

AGENDA

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

May 18, 2022
8:30-9:30 am

Join ZoomGov Meeting

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

Meeting ID: 160 116 1415

Passcode: 848357

(669) 254 5252

Meeting Objectives:

- Approve April meeting minutes
- Review and update metrics selection criteria
- Discuss inclusion of indicators in metrics framework and process for identifying indicators

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

OHA staff: Sara Beaudrault, Kusuma Madamala, Ann Thomas

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

8:30-8:40 am	Welcome and introductions <ul style="list-style-type: none">• Approve April minutes• Hear updates from subcommittee members	Sara Beaudrault, Oregon Health Authority
8:40-9:00 am	Metrics selection criteria, how accountability is demonstrated <ul style="list-style-type: none">• Review changes to metrics selection criteria and ensure alignment with updated framework•	Sara Beaudrault Kusuma Madamala, Program Design and Evaluation Services
9:00-9:20 am	Population indicators <ul style="list-style-type: none">• Discuss how the subcommittee envisions indicators being used within the framework for accountability metrics	Sara Beaudrault Kusuma Madamala

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- Review and provide input on proposed communicable disease metrics.

Ann Thomas,
Oregon Health
Authority

9:20-9:25 am

Subcommittee business

- Identify subcommittee member to provide update at 5/19 PHAB meeting
- Next meeting scheduled for June 15.
- Discuss recurring meeting schedule

All

9:25-9:30 am

Public comment

9:30 am

Adjourn

All

Minutes

draft

PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

April 20, 2022
8:30-9:30 am

Subcommittee members present: Cristy Muñoz, Kat Mastrangelo, Dr. Sarah Present, Dr. Ryan Petteway

Subcommittee members absent: Olivia Gonzales, Jeanne Savage

OHA staff: Sara Beaudrault, Kusuma Madamala, Lisa Rau, Ann Thomas, Sandra Rice, Tim Menza, Heather Jamieson, June Bancroft

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

Meeting Objectives

- Approve March meeting minutes
- Review and update metrics selection criteria, with focus on how accountability is demonstrated
- Hear updates and discuss measurement of data and data systems
- Discuss inclusion of indicators in metrics framework and process for identifying indicators

Welcome and Introduction

Sara B. welcomed everyone and asked committee members to introduce themselves. She mentioned this was a public meeting and asked the public to hold comments until the end. This meeting is recorded for the purpose of writing minutes but not published.

Meeting minutes were passed unanimously.

Metrics selection criteria, how accountability is demonstrated

Sara B. began with referring back to last summer and fall when these metrics were created. We want to make sure selection criteria still remains true, since they will be used for the next few years.

Sara B. showed a slideshow (see PowerPoint presentation) outlining the current deliverables for the committee:

April and May, 2022

- Review recommendations from Coalition of Local Health Official (CLHO) committees.

June 2022

- Metrics recommendations for PHAB approval.

July 2022 and beyond

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

Sara B. noted that we have two more meetings before an OHA report is due to the Legislative Fiscal Office which will include progress made by the committee so far.

Sara B. presented a slideshow and stated that the metrics have been revised, with the overarching theme of focusing on **actionable** metrics. She suggested one statement change from “may” to “will.”

- “Disease outcomes ~~may~~ **will** be used as indicators of progress but are secondary to process measures of public health system accountability.”

Kat shared that is she is in the HIE group, which has similar statements and language. Will our work be added to what other groups are doing? Will common definitions be established or will they stay separate?

Sara B. answered that those connections will not be made unless there is an intention to align. OHA can work to draw connections, but you and others on this committee can do so as well.

Kat agreed that it made sense to pull all common definitions together; i.e. data and data systems. We should verify terms and at the very least confirm that they do not contradict each other.

Questions for discussion on metrics selection criteria:

- *Are additional changes needed to metrics selection criteria to align with the metrics framework?*
- *In what ways can accountability metrics be used to demonstrate accountability to communities and for system-wide improvements?*
- *What do we mean when we say accountability and accountability metrics, and who are we accountable to?*

Kat asked if there was support for traditional cultures? She will follow up with Sara on her HEI meeting and what they discussed about this topic.

Ryan commented:

-
1. We should have examples of what each metric should look like. An example is tobacco use, where most measures don't consider context like environment, advertising, tobacco retail...
 2. What do we mean by actionable? Need to be concrete. Sample-based and cross-sectional is not actionable.
 3. Data availability – No accountability if we are basing metrics on data that are already available, based on funding. We don't have the data we need to address population health inequity and lack of data by design and because it hasn't been deemed important. It doesn't address who is responsible. If we are not committed up-front to using financial and human resources to get the data we need, we will not be able to make this actionable and it will be a waste of time.
 4. Data comparability – This should not be the core thing of what is collected. we should not collect the same data from each county. Each county should collect data that is most applicable to their situation. Otherwise, we are tying ourselves to needs that are outside our own community. In terms of macro needs across the state, this is valuable data to collect, but in terms of actionable needs, we should be careful about comparing one community's needs to another's.

