually to show the progress. She asked about the four categories in the OHA proposal.

Ms. Beaudrault explained that the categories were *no county policy*, *county policy that covers only health department buildings*, *a comprehensive policy that has exemptions to it*, *a county-wide policy with no exemptions*. The categories don't allow for a city-to-city look. It also doesn't reflect the strength of the coalition that is moving in the right direction.

Dr. Boles added that it was also complicated because the measure was *percent of population reached*. The assumption is that it's possible for anybody in a county's population to be affected, because they may go to any one of those locations where there is a tobacco-free policy, such as a park or health care system or a county building. Because everybody had the potential to be affected, the measure was all or nothing. The *population reached* portion of the measure is not very valuable, because it is imprecise. If the measure is changed, it has to identify the places that had tobacco-free policies, whether that is cities, parks, or county buildings, and the measure lists where that happened instead of the percent of population.

Ms. Tiel reiterated that this was a great process measure, because incremental change can be seen. Every year, there are more and more policies that are passed, or existing policies, including policies about e-cigarettes, or policies expanding in different ways. It is a challenge to visualize that information.

Dr. Boles asked if the measure could be returned to HPCDP to pull out every tobacco-free policy area, not just county properties.

Ms. Beaudrault answered that she didn't know whether that was possible. The OHA team can be asked to put the data into these four categories. CLHO will have a chance to look at it before anything goes into the report. The subcommittee will have a chance to look at it as well. Maybe a decision about what would go into the 2020 report should be made when the data has been reviewed. Moving forward from the 2020 report, the OHA team can continue to work on this process measure and refine it so it best shows where progress has been made.

Dr. Boles remarked that one of the three contextual points on every page could be about what the system has done or does, so it was very clear.

Ms. Beaudrault provided the next steps for the subcommittee: (1) whether it was possible to get information about where some LPHAs have city tobacco-free policies, (2) run the data by the four categories and let everyone see what those data looks like before a final decision is made about what goes in the report, (3) add some information about the state role.

Ms. Beaudrault explained that for process measure *active transportation*, the recommended change was for the measure to reflect an LPHA's participation in implementation, in addition to planning. Two CLHO committees—prevention and health promotion, environmental health—supported the change. For process measures related to drinking water, most measures are at close to 100% for all LPHAs. The recommendation from OHA and CLHO is to show the measures in the 2020 report and work through CLHO on identifying new, more meaningful process measures. For the process measure on *effective contraceptive use*, PHAB requested to expand the data collection mechanism to capture strategic plans not reported annually to OHA's reproductive health program. The recommendation from OHA and CLHO is to keep data collection as is and, if a local public health administrator has a strategic plan that addresses access to reproductive health services and effective contraceptive use, they can send it to the program and be counted as met.

Ms. Tiel remarked that in terms of the role discussion, what if there was a different entity in a community, such as a nonprofit or a health system, that led the strategic plan and the LPHA was an active participant in developing the plan. Does the plan have to be an internal LPHA strategies plan, or it can be a community plan?

Ms. Beaudrault answered that the strategic plan didn't have to be under the LPHA's name.

## *Subcommittee business*

Ms. Beaudrault asked who would like to give a subcommittee update at the PHAB meeting on January 16, 2020.

Ms. Thalhofer volunteered to provide an update.

Ms. Beaudrault informed the subcommittee that the next meeting would be in the first half of February so that the meeting was before the PHAB meeting.

Subcommittee members identified February 12 at 3:30 p.m. for the next meeting date and time. Ms. Beaudrault will schedule the meeting.

## *Public comment*

Ms. Beaudrault invited members of the public to ask questions and provide testimony.

There was no public comment.

## *Closing*

Ms. Beaudrault adjourned the meeting at 3:07 p.m.

# Timeline and scope of work

**December 2019**

Discuss purpose and use of the annual report; recommend changes to framing and layout.

**February 2020**

Review changes to report framing and layout.

**April 2020**

Initial review of 2020 data; discuss key findings and messages.

***Spring 2020***

*SHIP indicators finalized. (informational only)*

**May 2020**

Final review of 2020 report; recommend that PHAB votes to adopt.

