

# AGENDA

## PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee

November 17, 2021  
8:00-9:30 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 October meeting minutes
- Discuss state and national initiatives that inform Oregon’s public health accountability metrics
- Review proposed framework for accountability metrics

**Subcommittee members:** Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Present

**OHA staff:** Sara Beaudrault, Kusuma Madamala

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

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8:00-8:10 am	<b>Welcome and introductions</b> <ul style="list-style-type: none"><li>• Approve October minutes</li><li>• Hear updates from subcommittee members</li></ul>	Sara Beaudrault, Oregon Health Authority
8:10-9:10 am	<b>State and national initiatives that inform Oregon’s public health accountability metrics</b> <ul style="list-style-type: none"><li>• Review discussions to date on state and national initiatives that inform and align with this subcommittee’s work.</li><li>• Hear about additional initiatives that align with public health accountability metrics.</li><li>• Discuss whether changes are needed to metrics selection criteria.</li></ul>	Sara Beaudrault  Kusuma Madamala, Program Design and Evaluation Services

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9:10-9:20	<b>Proposed framework for accountability metrics</b>	<ul style="list-style-type: none"> <li>Review and discuss proposed framework.</li> <li>Discuss next steps for metrics development</li> </ul>	Sara Beaudrault
9:20-9:25 am	<b>Subcommittee business</b>	<ul style="list-style-type: none"> <li>Select subcommittee member to provide update at December PHAB meeting</li> <li>Next meeting scheduled for 12/15</li> </ul>	All
9:25-9:30 am	<b>Public comment</b>		
9:30 am	<b>Adjourn</b>		All

## **PUBLIC HEALTH ADVISORY BOARD Accountability Metrics Subcommittee**

October 20, 2021  
8:00-9:30 am

**Subcommittee members present:** Cristy Muñoz, Jeanne Savage, Kat Mastrangelo, Olivia Gonzalez, Sarah Poe, Sarah Present

**Subcommittee members absent:** Sarah Poe

**OHA staff:** Sara Beaudrault, Kusuma Madamala; Ann Thomas, Linda Drach, Rex Larsen, Kelly McDonald

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

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### **Welcome and introductions**

August and September minutes were not approved.

Sara B. will explore whether it is possible to approve subcommittee minutes through email.

Sara B. mentioned tomorrow's PHAB meeting with survey modernization partners to talk about their findings, recommendations, and lessons learned from the community-specific briefs that they shared with PHAB in May. It has a lot of implications for this subcommittee's work to establish public health accountability metrics.

Sara B reviewed group agreements, timelines and deliverables and metrics selection criteria.

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### **Communicable Disease Priorities and Measures**

Sara B. reminded the group of public health modernization goals for designing a public health system that provides core public health programs in a way that is equitable and drives us toward outcomes. The programmatic work is built upon the foundational capabilities which is the work we do every day. The subcommittee has been talking about environmental health but today we are switching to talking about communicable disease metrics. Environmental health and communicable disease are the areas that have been prioritized with Legislative funding.

Sara B. described the core public health system functions and roles for communicable disease control, as described in the Public Health Modernization Manual.

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Kusuma added that public health modernization is aligned with public health accreditation standards and what public health departments are accountable for. There is a direct connection.

Ann said that when we think about health disparities in communicable diseases, there is intersectionality between institutional racism and social determinants of health. COVID has highlighted this and made it very clear to people outside of public health. COVID has a disproportionate impact on people with underlying health conditions. Respiratory viruses are more commonly transmitted in crowded indoor settings, which affects multigenerational households, congregate care facilities and correctional facilities. Work settings, especially those for low wage jobs are a risk factor, and people in low wage jobs are not able to take time off when sick and certainly not to quarantine for 14 days.

Ann said her team started by looking at which other diseases have a disproportionate impact on certain racial and ethnic groups and based on risk factors. They saw a huge increase in hepatitis A, primarily in people who are homeless, people who inject drugs and among men who have sex with men. There is intersectionality between people who are homeless and people who inject drugs, and many had also been recently released from incarceration. Many had acquired chronic hepatitis B and C which leads to more severe liver disease when hepatitis A was contracted.

Ann said Oregon has also seen measles outbreaks among Russian-speaking immigrants of a particular religious group, and mumps among Pacific Islander communities.

Ann said that opioid and methamphetamine epidemics are also intertwined with infectious disease.

Ann reviewed communicable disease data. Refer to meeting slides for more complete information.

- Ann shared data on infectious diseases associated with injection drug use, including hepatitis C; hospital data for bacterial/fungal infections, endocarditis, bloodstream infections and bone infections; and group A strep.
- Ann reviewed data on infectious among homeless communities, including acute hepatitis A, B, and C; shigella.
- Ann reviewed racial and ethnic disparities in foodborne illnesses.
- Ann reviewed rates of two year olds up to date with immunizations by race and ethnicity. This is an existing metric.
- Ann reviewed influenza vaccination rates by age and race/ethnicity.

Ann's team developed metrics based on vulnerable populations: people who inject drugs; people who are homeless; and BIPOC communities along with immigrant refugees and migrant and seasonal farmworkers. For people who inject drugs, they focused on increasing access to harm reduction services which would reduce risk of a number of infections. For homeless populations, they focused on infections due to poor sanitation and lack of vaccination. For BIPOC, immigrant refugee, and migrant and seasonal farmworker they focused on increasing cultural competency and engagement with marginalized communities. The tri-counties had a good approach for measles outbreaks to establish connections with faith-based organizations and other trusted organizations.