Kusuma stressed that the Survey Modernization team informed this new framing around having a lack of context in public health data. This is not currently in selection criteria. It should include lack of context and the need to address contextual factors. She agreed with Ryan and shared that the committee has discussed the need for flexibility in terms of measures that are locally tailored, but the standard around it should show that we are working toward the same thing. The subcommittee could include something about flexibility and locally tailored measures in the selection criteria. Kusuma noted that data availability is an important piece, but there has to be some acknowledgement of whether we have the local and state workforce to collect new data that is not currently available?

Cristy stated that her work is around community engagement and when it comes to metrics, data can become old. How long do we have before it becomes out-of-date? Do we need something that determines a timeline for gathering data--creating an expectation that we don't rely on data that are old?

Ryan pointed out in the chat that public health data may be 2-3 years old when finally made public, need to work more closely with community residents to collect and share real-time data.

Sarah P. acknowledged that there has been a lot of discussion about dismantling our current public health system and rebuilding it to meet community needs, but is still science and data driven, and the tension of doing this with an exhausted work force. There is tension around this issue, to be finding things that are truly doable and still create system change.

Sarah P. also pointed out that there is a lot of opportunity now for public and private partnerships, such as OSHU being a thought leader providing ideas and resources to the public health system. Public health encompasses more than just government public health system. Perhaps drawing on these partnerships can increase our capacity. Not sure if this should be a criteria or not.

Ryan added in the chat that it sounds like LHD capacity/workforce should be itself an accountability metric; for example, how do we do this work without first making investments in the resources needed to do it?

Kusuma wanted to go back to the charter and reviewing what local and state governmental health are actually accountable for. We should make sure we're learning from the past, like lessons learned in the Health Officer Caucus Report to the Covid Response and doing the basics well before we add other requirements.

Measurement of data and data systems

Questions for discussion:

- *What questions, ideas or concerns do subcommittee members have about discussions on measurement of data and data systems?*
- *Is this consistent with the direction provided by this subcommittee?*

Sara shared slides that showed the CLHO committee discussion which focused on communicable diseases with a subset of data and data systems for communicable disease within the government system. In the future we hope to add a set of metrics around community partnership and policy for communicable disease control. Then at a higher level, we would identify population indicators and why we would need to be making these improvements in our communicable disease data.

Ryan agreed that the data looks good from a communicable disease standpoint but not sure how it transfers to population and community health. Also, examples would be helpful here, especially explaining context issues: such as risk factors related to living wage or sick leave. If we don't have this kind of data, it makes it difficult to intervene and provide resources to those who need them. This data is very good but needs to be reworked to serve accountability purposes.

Kusuma asked Ryan if he thinks that integrating additional data sources into our communicable disease data analysis and reporting would provide the additional context needed. Is there a possible measure for data use agreements with other agencies and integrating external data sources?

Ryan replied that he's not sure of OHA's data use agreements but feels as public government, we should have access to such databases as: transportation indicators: wage, property ownership, and tax data; parks and rec data; school data; Medicare and Medicaid and other databases relevant to public health. Therefore, the first step should be to see what other data sources are out there. Then, we need to think about how to fill in the gaps for data that is not available or that we do not have access to.

June Bancroft added in the chat - We do have our communicable disease data in a mapping portal with the CDC social vulnerability index which includes minorities, unemployed, % below poverty.

Ryan added in the chat, “I also think we need to spend some time accounting for the (limited) role of data as form of evidence/testimony in context of policy/politics. It's an important piece in policy decisions (or at least should be), but it's hardly ever the only piece or the most important piece. So we need to be asking ourselves which kinds/forms of data are most useful/valuable to complement other community health organizing/advocacy strategies.”

Ann agreed with Ryan, and is curious if Ryan is referring to obtaining individual data or census-track data? She asked how he envisions this working.

Ryan added in the chat that this work will inevitably require making asks of private entities for data as well. Many may be available at an ecological, neighborhood level. Identified data are aggregated as individual points and geocoded.

Ryan added a link in the chat:

Health affairs piece: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489>

Ann believes there is still a lot of data that we could get at the census-track level. She referenced CDC’s social vulnerability index. OHA developed a COVID vulnerability index that took into account a lot of these other factors mentioned based on census level tract.

Sara B. chimed in that data use agreements could be a state-level metric. It is long-term work to get those in place. Community information exchange is another mechanism for risk factor and population health data.

Ann replied that statewide communicable disease databases include demographic data such as age, gender, race, ethnicity, and we geocode all of our data. Data can change according to the disease being tracked. She referenced proposed metrics she shared last fall, one part of which addressed decreasing disease transmissions in the houseless population.

