PUBLIC HEALTH ADVISORY BOARD
Strategic Data Plan Subcommittee

June 21, 2022
1:00 - 2:00 PM

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Meeting ID: 160 542 1162

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Subcommittee members: Jackie Leung, Hongcheng Zhao, Rosemarie Hemmings, Veronica Irvin, Kelle Little, Jawad Khan, Dean Sidelinger

OHA staff: Victoria Demchak, Virginia Luka, Diane Leiva

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1:00 – 1:15 Welcome and Introductions
- Approve May meeting minutes
- Welcome new members and staff
- Recording of May 2021 PHAB meeting presentation with survey modernization partners: https://youtu.be/LEQN7kCy7rk

Diane Leiva, Oregon Health Authority

1:15 – 1:50 Strategic Data Plan Framework components
- Purpose
- Other topics for discussion

All

1:50 – 2:00 Public comment
2:00 Adjourn
Welcome and introductions

- **Overview:**
  - Have waited some time to meet with modernization partners. Making sure that we are centering modernization in how we collect data. In March PHAB meeting, discussed pulling group back together, PHAB recommended we continue to meet given the importance of data being collected, use of the data, and applying the recommendations that have come out.

- **What we’ve learned:**
  - Veronica - In depth review from surveys, great reach, comments and ideas that came back from surveys about wording and reach.
  - Hongcheng – lots of challenges we’ve been facing during the pandemic. Public Health department courage to face it and means to do it.
  - Look how we ground ourselves & surveys are relevant and brings up community. Started with behavioral risk factor surveillance survey, telephone survey. It has some issues and challenges of reaching people as well.
  - Working with several groups to collab with to use community identified priorities to guide analysis, interpretation contextualization data. Community led data collection.

- **PHAB role:**
  - What type of guidance for guiding OHA?
  - More systematic approach.
  - How we move these goals forward
    - Community led data collection systems
- State data systems for population based statewide estimates.
- Federally funded population-based surveys
- Local complementary surveys

Diane – requirement for federal funding but able to recommend. Complements modernization documents, innovation network participatory analysis, help develop and grow participation.

Work on a framework for the four ways that OHA partners with federal and local governments to collect and manage data and increase the way that those systems are focused on community

  o Hongcheng - On right track with community led and working with communities of color. A way to lower the price tag. Concerned about only a small portion of east Asian included with Pacific Islanders. Should be just Asian & Pacific Islanders.
  o Community-led research and bring that piece in. Time and cycles to be aware of it. How is this shared or not shared and process [for working with community members]. Concerns about communication through state. Be more upfront of benefits and how this help.
  o Look at one system of data authority/ engagement each for framework, rather than all 4 due to complexity of all. Will be more tangible.
1. Introduction
2. Acknowledgments
   - Survey modernization partners
3. Executive Summary
4. Values for modern public health data (with definitions)
   - Data justice
   - Data sovereignty
   - Dismantling white supremacy in public health practice
   - PHAB Accountability Metrics Shifts
5. Components of the public health data system
   - Framing: where we are today and where we need to move
   - Framing: dependencies on other public health system partners
   - Race, Ethnicity, Language and Disability (REALD) data
   - Sexual Orientation and Gender Identity (SOGI)
6. Continuum of public health data
   - Community-led data collection systems
   - State data systems for population-based statewide estimates
   - Federally-funded population-based surveys
   - Local complementary surveys
White Supremacy and the Core Functions of Public Health

Sirry Alang, PhD, Rachel Hardeman, PhD, MPH, J’Mag Karbeah, MPH, Odichinma Akosionu, MPH, Cydney McGuire, MPH, Hamdi Abdi, MPH, and Donna McAlpine, PhD

ABOUT THE AUTHORS

Sirry Alang is with the Department of Sociology and Anthropology, and the Program in Health, Medicine, and Society, Lehigh University, Bethlehem, PA. Rachel Hardeman, J’Mag Karbeah, Odichinma Akosionu, Cydney McGuire, Hamdi Abdi, and Donna McAlpine are with the Division of Health Policy and Management, University of Minnesota School of Public Health Minneapolis.