Kusuma asked about data sources.

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Ann said that routine communicable diseases are investigated by LPHA staff. We collect demographic data including race and ethnicity in REALD format, information on injection drug use and houseless status. These are collected in the communicable disease database. Immunization data are collected in the statewide immunization registry, ALERT IIS.

Rex said that ALERT IIS includes data from local public health, health systems and providers, CCOs and payors. Race and ethnicity data is very complete but not in REALD standards.

Kat asked how we know what the denominator is, especially for immigrant populations. She noted that her community was doing well with immunizations for the Latinx population, sometimes over 100%, which leads people to believe we don't know what the denominator is.

Rex said that denominator management is a challenge. As we work to improve our data and link to different data sources, we are getting better at figuring out how the IIS data can best match different data sources. We rely a lot on the census and have been working with PSU Population Health Research Center to get updated denominators. Particularly for smaller counties we're going to run into quirks in the data. This is true for immunizations and other metrics.

Cristy asked about a 2019 increase in injection related illnesses, possibly correlated with houselessness.

Ann said that there weren't any big markers in 2019. It has been a slow rise over the last 7-8 years.

Linda noted a Multnomah County outbreak of HIV related to homelessness in 2019.

Cristy is trying to get a better understanding of what it means for refugee and immigrant communities or those displaced by disasters to be moving into spaces that already have housing issues and how that might impact communities again in terms of infectious diseases. How is OHA able to track the relationship between houseless and illnesses?

Ann responded that most data is collected through interview data or review of medical records. We likely have an underestimate of the problem. Also, people who become infected with diseases like HIV may be asymptomatic and do not seek health care. Ann noted that she is involved in an OHSU study that involves doing outreach to people who inject drugs. Generally people are recruited at syringe exchange programs or homeless camps, or places like bottle drops or food pantries. In Douglas County, 75% of the people recruited were homeless. This is not an unbiased estimate because staff are seeking people from marginalized communities. Infections and substance use are very intertwined and houselessness is a third piece of intersectionality.

Cristy asked whether OHA uses the most current census data points.

Ann responded that we use the most current census data available.

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Rex said that the immunization program uses 2020 census data and PSU population numbers are also updated to the most recent census data.

Olivia asked how we track vaccination of migrant or seasonal farmworkers coming from outside the United States. We don't know until we research or communicate directly with them. This will also provide more accuracy about the disease.

Ann reviewed metrics for the subcommittee to consider. Please review to meeting slides for more complete information.

- For each of the vulnerable or higher risk communities, there are several diseases that could be mitigated through community-based interventions like syringe exchange. LPHAs can target interventions depending on local burden of disease. For process measures, these focus on public health modernization foundational capabilities for health equity and cultural responsiveness, community partnerships, assessment and epidemiology, and policy.
- For people who inject drugs (PWID), measures focus on harm reduction services and referrals to treatment.
- For PWID disease outcomes, you could track HIV; congenital syphilis; acute cases of hepatitis A, B, and C; chronic cases of hepatitis C in people under age 30; invasive rates of Group A Strep; county level rates of hospitalization by zip code.
- For PWID process measures, we can look at many factors for syringe exchange programs, including travel time within a county; getting people to take medication for opioid use disorder; vaccinations given at these sites.
- For PWID measures, Ann discussed alignment with state and national priorities.
- For disease outcomes for homeless population, proposed measures look at foodborne disease and vaccine preventable diseases. These diseases, hepatitis A and B, pertussis, salmonella, shigella, STEC are all reportable diseases and can be looked at to determine the proportion of cases in homeless populations.
- For homeless population proposed process measures, we could look at the volume of supplies dispensed, availability of portable toilets or handwashing stations, vaccinations provided.
- For homeless populations measures, Ann discussed alignment with state and national priorities.
- For disease outcomes for BIPOC, immigrant and refugee, and migrant and seasonal farmworker communities, we can look at vaccine preventable diseases such as hepatitis A and B, measles pertussis and mumps, by race and ethnicity. Similarly we can look at foodborne illnesses by race and ethnicity.
- For process measures for BIPOC, immigrant and refugee, and migrant and seasonal farmworker communities, we can think about how we are engaging with these communities. It could include public health workforce training, proactive outreach to organizations and institutions, mapping out where populations are and using things like CDC's social vulnerability index and county census tract data, communications that are linguistically and culturally appropriate, community-driven needs assessment; community-led advisory boards. This is who we are and what we need to be doing. We have OHA's commitment to eliminate health inequities by 2030.

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Diane asked about having access to garbage cans and clean water in homeless populations, and when LPHAs would start tracking this.

Ann responded that this is not funded by OHA currently. It is an example of the kind of things LPHAs could do and could be prioritized by the public health system.

Sarah Present thanked Ann for the thought that went into this and the new way of thinking that we're all looking for. Sarah encouraged PHAB and this committee to step back and grasp the lessons we're learning from the pandemic about communicable diseases and communicable disease control. This should inform the metrics that LPHAs will be accountable for. LPHAs are struggling with CBOs and with the public health system in general, and not because of lack of funding but because our health system is devastated and exhausted right now. We need to take this into account. Clackamas County recently put out Blueprint Equity grants and a lot of what they heard from community partners was that they could use the money but do not have the manpower to take on new projects. Now is a good opportunity to think about this and which of these evaluate how we've done in this pandemic. Also, what being a modernized public health system means. Thinking about what the public health system has control over compared with how the health system, or politicians or community hears us and decides whether to take our recommendations or not has been challenged. We need to use our metrics to start questioning, assessing and evaluating. How do we prepare for the next pandemic or outbreak in ways so that our partnerships are better set up first and our data systems are better set up first.