Heather added in the chat: “OHA PHD ACDP : housing status, SOGI, REAL D, occupation *for reportable diseases that receive interview.”

Tim Menza agreed with Ryan that there is plenty of opportunities to pull together and integrate information. CDC metrics don’t necessarily explain Oregon context – they are made for national use and not for the local level. Took social vulnerability index from CDC and made one for Oregon specifically. We need to do more of this work. It is a complex process. Tim referenced a Health Affairs article, discussing measurement of structural racism in research or in explanatory data. This is a big question with great applications to public health, and not rely on things like race and ethnicity.

Cristy shared that there might be some states that are already working on improving the measurement of structural racism and added two resources in the chat:

1. Institute for the study for race and ethnicity : <https://kirwaninstitute.osu.edu/>
<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489>
2. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01489>

Sara B. summarized that we need to create useful metrics that will be relevant over the next few years. These metrics can be used to leverage the changes we need to make to be an accountable and equity-centered public health system. This is long-term work.

Population Indicators

Questions to be asked:

- *In what ways would the subcommittee recommend including indicators within the framework for accountability metrics?*
- *What role does the subcommittee want to play in identifying metrics?*

This discussion will be carried over to the next subcommittee meeting in May.

Next steps

There were some changes suggested to the selection criteria.

- De-emphasizing that we already have data available and not wanted to lead with that.
- De-emphasizing data comparability
- Building in flexibility

Subcommittee business

Kat was chosen to present today's update to the 4/21 PHAB meeting.

Public Comment

None.

Adjourn

Next meeting is 5/18/22.

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.

New framework for public health accountability metrics

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

Metrics selection criteria

For discussion

- Do the definitions provided for indicators and accountability metrics reflect the subcommittee's expectations? Do they demonstrate accountability to communities and for system-wide improvements?
- Are other changes consistent with subcommittee input?

PHAB Accountability Metrics Subcommittee

Metrics selection criteria

May 2022, draft

Updates in blue

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

Definitions:

Indicators

- Data points that draw attention to priority communicable disease and environmental health issues that affect the health and wellbeing of people in Oregon.
- Over time, changes in indicator data show whether Oregon is making progress toward eliminating inequities and whether health outcomes are improving as a result of investments in the governmental public health system and other sectors. improving health outcomes.
- When possible, indicator data are reported by race, ethnicity and other demographic and risk factor data.

Accountability metrics

- Process measures of the governmental public health system's core functions for which the system is accountable.
- These core public health functions are necessary for achieving improvements in communicable disease and environmental health indicators.
- Over time, changes in accountability metrics show whether the governmental public health system is increasing capacity for providing core functions.
- Accountability metrics are not reported at a population level and are not reported by race, ethnicity and other demographic factors.
- Examples may include completeness of communicable disease risk factor data or provision of data to community partners for decision-making.

Example indicators and accountability metrics

Indicator	Accountability metrics
Acute hepatitis infections among homeless populations	<p>Percent of acute hepatitis infection case interviews with complete REALD, SOGI and housing status data</p> <p>Percent increase in REALD data completeness as a result of data exchange with other state data systems.</p>
Heat-related emergency department and urgent care visits	<p>Percent of LPHAs that provide routine data to partners and the community highlighting communities/populations most at risk of heat-related illness.</p> <p>Number/percent of LPHAs with communications materials for implementing protections for outdoor workers during heat events.</p>

Metrics criteria can be applied in three phases:

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

Phase 1: Indicators of population health priorities	
Selection criteria	Definition
Population health priority	Indicator has been identified as a population health priority by community members and/or public health professionals
Data disaggregation relevance	<p>Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District</p> <p>Data provide context for health outcomes, which includes systemic issues that result in poorer health outcomes for certain groups.</p>

Commented [BS1]: Consider moving community leadership/community-led metrics to this section.

	<p>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.</p> <p>When applicable, data are reportable by race and ethnicity, gender, sexual orientation, age, disability, income level, insurance status or other relevant risk factor data.</p>
Alignment with strategic initiatives	<p>Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other plans</p> <p>Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.</p> <p>National or other benchmarks exist for performance on this measure</p>

Commented [BS2]: Cristy's comment from 4/20: Data can become old. How long do we have before it is out of date? Do we have an expectation for timeliness so we don't rely on data that are old?