Global outrage followed the murder of George Floyd by now former Minneapolis, Minnesota, police officers. The outrage was targeted at police brutality—police conduct that dehumanizes through the use of physical, emotional, or sexual violence as well as verbal and psychological intimidation, regardless of conscious intent—one of the oldest forms of structural racism. In decrying police brutality, many public health organizations issued statements declaring racism a public health crisis, with promises of change. However, change is stymied if we do not critically evaluate how the discipline (scholarship, conceptual frameworks, methodologies), organizations (governmental, nonprofit, and private institutions that seek to promote population health), and public health professionals (in academia or practice) contribute to structural racism that is manifested in police brutality, among many other outcomes.

“Structural racism” here refers to policies and practices, in a constellation of institutions, that confer advantages on people considered White and ideologies that maintain and defend these advantages, while simultaneously oppressing other racialized groups. Structural racism is sustained through White supremacy: the glossary of conditions, practices, and ideologies that underscore the hegemony of whiteness and White political, social, cultural, and economic domination. White supremacy makes it possible for structural racism to reproduce over time, albeit with different mechanisms, from the enslavement of Black people to mass incarceration. Consideration of White supremacy makes visible that structural racism is “White controlled,” and without examining the former, we will not dismantle the latter in public health.

Public health is organized in a framework of three core functions—assessment, policy development, and assurance—and 10 essential public health services (EPHSs). The framework is meant to help public health “speak with one voice” about what public health is and what it aspires to do. This framework has been immensely influential. Accreditation of public health departments and educational programs partially relies on EPHSs and is included in some state statutes. The EPHSs are taught in our classrooms, are used for performance measurement and evaluation, and have helped to communicate to the public and policymakers what public health is about.

The revised EPHSs were recently released, 25 years after the original framework was developed. The most important change is that the framework now centers equity, defined as a “fair and just opportunity for all to achieve good health and well-being.” In the equity statement, racism is mentioned as one of the “forms of oppression” that the EPHSs should address. Living up to the potential of equity requires directly addressing structural racism and White supremacy. We provide examples of strategies in the core functions and EPHSs to do so (Table 1 presents a summary of these).

ASSESSMENT

The core function of assessment is a focus on surveillance. The first EPHS is to assess and monitor population health status, factors that influence health, and community needs and assets. The revision to this EPHS emphasizes “root causes of inequities.” If police brutality and structural racism are root causes, then our health surveillance systems and surveys, such as the National Health Interview Survey, and the Behavioral Risk Factor Surveillance System (BRFSS), should routinely track experiences of police brutality, as well as exposure to structural racism. Embedding geocoded information on racial inequities in socioeconomic status in the National Longitudinal Study of Adolescent Health is a good example of this approach. We should assess indicators of structural racism, such as racial inequities in...
TABLE 1—Public Health's Core Functions and Essential Services as an Organizing Framework for Dismantling White Supremacy

<table>
<thead>
<tr>
<th>Core Functions</th>
<th>Essential Services</th>
<th>Example Strategies for Dismantling White Supremacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment</td>
<td>1. Assess and monitor population health status, factors that influence health, and community needs and assets</td>
<td>Routinely track and report respondents’ exposures to and experiences of police brutality and other indicators of structural racism and White supremacy</td>
</tr>
<tr>
<td></td>
<td>2. Investigate, diagnose, and address health problems and hazards affecting the population</td>
<td>Investigate the complex mechanisms through which White supremacy shapes health outcomes</td>
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<td></td>
<td>3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it</td>
<td>Educate the public and policymakers on indicators of White supremacy and how these might shape the social determinants of health</td>
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<tr>
<td></td>
<td>4. Strengthen, support, and mobilize communities and partnerships to improve health</td>
<td>Ensure equitable allocation of resources and redistribution of power in community partnerships</td>
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<td></td>
<td>5. Create, champion, and implement policies, plans, and laws that affect health</td>
<td>Policies must center the experiences of those most affected by structural racism and White supremacy</td>
</tr>
<tr>
<td></td>
<td>6. Utilize legal and regulatory actions designed to improve and protect the public’s health</td>
<td>Develop and enforce regulations and policies to dismantle practices that maintain structural racism and White supremacy</td>
</tr>
<tr>
<td>2. Policy development</td>
<td>7. Ensure an effective system that enables equitable access to the individual services and care needed to be healthy</td>
<td>Acknowledge racist systems, advocate antiracist policies, and link Black people, Latinx people, Indigenous people, and other people of color with a range of resources</td>
</tr>
<tr>
<td></td>
<td>8. Build and support a diverse and skilled public health workforce</td>
<td>Set clear expectations for education on equity. Schools of public health and public health institutions should set measurable goals on racial equity competency for students and practitioners</td>
</tr>
<tr>
<td></td>
<td>9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement</td>
<td>Focus on critical race conceptual frameworks and antiracist methodologies. Mandate measuring and reporting diversity, equity, and inclusion efforts</td>
</tr>
<tr>
<td></td>
<td>10. Build and maintain a strong organizational infrastructure for public health</td>
<td>The infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed</td>
</tr>
</tbody>
</table>

In communities should be a critical aspect of assessment.