Sarah Present likes the ideas of equity in the metrics and wants to make the disease specific disease tracking is an outcome of the processes we change. For example, she would love for all LPHAs to be working on hepatitis C, but we do not have good data tracking systems and before we start looking at decreasing hepatitis C we need to make sure we have the right programs and processes in place. A lot of injection drug use work is dependent on good partnerships, and maybe focusing on the partnerships becomes the focus.

Sarah Present's last caution is around work with homeless camps. Building relationships and trust is hugely important and it can be a politically challenging position. Getting vaccines to homeless camps is a doable thing. We should look at making improvements on what we have capacity for now rather than making big changes as far as programs. Focusing on data modernization and partnership metrics are really good.

Kusuma thanked Sarah for her comments and said she has been thinking similarly. She is reflecting on lessons from survey modernization and data modernization and what we've learned from COVID.

Kat said that she is very interested in the engagement piece. She noted four areas. First homeless populations and camos is managed at the city level and not at the county level. Are there connections between cities and counties in terms of funding and programs? Is there a metric that could show that engagement? With faith communities, there is a need for expertise and if county employees are not embedded in the faith community, this can be challenging. Kat asked about linkages with the Unite Us platform for closed loop referrals to social services. Is there a metric in

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this area? Fourth is a consideration of kids leaving foster care as a vulnerable population. With additional support we could move further upstream with this group.

Sarah Present said that the whole public health system needs to be accountable and not just the LPHAs. For example, LPHAs can make referrals to programs, but only if the programs are in place locally to accept referrals. What is the accountability of the mental and behavioral health systems?

Olivia commented in the chat that it is also important to include the private sector.

Linda gave a highlight of proposed measurement areas for HIV. The HIV and STD program works closely with communicable disease and immunization programs, and the vulnerable populations highlighted today are also important for HIV and STD also. The HIV program has an integrated planning group that sets measures for HIV and STD. This is a way to get to community leadership and alignment. Linda reflected on Sarah Present's comments about shared accountability. Linda has included measures that look at both OHA and LPHAs. The End HIV Oregon initiative has been in place since 2016 and aims to end new HIV transmissions and other STD. They have been putting out community grants and are seeing benefits and better outcomes. Linda's proposed measures also include policy strategies.

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**Subcommittee business**

- Next meeting scheduled for 11/17

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**Public comment**

No public comment was provided.

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**Adjourn**

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# 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

2021 timeline for discussions and deliverables

April	<ul style="list-style-type: none"> <li>- Discuss charter and group agreements</li> <li>- Hear overview on public health modernization and accountability metrics statutory requirements</li> </ul>
May	<ul style="list-style-type: none"> <li>- No meeting</li> </ul>
June	<ul style="list-style-type: none"> <li>- Finalize charter</li> <li>- Discuss survey modernization findings and how to apply findings to public health accountability metrics</li> <li>- Discuss criteria for measure selection</li> </ul>
July	<ul style="list-style-type: none"> <li>- Discuss and make recommendations for public health system accountability</li> <li>-</li> <li>- Discuss <i>Healthier Together Oregon</i> and its relation to public health system accountability</li> <li>- Continue developing criteria for measure selection</li> <li>- Begin review of communicable disease and environmental health outcome measures</li> </ul>
August	<ul style="list-style-type: none"> <li>- Finalize criteria for measure selection (deliverable)</li> <li>- Continue review of measures</li> </ul>
September	<ul style="list-style-type: none"> <li>- Continue review of measures</li> </ul>
October	<ul style="list-style-type: none"> <li>- Continue review of measures</li> </ul>
November	<ul style="list-style-type: none"> <li>- Finalize recommendations for measures</li> <li>- Final PHAB approval</li> </ul>
2022	<ul style="list-style-type: none"> <li>- Continue work to identify public health accountability metrics for additional programmatic areas, including developmental measures.</li> <li>- Develop 2022 public health accountability metrics</li> </ul>

# Charter deliverables

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

## PHAB Accountability Metrics Subcommittee

### Metrics selection criteria

August 2021, draft

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

Criteria can be applied in two phases:

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

Phase 1: Community priorities and acceptance	
Selection criteria	Definition
<b>Actively advances health equity and an antiracist society</b>	Measure addresses an area where health inequities exist  Measure demonstrates zero acceptance of racism, xenophobia, violence, hate crimes or discrimination  Measure is actionable, which may include policies or community-level interventions
<b>Community leadership and community-driven metrics</b>	Communities have provided input and have demonstrated support  Measure is of interest from a local perspective  Measure is acceptable to communities represented in public health data
<b>Transformative potential</b>	Measure is actionable and would drive system change  Opportunity exists to triangulate and integrate data across data sources  Measure aligns with core public health functions in the Public Health Modernization Manual
<b>Alignment with other strategic initiatives</b>	Measure aligns with State Health Indicators or priorities in state or community health improvement plans or other local health plans

Measure is locally, nationally or internationally validated; with awareness of the existence of white supremacy in validated measures.