Phase 2: Community priorities and acceptance	
Selection criteria	Definition
Actively advances health equity and an antiracist society	<p>Measure addresses an area where health inequities exist</p> <p>Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination</p> <p>Measure is actionable, which may include policies or community-level interventions</p>
Community leadership and community-led metrics	<p>Communities have provided input and have demonstrated support</p> <p>Measure is of interest from a local perspective</p> <p>Measure is acceptable to communities represented in public health data</p>
Transformative potential	<p>Measure is actionable and would drive system change</p> <p>Opportunity exists to triangulate and integrate data across data sources</p>

	Measure aligns with core public health functions in the Public Health Modernization Manual
Alignment with other strategic initiatives	<p>Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other local health plans</p> <p>Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.</p> <p>National or other benchmarks exist for performance on this measure</p>

Phase 3: Suitability of measurement and public health sphere of control	
Data disaggregation	<p>Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District</p> <p>When applicable, data are reportable by:</p> <ul style="list-style-type: none"> — Race and ethnicity — Gender — Sexual orientation — Age — Disability — Income level — Insurance status
Feasibility of measurement	<p>Data are already collected, or a mechanism for data collection has been identified, which could include establishing data sharing agreements with other sectors.</p> <p>Updated data available on an annual basis</p>
Public health system accountability	<p>State and local public health authorities have some control over the outcome in the measure</p> <p>Measure successfully communicates what is expected of the public health system</p> <p>Measure aligns with core system functions in the Public Health Modernization Manual</p>

Commented [BS3]: Ryan's comment from 4/20: Should not base metrics on data that are already available. We don't have the data to address population health inequities. Need to commit financial and human resources to get the data that are needed.

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.

Commented [BS4]: Ryan's comment from 4/20: data comparability should not be the goal. Each county should collect data that is applicable to local situation.

Resourced or likely to be resourced

Funding is available or likely to be available
Local public health expertise exists

Accuracy

Changes in public health system performance will be visible in the measure
Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years

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

Indicators

- Hear proposed communicable disease indicators.
- What propose do subcommittee members recommend using to identify 1-3 indicators?

Current communicable disease indicators

Indicator	Source
Gonorrhea incidence rate per 100,000 population	PHAB public health accountability metric
Percent of two-year olds who received recommended vaccines	PHAB public health accountability metric
	State Health Improvement Plan
Escherichia coli O157 incidence	State Population Health Indicator
Healthcare acquired infections	State Population Health Indicator
Chronic hepatitis C deaths	State Population Health Indicator
HIV diagnoses by year	State Population Health Indicator
Tuberculosis incidence	State Population Health Indicator

ACDP/Immunization/HST Proposed Accountability Metrics

Ann Thomas, MD, MPH
Acute and Communicable Disease Prevention



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

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

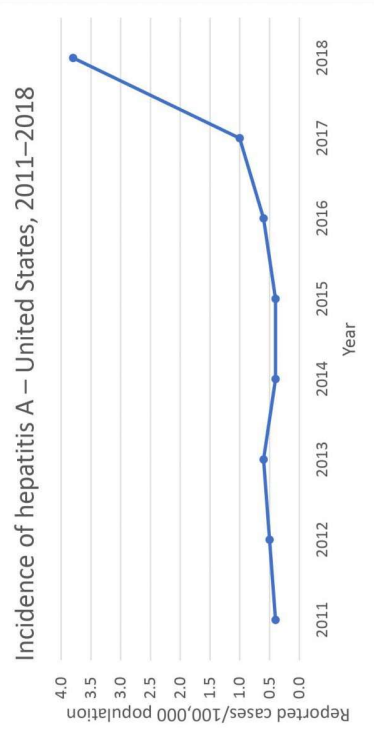
Major communicable disease disparities in the pre-COVID-19 era