The second EPHS is to “investigate, diagnose, and address health problems and hazards.” Using the example of police brutality, scholars need to continue to identify mechanisms such as mass incarceration, stress proliferation, institutional mistrust, and economic and financial strain that link health with exposure to and experiences of police brutality. We must also investigate the mechanisms through which other indicators of structural racism and White supremacy shape health outcomes.

Hitherto, public health has accounted for race in health disparities research but has rarely examined the role of structural racism.

Opportunities, legislation, and policy outcomes; criminalization and incarceration; and neighborhood- or zip code–level inequities in assets, debts, political participation, housing, and employment patterns.

In 2002, BRFSS added an optional module, Reactions to Race, but few states administered it. That our surveillance systems do not routinely collect data on racism is one indication of how White supremacy plays out in public health: ignoring everyday experiences of, and exposures to, salient stressors among Black people, Indigenous people, and other people of color (BIPOC).

Expanding analyses of the impact of structural racism and White supremacy on the distribution of needs and assets in communities should be a critical aspect of assessment.

The second EPHS is to “investigate, diagnose, and address health problems and hazards.” Using the example of police brutality, scholars need to continue to identify mechanisms such as mass incarceration, stress proliferation, institutional mistrust, and economic and financial strain that link health with exposure to and experiences of police brutality. We must also investigate the mechanisms through which other indicators of structural racism and White supremacy shape health outcomes. Hitherto, public health has accounted for race in health disparities research but has rarely examined the role of structural racism.

**POLICY DEVELOPMENT**

Public health’s third essential service is to “communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.” Global protests against racism and the attention to racial inequities in the impact of COVID-19 present no better time to confront White supremacy in communication. However, public health institutions such as the Centers for Disease Control and Prevention did not issue any specific official statements on structural racism. Statements that some other public health organizations have released fall short. For example, the American Public Health Association stated:
As a public health crisis, it neither educates readers on the meaning and manifestations of racism nor implicates White supremacy. Public health organizations, institutions, and practitioners must actively educate the public about racism in producing health inequities. For example, speaking up against the recent surgeon general’s report on maternal mortality, which does not mention racism as a fundamental cause of racial inequities in maternal health outcomes, and against policies such as former president Trump’s Executive Order 13950, which banned training in critical race theory, are necessary actions for educating the public about factors that influence health.

The fourth EPHS is “strengthen, support, and mobilize communities and partnerships to improve health.” The revised version focuses on authentic relationships to promote equity. Authenticity is difficult to achieve given inherent power differentials. Public health leaders, most of whom are White, primarily make decisions about the allocation of resources for research and practice, shape engagement of stakeholders, and determine whether and how the perspectives of community members are used. Redistributing power in community partnerships can help challenge White supremacy. Our community partnerships should be characterized by frequent open conversations about power dynamics that are at play. We also think it is time for our funding agencies to not fund community-based research unless researchers demonstrate that the allocation of resources is fair and there is equitable compensation for community partners.

Public health’s fifth EPHS is to “create, champion, and implement policies, plans, and laws that affect health.” The knowledge that informs policy should be grounded in the experiences of those most affected. But policymakers and academic researchers are predominantly White. As a result, White intellectual dominance characterizes the production of knowledge, its translation into practice, and the formulation of policy. As a profession, we need to address the reality that research led by Black scholars who have the experiential knowledge of how racism and White supremacy affect health is less likely to be funded than research led by their White counterparts. We must also prioritize work that centers the experiences of historically excluded populations most affected by White supremacy. One way forward is to engage more meaningfully with grassroots organizations such as Black Lives Matter and to extend our professional responsibilities to include community-engaged advocacy for the policy priorities these organizations have articulated. Public health must be intentional about finding ways to create space for those without formal power to influence decision-making through the expertise of their lived experiences, especially experiences of racism.