National or other benchmarks exist for performance on this measure

## Phase 2: Suitability of measurement and public health sphere of control

### Data disaggregation

Data are reportable at the county level or for similar geographic breakdowns, which may include census tract or Medicare Referral District

When applicable, data are reportable by:

- Race and ethnicity
- Gender
- Sexual orientation
- Age
- Disability
- Income level
- Insurance status

### Feasibility of measurement

Data are already collected, or a mechanism for data collection has been identified

Updated data available on an annual basis

### Public health system accountability

State and local public health authorities have some control over the outcome in the measure

Measure successfully communicates what is expected of the public health system

### 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

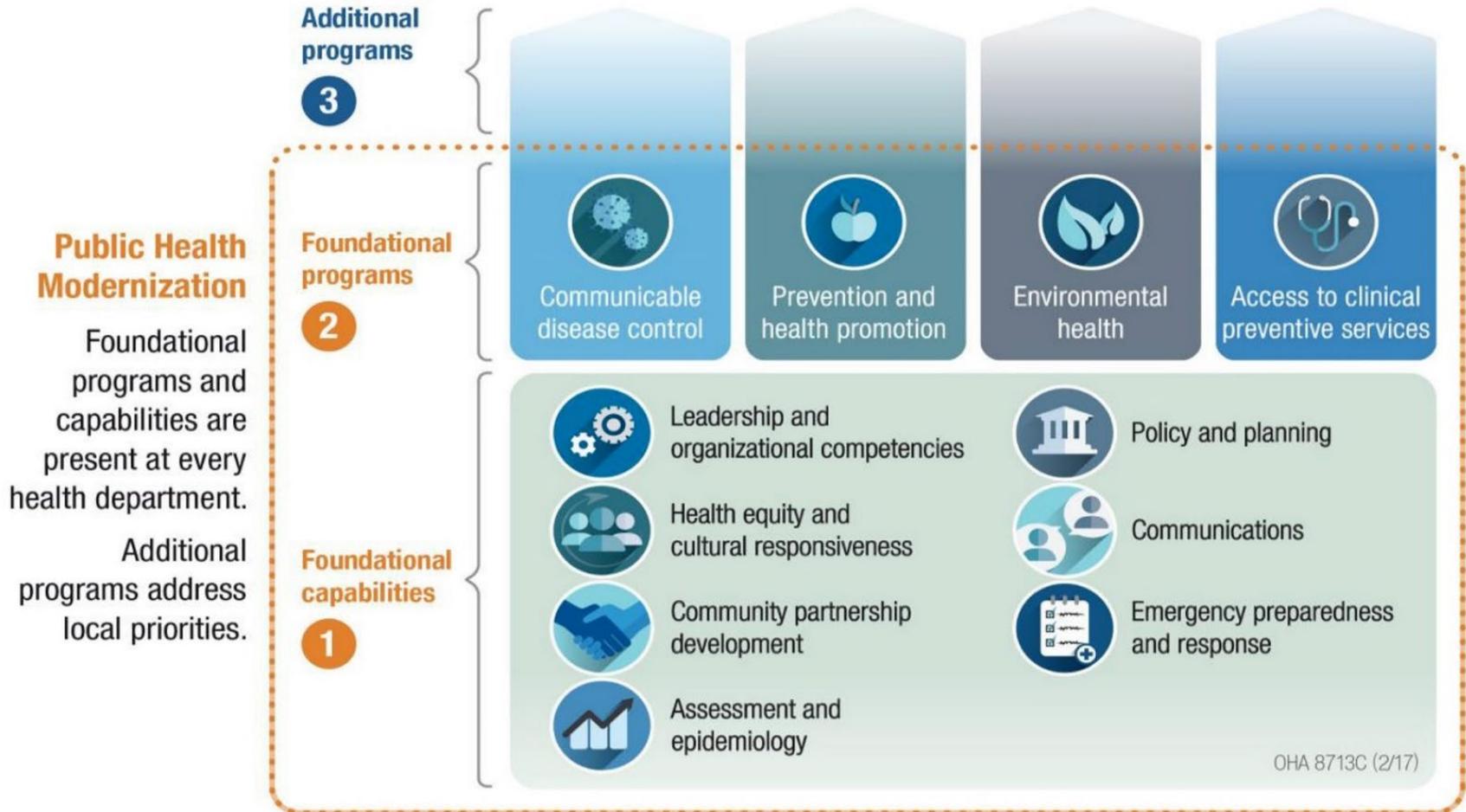


\*Adapted from selection criteria used previously by the PHAB Accountability Metrics subcommittee and for selection of Healthier Together Oregon indicators and measures.

# Discussions to date

- Survey modernization
- Healthier Together Oregon
- Climate and health
- Communicable disease

# Modernized framework for governmental public health services



# 2021-23 Public Health Modernization Funding Priorities

Public health interventions that are equitable, community-driven, and address historical and contemporary injustices