National

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

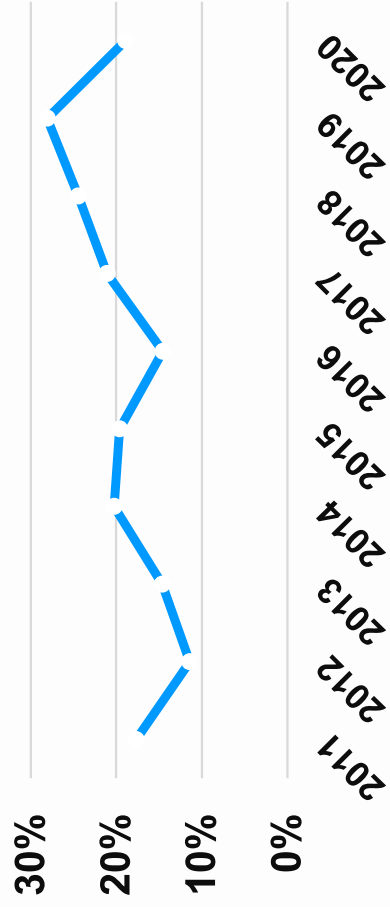
Oregon

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

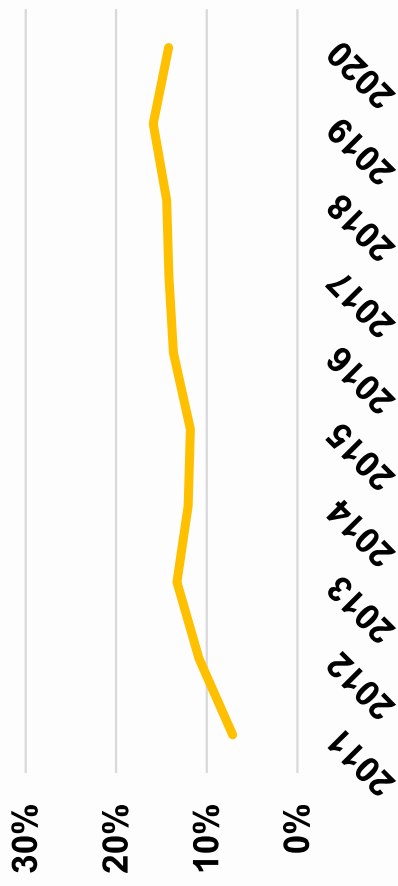


Increase in infections associated with injection drug use

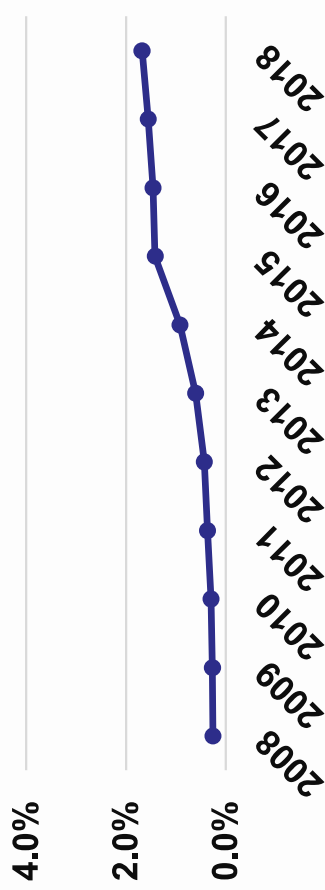
*Percent of all HIV diagnoses in PWIDs