The sixth EPHS is “utilize legal and regulatory actions designed to improve and protect the public’s health.” Public health performs this service well when it comes to enforcement in areas such as immunization, tobacco, and alcohol regulations. However, the field is yet to develop regulations to dismantle practices that specifically uphold structural racism and White supremacy. For example, public health should be at the forefront of enforcing regulations to prevent disposal of toxic waste in Black and Indigenous communities. Mandating restorative justice practices that prevent the disproportional incarceration of BIPOC is necessary.

**ASSURANCE**

Under the core function of assurance, the seventh EPHS is ensuring “an effective system that enables equitable access to the individual services and care needed to be healthy.” We must first recognize areas of significant need and acknowledge how historical and contemporary forms of racism act as barriers to accessing services that meet these needs. For example, public health institutions and organizations should address the ongoing mistrust in medical institutions and the COVID-19 vaccine hesitancy by first acknowledging the harm science and medicine have inflicted on Black, Latinx, and Indigenous communities. Promoting vaccine uptake must be done simultaneously with advocating policies to ensure access to testing, treatment, and other resources needed to survive the pandemic. For communities to trust in public health and utilize the services and systems we
provide, public health must first be trustworthy. The eighth EPHS is “build and support a diverse and skilled public health workforce.” We know that the public health workforce is disproportionately White, especially at the supervisory and managerial levels. Schools of public health are also disproportionately White. In 2017, only 0.2% of tenured faculty were Native American, 3.8% were Black, and 7.4% were Latinx/Hispanic, and those numbers have barely budged in years. That a predominantly White profession and discipline is charged with educating and addressing the needs of communities that are disproportionately Black, Indigenous, and Latinx sustains White supremacy within public health. White frames dominate the information we convey, the interventions we develop, and the policies we implement, all of which are often completely disconnected from the experiences of the people most likely to experience health inequities.

The training that public health practitioners often receive is partially responsible for our inability to address structural racism and White supremacy. Leading textbooks intended for undergraduate education often fail to critically analyze the concept of race and barely touch on racism. Moreover, a recent review of 59 accredited schools of public health found that only 33% mentioned diversity, inclusion, or equity in their public mission, vision, or values statements, and 20% made no mention of any of these terms in their goals, objectives, or strategic plans. It is encouraging that the revised EPHS now mentions building a workforce that “practices cultural humility.” But cultural humility in place of discussions of structural racism and White supremacy will not change much and echoes hanging our hats on the term “implicit bias,” rather than talking about forms of racism.

To begin to make antiracist training real, it is imperative that the Council on Education for Public Health set clear expectations for education on equity and racism and that schools and organizations set goals for racial equity competency for students and practitioners that are measurable and for which someone is accountable. Metzl and Hansen have made the case for structural competency to be integrated into medical education, and the same should be promoted in public health.

The ninth EPHS is “improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.” It has been 10 years since Ford and Airhihenbuwa laid the foundation of how critical race theory could help examine and address health inequities, but much of public health research still documents how health risks, behaviors, and outcomes vary by race, rarely naming racism and with the concept of White supremacy almost invisible. We fully support the recommendations of Boyd et al. for standards that include rejecting the publication of articles that use race but do not examine racism. Dismantling White supremacy through quality improvement also requires us to make diversity, equity, and inclusion a meaningful part of the Public Health Accreditation Board and Council on Education for Public Health accreditation standards by requiring institutions and organizations to publicly report student, faculty, and workforce statistics by racial group.

The 10th EPHS is to “build and maintain a strong organizational infrastructure for public health.” This service emphasizes ethical leadership, transparency, inclusivity, accountability, and equitable distribution of resources. Yet, many public health teaching institutions reside on land and have built endowments by selling land taken from Indigenous people through displacement and genocide. The wealth of other institutions is grounded in the selling of Black persons who were enslaved. Public health institutions have to thoughtfully engage with the reparations movement within their own institutions and nationally. And the infrastructure for teaching, research, and practice should be grounded in critical race theory so that the implications of historical and contemporary manifestations of White supremacy are addressed.