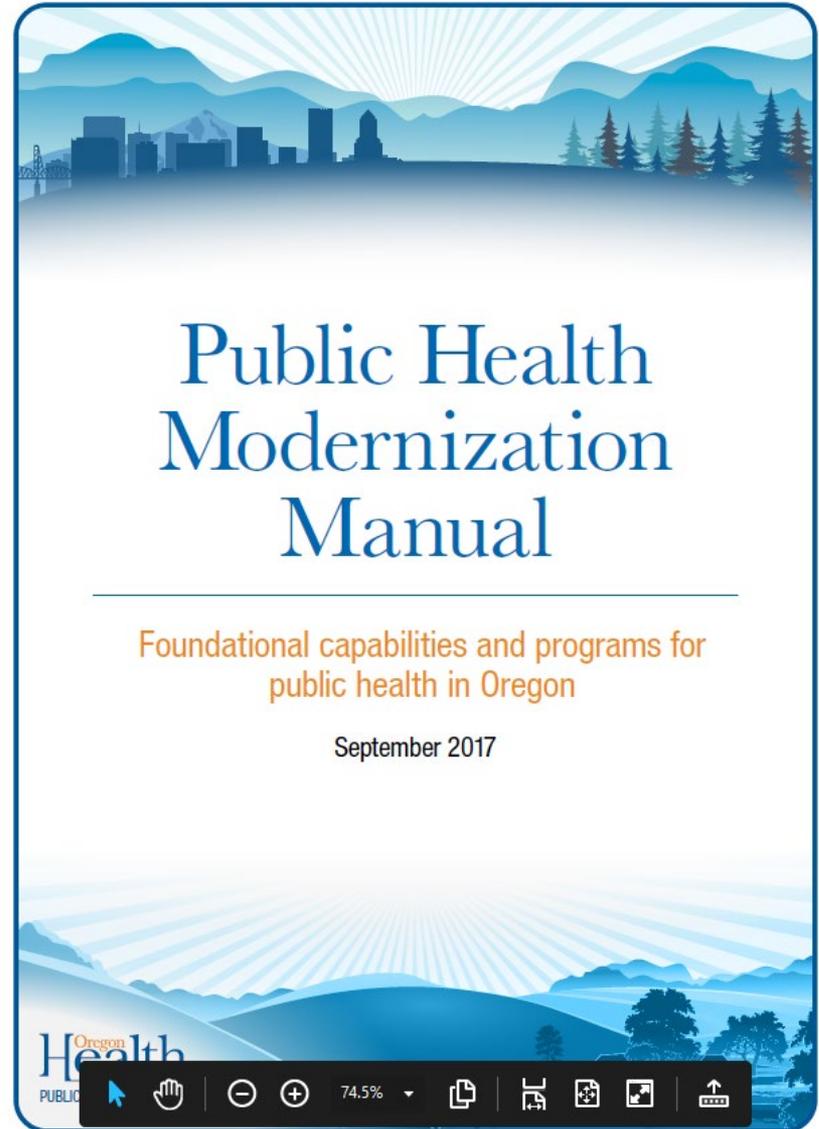
Communicable  
disease and  
environmental  
health threats  
planning and  
response

Communicable  
disease  
prevention

Impacts of  
climate related  
emergencies  
and threats on  
health

# Public Health Modernization Manual

- Describes core functions of the governmental public health system.
- Describes core, inter-related roles for state and local public health.
- [https://www.oregon.gov/oha/p/h/About/TaskForce/Documents/public\\_health\\_modernization\\_manual.pdf](https://www.oregon.gov/oha/p/h/About/TaskForce/Documents/public_health_modernization_manual.pdf)



# Public Health Accreditation Board Standards

Public Health Accreditation Board

## STANDARDS: AN OVERVIEW

### ASSESS

**DOMAIN 1:** Conduct and disseminate assessments focused on population health status and public health issues facing the community

- Standard 1.1:** Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment
- Standard 1.2:** Collect and Maintain Reliable, Comparable, and Valid Data that Provide Information on Conditions of Public Health Importance and On the Health Status of the Population
- Standard 1.3:** Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health
- Standard 1.4:** Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions

### INVESTIGATE

**DOMAIN 2:** Investigate health problems and environmental public health hazards to protect the community

- Standard 2.1:** Conduct Timely Investigations of Health Problems and Environmental Public Health Hazards
- Standard 2.2:** Contain/Mitigate Health Problems and Environmental Public Health Hazards
- Standard 2.3:** Ensure Access to Laboratory and Epidemiologic/Environmental Public Health Expertise and Capacity to Investigate and Contain/Mitigate Public Health Problems and Environmental Public Health Hazards
- Standard 2.4:** Maintain a Plan with Policies and Procedures for Urgent and Non-Urgent Communications

### INFORM & EDUCATE

**DOMAIN 3:** Inform and educate about public health issues and functions

- Standard 3.1:** Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness
- Standard 3.2:** Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences

### COMMUNITY ENGAGEMENT

**DOMAIN 4:** Engage with the community to identify and address health problems

- Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes
- Standard 4.2:** Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health

### POLICIES & PLANS

**DOMAIN 5:** Develop public health policies and plans

- Standard 5.1:** Serve as a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity
- Standard 5.2:** Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan
- Standard 5.3:** Develop and Implement a Health Department Organizational Strategic Plan
- Standard 5.4:** Maintain an All Hazards Emergency Operations Plan

### PUBLIC HEALTH LAWS

**DOMAIN 6:** Enforce public health laws

- Standard 6.1:** Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed
- Standard 6.2:** Educate Individuals and Organizations on the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply
- Standard 6.3:** Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among Appropriate Agencies

VERSION 1.5

### ACCESS TO CARE

**DOMAIN 7:** Promote strategies to improve access to health care

- Standard 7.1:** Assess Health Care Service Capacity and Access to Health Care Services
- Standard 7.2:** Identify and Implement Strategies to Improve Access to Health Care Services

### WORKFORCE

**DOMAIN 8:** Maintain a competent public health workforce

- Standard 8.1:** Encourage the Development of a Sufficient Number of Qualified Public Health Workers
- Standard 8.2:** Ensure a Competent Workforce through Assessment of Staff Competencies, the Provision of Individual Training and Professional Development, and the Provision of a Supportive Work Environment