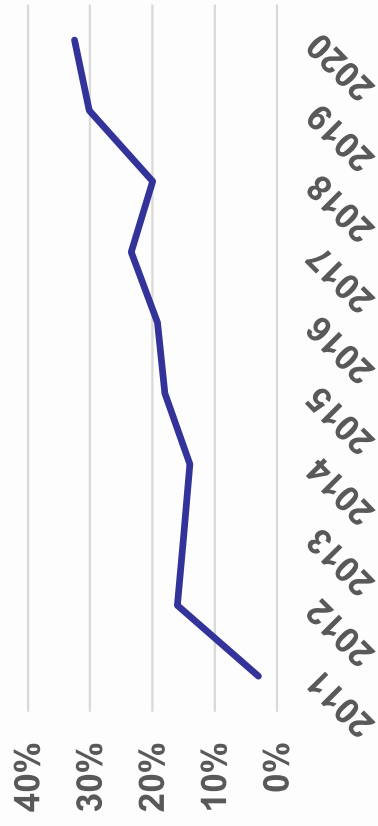
*Percent of chronic HCV cases < age 30



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

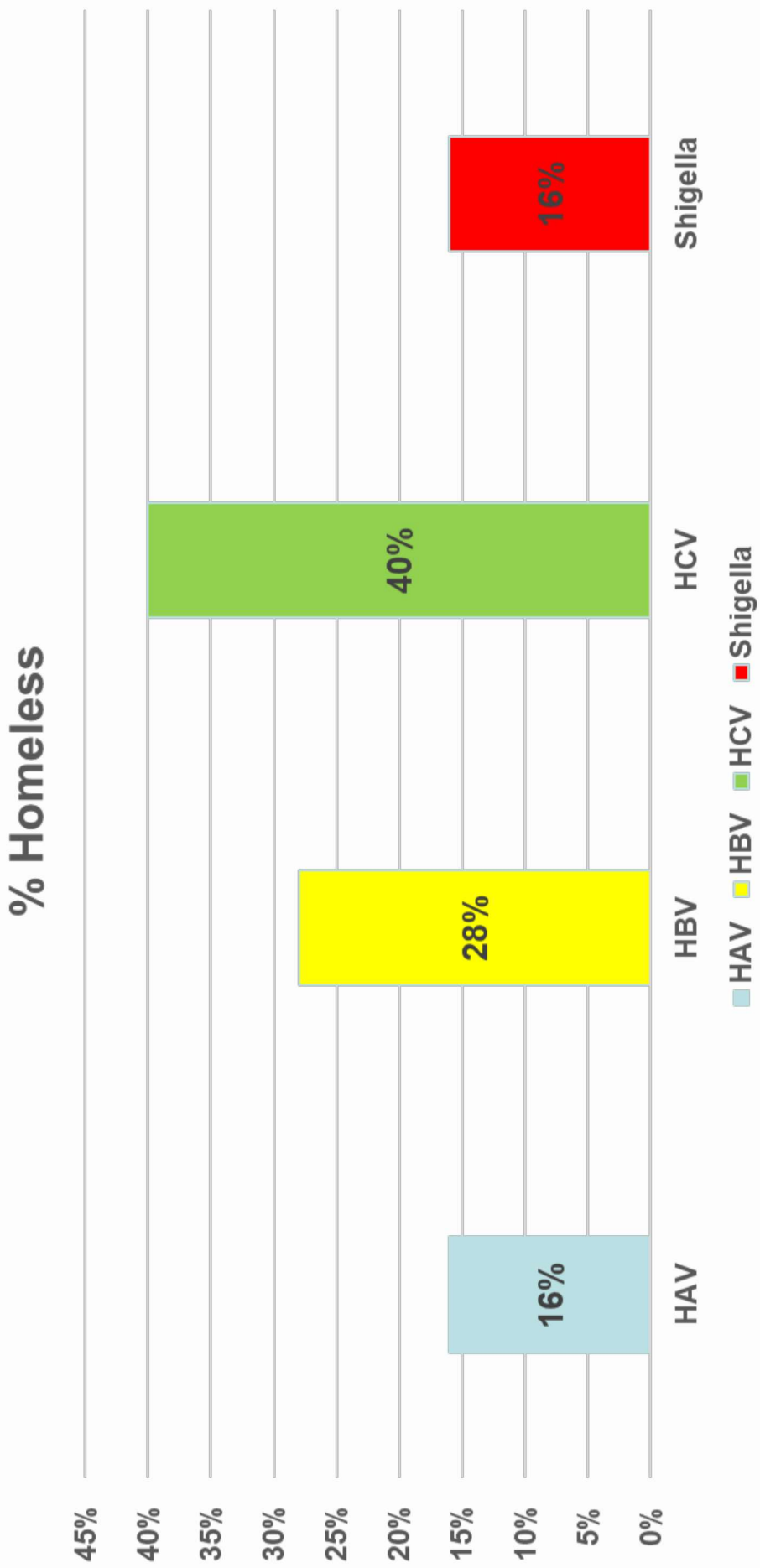


#Percent of invasive GAS cases in PWIDs



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

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



Source: Orpheus

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