**June 2020**

Report published; OHA submits funding report to Legislative Fiscal Office

Oregon Health Authority

# 2020 report framing and layout

- Do the draft changes to the introduction section address the points of discussion from the December subcommittee meeting?
- Do the metrics pages:
  - Convey the right information?
  - Convey the information in a way that is easily understandable?
- What additional changes are needed to the introduction section or the metrics pages?

Oregon Health Authority

# DRAFT

# Public Health Accountability Metrics Annual Report 2020

**TITLE PAGE**

- Title
- Date
- Photos

**ABOUT**

- This report fulfills statutory requirements under ORS 431.139 for reporting on public health accountability metrics.
- For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority, Office of the State Public Health Director at: (971) 673-1222 or PublicHealth.Policy@state.or.us

**ACKNOWLEDGEMENTS**

- PHAB
- PHAB Accountability Metrics Subcommittee

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**EXECUTIVE SUMMARY**

- What
- How
- Why

**INTRODUCTION**

PUBLIC HEALTH MODERNIZATION FRAMEWORK

Oregon's public health system is changing how it prevents disease and protects and promotes health. A modern public health system ensures critical public health protections are in place for every person in Oregon, that the public health system is prepared to address emerging health threats, and that all parts of the public health system work together to eliminate health disparities.

To accomplish the population health priorities, a modern public health system is built on foundational capabilities in the following areas:

- Leadership and organizational competencies
- Health equity and cultural responsiveness
- Community partnership development
- Policy and planning
- Communications
- Emergency preparedness and response
- Assessment and epidemiology

Public health accountability metrics are one way that Oregon's public health system demonstrates how it is improving health and effectively using public dollars through a modern public health system. Established by the Public Health Advisory Board in 2017, public health accountability metrics provide an annual review of the population health priorities for all Oregonians and highlight the work of local public health authorities (LPHAs) to achieve population health goals.

Modernization evaluation and accountability metrics. An effort is currently underway to evaluate the implementation of public health modernization. Both reports show where the public health system is making progress, as well as highlight where the system is not making progress and where new approaches or resources are needed.

FUNDING

Efforts to modernize the governmental public health system have been driven by Oregon's legislature, which enacted laws to use public health accountability metrics to track the progress of state and local public health authorities to meet population health goals to measure the effective and equitable provision of public health services (Oregon Revised Statute 431.115).

In 2019, the Oregon Legislature made a $15.6 million investment in the modernization of the governmental public health system. The Oregon Health Authority (OHA) distributed most of these funds to LPHAs to address local and regional priorities for communicable disease control.

HEALTH EQUITY

Public health authorities have a responsibility to address the social conditions and correct historical and contemporary injustices that undermine health. One way the public health system begins to do this is by collecting and reporting data that show where health disparities exist and highlighting the underlying causes for why certain racial and ethnic groups experience poor health. Differences in health outcomes across racial and ethnic groups occur because of generations-long social, economic and environmental injustices that result in poor health. These injustices have a greater influence on health outcomes than biological or genetic factors or individual choices.

Where possible, data are reported by race/ethnicity in this report. While health is improving for some, not everyone is benefitting equally. Some groups, including those living with fewer financial resources and communities of color, continue to bear a greater burden of illness and disease.

## ORGANIZATION OF THIS REPORT

This report is organized by Public Health Modernization foundational program areas: Communicable Disease Control, Prevention and Health Promotion, Environmental Health, Access to Clinical Preventive Services.

The collection of health outcome and local public health process measures, defined below, are collectively referred to as public health accountability metrics. Measures are shown in Table 1.

- Health outcome measures reflect population health priorities for the public health system. Making improvements on the health outcome measures will require long-term focus and must include other sectors.
- Local public health process measures reflect the core functions of a local public health authority to make improvements in each health outcome measure. Local public health process measures capture the work that each local public health authority must do in order to move the needle on the health outcome measures.
- Developmental metrics reflect population health priorities but for which comprehensive public health strategies are yet to be determined. These health outcome measures will be tracked and reported but will not be incentivized.

Technical documentation and data tables are available at _____.