### QUALITY IMPROVEMENT

**DOMAIN 9:** Evaluate and continuously improve processes, programs, and interventions

- Standard 9.1:** Use a Performance Management System to Monitor Achievement of Organizational Objectives
- Standard 9.2:** Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions

### EVIDENCE-BASED PRACTICES

**DOMAIN 10:** Contribute to and apply the evidence base of public health

- Standard 10.1:** Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions
- Standard 10.2:** Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-Based Practices with Appropriate Audiences

### ADMINISTRATION & MANAGEMENT

**DOMAIN 11:** Maintain administrative and management capacity

- Standard 11.1:** Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions
- Standard 11.2:** Establish Effective Financial Management Systems

### GOVERNANCE

**DOMAIN 12:** Maintain capacity to engage the public health governing entity

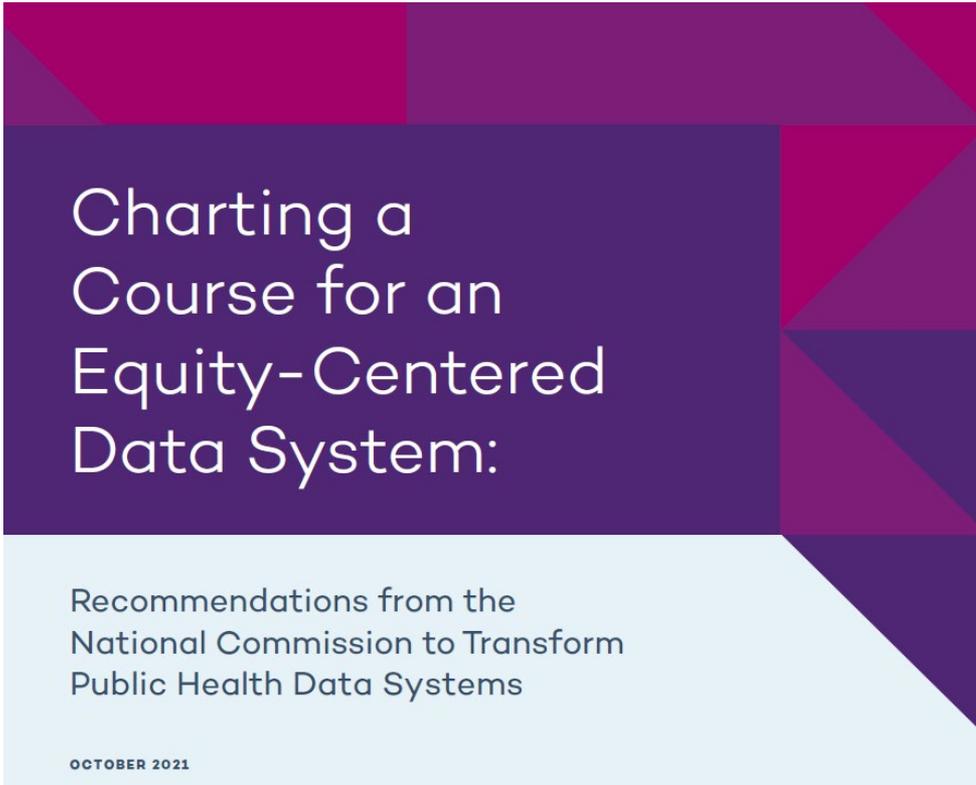
- Standard 12.1:** Maintain Current Operational Definitions and Statements of the Public Health Roles, Responsibilities, and Authorities
- Standard 12.2:** Provide Information to the Governing Entity Regarding Public Health and the Official Responsibilities of the Health Department and of the Governing Entity
- Standard 12.3:** Encourage the Governing Entity's Engagement In the Public Health Department's Overall Obligations and Responsibilities



The **PHAB STANDARDS** apply to all health departments—Tribal, state, local, and territorial. Standards are the required level of achievement that a health department is expected to meet. Domains are groups of standards that pertain to a broad group of public health services. The focus of the PHAB standards is "what" the health department provides in services and activities, irrespective of "how" they are provided or through what organizational structure. Please refer to the **PHAB Standards and Measures** Version 1.5 document, available at [www.phaboard.org](http://www.phaboard.org), for the full official standards, measures, required documentation, and guidance.

VERSION 1.5

- Report available:  
<https://www.rwjf.org/en/library/research/2021/10/charting-a-course-for-an-equity-centered-data-system.html>
- Webinar recording:  
<https://www.youtube.com/watch?v=lg4GLFsis>

The image shows the cover of a report. The top half has a dark purple background with a geometric pattern of triangles in various shades of purple and magenta. The title 'Charting a Course for an Equity-Centered Data System:' is written in white, sans-serif font. Below the title, on a light blue background, is the subtitle 'Recommendations from the National Commission to Transform Public Health Data Systems' in a smaller, dark blue font. At the bottom left, the date 'OCTOBER 2021' is printed in a small, dark blue font.

# Charting a Course for an Equity-Centered Data System:

Recommendations from the  
National Commission to Transform  
Public Health Data Systems

OCTOBER 2021

# SUMMARY OF RECOMMENDATIONS

## Center health equity and well-being in narrative change

- Identify the stakeholders in public health data system transformation and how to engage them at each step of the transformation process.
- Build on stakeholder identification and develop a campaign to promote the importance of public health data and the need for a transformed public health data system.
- Develop a competencies framework to increase data literacy for various stakeholders about the importance of equity considerations in data systems.
- Build the public health data system needed to shift the narrative to one that is just, positively oriented, and equity-based (e.g., from deficit to strengths, from oppressive to restorative).