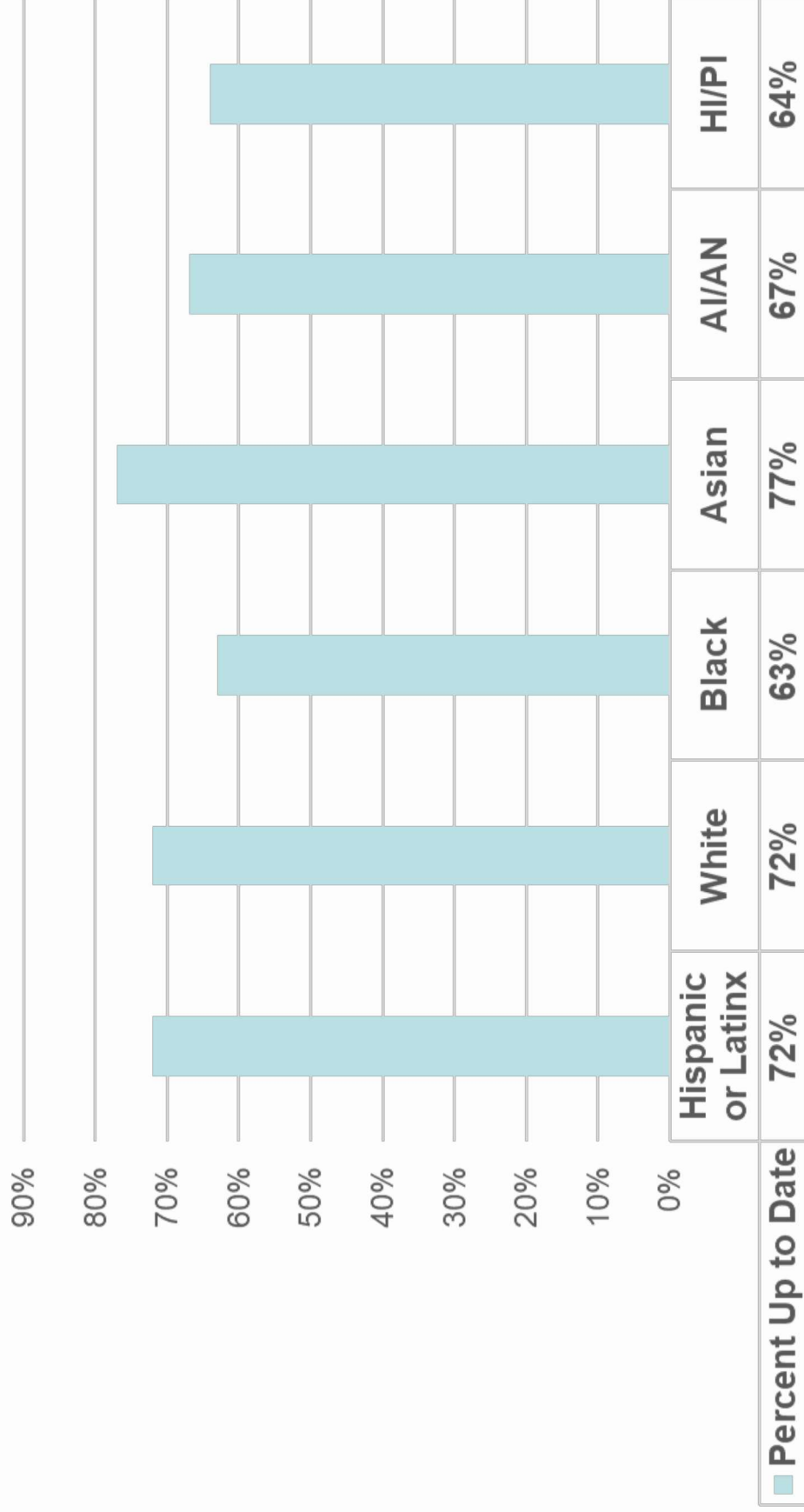
	Salmonella		Shigella		STEC	
	Rate*	RR**	Rate	RR	Rate	RR
Blacks	14.3	2.4	6.4	3.1	4.8	1.6
Asians	6.1	1.1	2.1	1.0	2.8	0.9
AI/ANS	10.3	1.8	2.6	1.3	2.6	0.9
NH/PI	13.9	2.4	11.7	5.6	-	-
Hispanic or Latinx	10.2	1.7	5.2	2.5	5.8	1.9
US rates or HP 2030 goals	HP 2030: <11.5		US rate in 2016: 3.92		HP 2030: <3.7	