**Table 1. 2020 Public Health Accountability and Developmental Metrics**

Communicable Disease Control

- Outcome measure: Percent of two-year olds who received recommended vaccines
  - Process measure: Percent of Vaccines for Children clinics that participate in the Assessment, Feedback, Incentives and eXchange (AFIX) program
- Outcome measure: Gonorrhea incidence rate per 100,000 population
  - Process measure: Percent of gonorrhea cases that had at least one contact that received treatment
  - Process measure: Percent of gonorrhea case reports with complete priority fields

Prevention and Health Promotion

- Outcome measure: Percent of adults who smoke cigarettes
  - Process measure: Percent of population reached by tobacco-free county properties policies
  - Process measure: Percent of population reached by tobacco retail licensure policies
- Outcome measure: Opioid mortality rate per 100,000 population (1)
  - Process measure: None (2)

Environmental Health

- Outcome measure: Percent of commuters who walk, bike, or use public transportation to get to work
  - Process measure: Local public health authority participation in implementation or leadership or planning initiatives related to active transportation, parks and recreation, or land use (3)
- Outcome measure: Percent of community water systems meeting health-based standards
  - Process measure: Percent of water systems surveys completed
  - Process measure: Percent of water quality alert responses
  - Process measure: Percent of priority non-compliers resolved

Access to Clinical Preventive Services

- Outcome measure: Percent of women at risk of unintended pregnancy who use effective methods of contraception
  - Process measure: Annual strategic plan that identifies gaps, barriers and opportunities for improving access to effective contraceptive use

Developmental measure: Percent of children age 0-5 with any dental visit

Process measure: None

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Table notes

(1) Formerly “prescription” opioid mortality rate per 100,000 population in the 2018 and 2019 reports
(2) Formerly “percent of top opioid prescribers enrolled in the Prescription Drug Monitoring Program (PDMP) Database” in the 2018 and 2019 reports
(3) Formerly “local public health authority participation in leadership or planning initiatives related to active transportation, parks and recreation, or land use” in the 2018 and 2019 reports (“implementation” excluded)

# Childhood Immunization

## HEALTH OUTCOME MEASURE

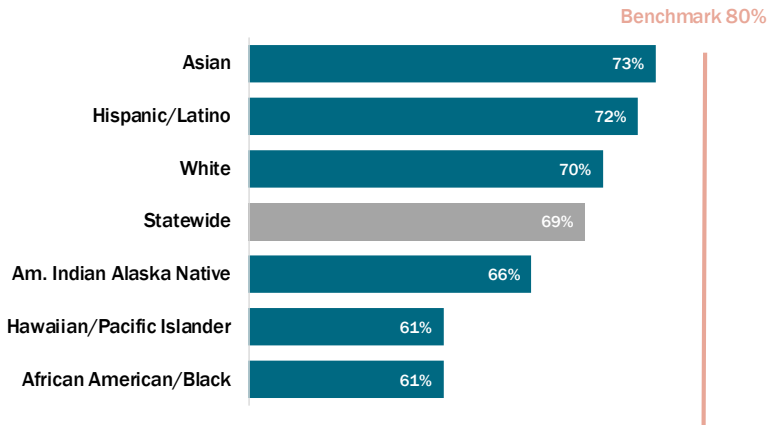
Percent of two-year olds who received recommended vaccines, Oregon 2018

Oregon ranks 45th out of 50 U.S. states in childhood immunizations

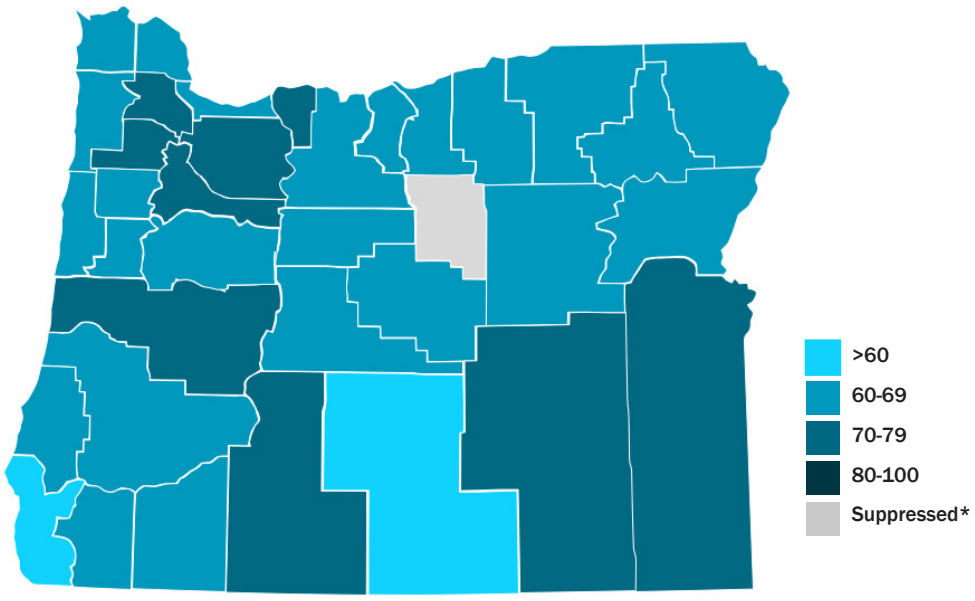
The Oregon Legislature prioritized communicable disease control as part of modernization funding