# SUMMARY OF RECOMMENDATIONS

## Prioritize equitable governance and community engagement

- Prioritize and accelerate implementation of the Evidence Act (Foundations for Evidence-Based Policymaking Act of 2018) for improved transparency, quality, and availability of data.
- Establish and implement a coordinated state and federal investment strategy that includes regular fiscal support of state infrastructure coupled with intermediate and long-term system development and data collection.
- Generate and sustain system transformation with defined governance and stewardship models and structures.
- Make sharing and pooling data (at both the individual level and system level) the default for agencies receiving public money and provide data to all actors.
- Build efficient and interoperable data systems to generate comprehensive, complete, and timely data. Collect data with adequate granularity across population groups (inclusive of race/ethnicity, language ability, disability) and geographic levels that are useful at the community level and can be aggregated and disaggregated.
- Develop agile, analytical methods to work with existing data sets and across diverse sets of quantitative/qualitative data, including historical data.
- Technology companies should support public health data system transformation in under-resourced areas of the country with the largest health inequities, either by direct financial support (corporate social responsibility-CSR) or through skills-based volunteer approaches.
- Philanthropy should fund gaps in public health data, particularly for communities with less resources.

**Recommendation 2d. Make sharing and pooling data (at both the individual level and system level) the default for agencies receiving public money — because no one sector or institution holds all the data needed to understand the factors that drive inequities in health and well-being — and provide data to all actors.**

### **WHAT NEEDS TO BE DONE**

#### **SHORT-TERM**

- Enable linkage of data from multiple cross-sector sources with governance oversight (e.g., privacy, security, and anti-discrimination protections) that includes representatives from groups most at risk for harm from data misuse.
- Governance of data sharing should be driven at the local/state/tribal level, where the laws and the needs of the population vary dramatically, and should inform what information can be shared, with whom, and under what conditions.
- Address proprietary and other disincentives to sharing data and implement public accountability mechanisms functions where needed.
- Implement the Information Blocking Rule,<sup>22</sup> which prohibits practices by healthcare providers and others that are likely to interfere with, prevent, or discourage data access, exchange, or use of electronic health information.<sup>23,24</sup>

### **WHO NEEDS TO ACT**

- Government leaders
- State and local public health officials
- Private sector/Business leaders
- Academia/Research Institutions
- Communities/community members
- Commission members and other experts

## SUMMARY OF RECOMMENDATIONS

### Ensure public health measurement captures and addresses structural racism and other inequities

- Build on the Executive Order (EO) on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government: Equitable Data Working Group, to establish an Interagency Data Council, with responsibility for equity, racial justice, & social and public health data.
- As part of public health data system redesign, collect self-reported data by race, ethnicity, income, education, gender identity, sexual orientation, disability, and social position (i.e., how people are placed in a hierarchy of value by society, as perceived by the individual).
- Invest in community relevant and nationally significant metrics on factors that influence health outcomes.
- Collect data that are more accurate and relevant at the community level to enable small area estimates that enable communities and local health departments to prioritize and address local health challenges and measure progress towards healthier communities.
- Develop methods for interpreting public health data that are inclusive of community input, paying attention to messaging, communication, and narrative.

**Recommendation 3d. Collect accurate, relevant community-level data that support small-area estimates so that communities and local health departments can better prioritize and address local health challenges and measure progress toward healthier communities.**

### **WHAT NEEDS TO BE DONE**

#### **SHORT-TERM**

- Guide local leaders in identifying parochial public health measures and data priorities, with consideration of uniformity to support analysis and interoperability over time, including interoperability at intra-local levels, which can be rolled up optimally to the state level.

#### **LONG-TERM**

- Provide supports to a local data workforce that can tailor data collection efforts locally and employ small-area estimations and other techniques.
- Ensure that the National Secure Data Service can support small-area estimation needs through access to administrative data that lend strength to local data to produce statistics.

### **WHO NEEDS TO ACT**

- Census Bureau
- National Center for Health Statistics
- NIH
- Department of Housing and Urban Development
- Departments of Education and Public Health
- Department of Agriculture
- Department of Commerce
- Parallel agencies at state and local levels
- Municipal and county planning agencies
- Academia/Research institutions

**Recommendation 3e. Develop methods for interpreting public health data that include community input, paying attention to messaging, communication, and narrative. Advance training for the workforce, the public, and communities to use and interpret data.**

#### **WHAT NEEDS TO BE DONE**

##### **SHORT-TERM**

- Establish a community advisory council (via the federal advisory committee process) to provide guidance on public health data sources, uses, and interpretation of data and ensure genuine community engagement.
- Work with higher education to develop public health data analytic methods that are interdisciplinary, action oriented, data driven, and aligned with the revised 10 essential public health services.

##### **LONG-TERM**

- HHS should provide resources to states, tribes, local health departments, and coalitions to develop best practices for bringing community voice to governance, collection, use case prioritization, and interpretation of data and outcome measures.
- Use a Community Commons (a method of creating a network of changemakers focused on health, equity, and sustainability) model as a data repository to help communities engage with and promote data that are compelling, advance a public health narrative, support action, and demonstrate that health equity can be improved.