*Rate in cases /100,000

**RR=Relative risk compared to Oregon average

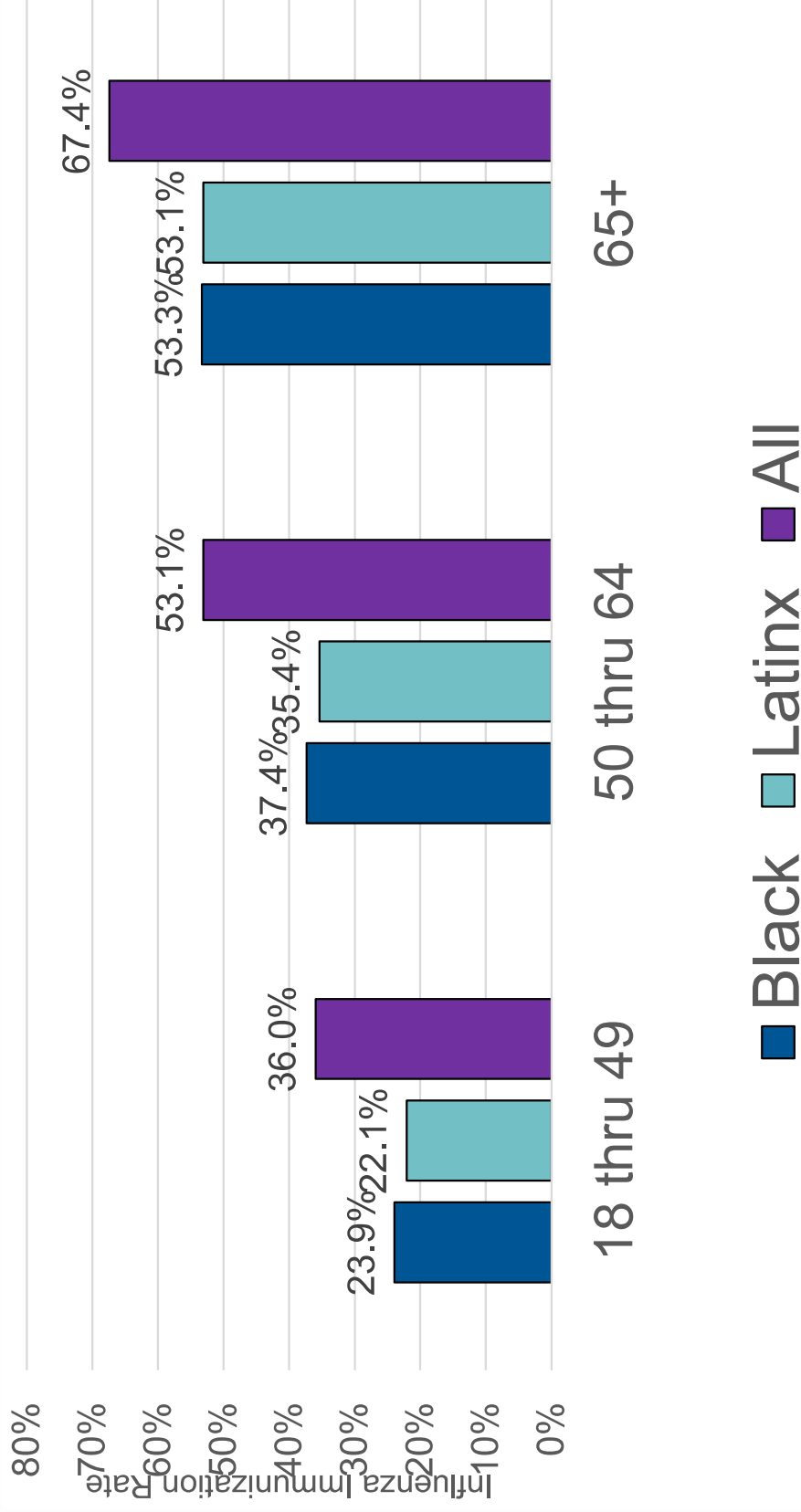
Source: Orpheus, OHA

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



Source: Oregon ALERT Immunization Information System

Oregon Adult Influenza Immunization Disparities (2019-20)



Source: Oregon ALERT Immunization Information System

ACDP approach: Start with key vulnerable populations

I. Persons who inject drugs (PWIDs)

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

II. Homeless

- Decrease infections related to poor sanitation and lack of vaccination

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

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

How the metrics will work

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

I. Injection Drug User Health: Disease Indicators

County level rates of:

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

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

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

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

County level rates of:

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

* Collected routinely as part of case investigations since 2019

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

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

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

County rates of:

- Vaccine-preventable diseases (focus on acute hep A and B, pertussis, measles, mumps), stratified by race and ethnicity (Orpheus)
- Foodborne diseases (STEC, salmonella and shigella) stratified by race and ethnicity (Orpheus)
- Vaccination rates stratified by race (ALERT IIS currently tracks OMB race/ethnicity designations, need to revise to capture REALD)

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

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

Contact information

Ann Thomas
Acute & Communicable Disease Prevention
Public Health Physician
Viral Hepatitis Program Director
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Proposed indicators	Measure source/related plan	Data source	Notes	Phase 1 Selection Criteria: Indicators of population health priorities		
				Population health priority	Data relevance	Alignment with strategic initiatives
Communicable disease control						
Percent of two-year olds who received recommended vaccines	Current public health accountability metric (PHAB); Healthier Together Oregon	ALERT Immunization Information System				
Gonorrhea incidence rate per 100,000 population	Current public health accountability metric (PHAB)	ORPHEUS				
County level rates of HIV; syphilis; acute hep A/B/C syphilis with proportion occurring among PWID; chronic cases of HCV under the age of 30 years						
Invasive rates of group A streptococcus						
County level rates of hospitalizations for skin and soft tissue infections, septicemia/bloodstream infection, osteomyelitis, endocarditis in persons with substance use disorder						
For chronic HBV/HCV, estimates of hospitalizations for complications of chronic liver disease related to viral hepatitis						
For chronic HBV/HCV, cases of liver cancer associated with HBV/HCV						
For chronic HBV/HCV, rates of death related to chronic HBV, HCV						
Decrease infections related to poor sanitation and lack of vaccination among homeless						
County levels of rates of vaccine preventable diseases such as HAV and HBV and various foodborne bacteria occurring in homeless (Orpheus), with proportion of cases occurring among homeless.						
Increase cultural competence and level of community engagement/outreach that LPHAs have with marginalized communities (such as BIPOC populations, immigrants, refugees, migrant and seasonal farmworkers) to improve prevention and control of vaccine preventable diseases, particularly when associated with vaccine hesitancy						
Rates of vaccine-preventable diseases (focus on acute hep A and B, pertussis, measles, mumps) stratified by race						
Proportion of people newly diagnosed with HIV who achieve viral suppression within 90 days of diagnosis.	End HIV Oregon					
Proportion of people in Oregon with a PrEP prescription.	End HIV Oregon					

Percentage of population age 12+ with a substance use disorder in past year	Healthier Together Oregon					
Percentage of population that is food insecure	Healthier Together Oregon					
Percent of population that lacks transportation						
Increase access to harm reduction services like syringe service programs (SSPs), wound care supplies, and medication for opioid use disorder (MOUD) to reduce infections related to injection drug use						