Rates have increased steadily, going from 60% in 2014 to 69% in 2018

### There are large disparities in vaccination rates by race/ethnicity




### No counties in Oregon met or exceeded the 80% benchmark in 2018




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

# Childhood Immunization

## LOCAL PUBLIC HEALTH PROCESS MEASURE

### Percent of Vaccines for Children clinics participating in AFIX*, by County 2017-2019

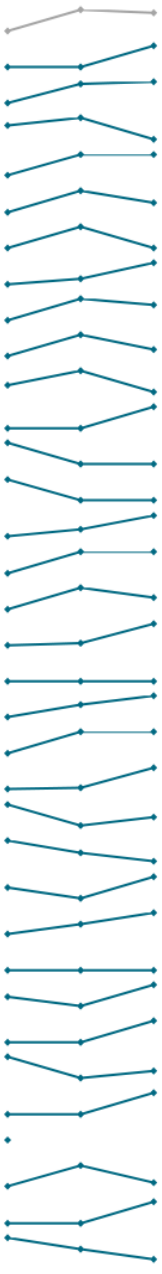
20 Oregon counties exceeded the 25% benchmark in 2019

All LPHAs received funding from OHA to provide immunization services

LPHAs use the following capabilities to achieve this measure: community partnership development and assessment and epidemiology

Benchmark 25%

| | 2017 | 2018 | 2019 |
|---|---|---|---|
| Statewide | 14% | 28% | 26% |
| Baker | 33% | 33% | 67% |
| Benton | 18% | 36% | 38% |
| Clackamas | 21% | 33% | 0% |
| Clatsop | 14% | 57% | 57% |
| Columbia | 0% | 50% | 22% |
| Coos | 18% | 70% | 18% |
| Crook | 0% | 25% | 100% |
| Curry | 0% | 100% | 71% |
| Deschutes | 13% | 48% | 24% |
| Douglas | 39% | 79% | 20% |
| Grant | 0% | 0% | 67% |
| Harney | 67% | 33% | 33% |
| Hood River | 33% | 20% | 20% |
| Jackson | 2% | 8% | 20% |
| Jefferson | 0% | 50% | 50% |
| Josephine | 0% | 54% | 29% |
| Klamath | 0% | 8% | 77% |
| Lake | 33% | 33% | 33% |
| Lane | 11% | 29% | 42% |
| Lincoln | 0% | 67% | 67% |
| Linn | 5% | 6% | 20% |
| Malheur | 43% | 0% | 17% |
| Marion | 34% | 24% | 17% |
| Morrow | 50% | 0% | 100% |
| Multnomah | 6% | 12% | 19% |
| North Central PH District** | 29% | 29% | 29% |
| Polk | 33% | 20% | 50% |
| Tillamook | 0% | 0% | 50% |
| Umatilla | 45% | 27% | 33% |
| Union | 0% | 0% | 44% |
| Wallowa*** | 0% | | |
| Washington | 10% | 21% | 12% |
| Wheeler | 0% | 0% | 100% |
| Yamhill | 17% | 8% | 0% |



**Assessment, Feedback, Incentives and eXchange (AFIX) quality improvement program. **North Central Public Health District is comprised of Gilliam, Sherman and Wasco Counties. ***Wallowa County legally transferred its public health authority to the Oregon Health Authority in 2018.*

# Subcommittee business

- Decide who will give subcommittee update at March 19 PHAB meeting.
- Discuss meeting schedule for April, May and June.

# Public comment

Oregon Health Authority

# Adjourn

Oregon Health Authority