CONCLUSIONS

The core functions and EPHSs have alternatively been called “guidelines,” “vocabulary standards,” a “framework,” and “principles.” They provide a way of making sense of what public health is to us and to others. It is encouraging that the most recent revision centers the concept of equity. But to live up to equity in our EPHSs, they must also tackle structural racism and its roots: White supremacy. In the tradition of public health, we advocate going upstream to deliver the EPHSs, but fully going upstream requires naming and dismantling White supremacy. Success requires building alliances across systems to address the range of social determinants of health caused by White supremacy.

Assessment must include data collection, monitoring, and reporting racism pertinent to the health of BIPOC. Policy development must center on communication about White supremacy, building authentic community partnerships, eliminating regulations that sustain White supremacy, and centering the experiences of people most affected by White supremacy. Assurance requires us to
analyze the impact of White supremacy on training curricula, scholarship, the racial composition of the public health workforce, and the public health infrastructure.

Sustained underinvestment in public health is a considerable barrier to achieving equity in the EPHSs, but this barrier fades in comparison with the disproportionately greater underinvestment in people who are more likely to experience early mortality because of White supremacy. We believe that addressing White supremacy does not require more money; it requires the reallocation of resources.

Although the strategies presented here are based on deeply and honestly examining the field and profession of public health, we echo an earlier call for self-reflection by individual scholars and practitioners: “We must ask ourselves if our own research, teaching, and service are fundamentally and unapologetically antiracist.”

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

REFERENCES

The BRFSS is the largest, continuously conducted, telephone health survey in the United States. It enables the Center for Disease Control and Prevention (CDC), state health departments, health care providers, universities, and other organizations to collect data on health-related behaviors, perceptions, and experiences. Data collected through the BRFSS has been used to identify public health goals and measure progress toward state and national health objectives.

The objective of the BRFSS is to collect uniform, consistent data on a wide variety of health-related topics. These topics include health care access and utilization, health-risk behaviors, perceptions, and beliefs. The survey is conducted annually to track changes in health-related behaviors and identify trends.

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The BRFSS is conducted by state health departments and the CDC, using stratified random digit dialing to ensure that surveys are representative of the target population. The survey is conducted by telephone and includes questions on a variety of health-related topics, including:

- Health care access and utilization
- Health-risk behaviors
- Perceptions and beliefs

Survey data is used to identify public health goals and measure progress toward state and national health objectives. The BRFSS provides a valuable tool for planning and evaluating health promotion and disease prevention programs.
Behavioral Risk Factor Surveillance System (BRFSS) survey of State and School Employees (BSSE)

Every two years a telephone survey is conducted among Oregon’s public sector workforce to assess its overall health. Employees covered by the Public Employees Benefit Board (PEBB) include those working in State Agencies and the Oregon University System. Employees covered by the Oregon Education Benefit Board (EBB) include those working in K-12 School Districts, Educational Service Districts, Community Colleges, and some charter schools.

The BSSE’s results inform efforts to establish, monitor, and modify benefits and programs to fit the health needs of PEBB and EBB members. The BSSE helps identify appropriate benefits and programs to support all Oregon state and school employees, including employees who have disabilities. BSSE results also inform Worksite Wellness efforts for public health organizations and partners working with state and local systems to create healthy worksite and school environments.

Survey data are self-reported. Results are applicable to employees who are primary subscribers, not the entire PEBB and EBB member population. Low response rates, small numbers for specific populations, missing those without a phone number at work or home.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Data Collection</th>
<th>Data Applicability</th>
<th>Response Rate</th>
<th>Missingness</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 years and older</td>
<td>Yes</td>
<td>Yes</td>
<td>Low</td>
<td>Yes</td>
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## New framework for public health accountability metrics

<table>
<thead>
<tr>
<th>Current accountability metrics</th>
<th>New metrics framework</th>
</tr>
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<tbody>
<tr>
<td>Minimal context provided for disease risks and root causes of health inequities</td>
<td>Provides context for social determinants of health, systemic inequities and systemic racism</td>
</tr>
<tr>
<td>Focus on disease outcome measures</td>
<td>Disease outcomes may be used as indicators of progress, but are secondary to process measures of public health system accountability</td>
</tr>
<tr>
<td>Focus on programmatic process measures</td>
<td>Focus on data and data systems; community partnerships; and policy.</td>
</tr>
<tr>
<td>Focus on LPHA accountability</td>
<td>Focus on governmental public health system accountability.</td>
</tr>
<tr>
<td>Minimal connection to other state and national initiatives</td>
<td>Direct and explicit connections to state and national initiatives.</td>
</tr>
</tbody>
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