#### **WHO NEEDS TO ACT**

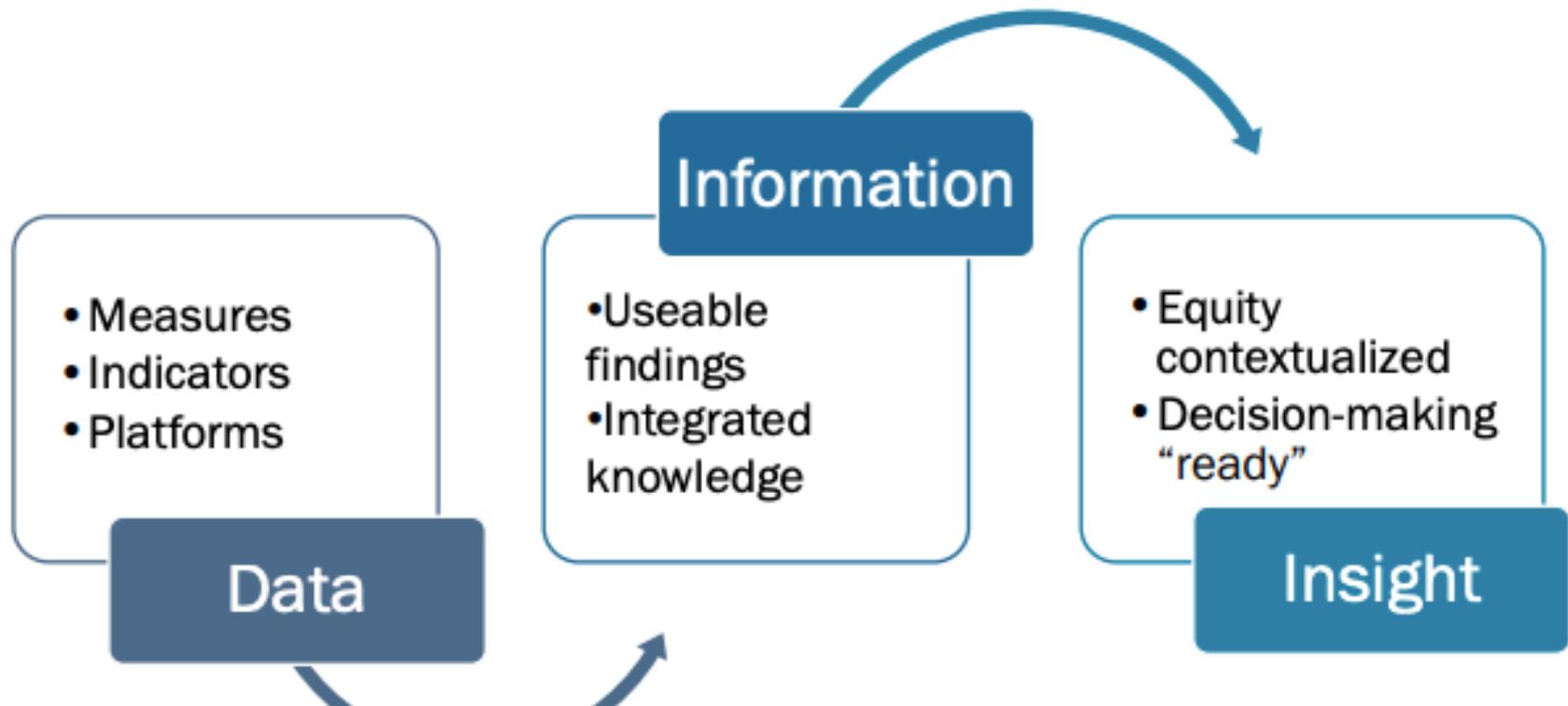
- HHS
- State and local health departments
- State, regional, county, and municipal planning agencies
- Academia/Research institutions

SECTOR	ACTION
<p><b>FEDERAL GOVERNMENT</b></p>	<ul style="list-style-type: none"> <li>▪ Develop minimum standards about data collection, disaggregation, presentation, and access, in federally funded data collection efforts, with an orientation to “freeing federal data” or promoting greater access.</li> <li>▪ Strengthen public health data infrastructure and incentivize the use of new data collection and analytic approaches.</li> <li>▪ Federal funding for data infrastructure should be prioritized to systems that are standards-based and interoperable.</li> </ul>
<p><b>STATE GOVERNMENT</b></p>	<ul style="list-style-type: none"> <li>▪ Offer guidance on interpretation of racial/ethnic variation in health-relevant data to counter longstanding acceptance of the idea that these variations reflect biological differences rather than systemic, cultural, behavioral, and social factors.</li> <li>▪ Ensure that state policies for public health data collection, sharing (including balancing privacy and transparency), and analysis are equity driven and explicitly call out the influence and consequences of structural racism and other inequities on health.</li> <li>▪ Partner with local health departments and departments that provide public health data (e.g., social services data) to consider new models of collaboration to improve efficiency and timeliness of decision-making and action at both state and local levels.</li> </ul>
<p><b>LOCAL GOVERNMENT</b></p>	<ul style="list-style-type: none"> <li>▪ Regularly connect public health data to local communications (i.e., what is happening in the community and how it relates to overall community well-being, or the impact of inequity).</li> <li>▪ Ensure the local voice is represented not only in public health data (e.g., from whom data are collected), but in positions of authority responsible for making sense of the data and informing decisions.</li> <li>▪ Explore data-sharing collaborations across government and civil society (e.g., nonprofits, businesses) that can more consistently generate public health data to support equity considerations and advance innovative public-private collaborations on data and analysis.</li> </ul>

## **PUBLIC HEALTH**

- Lead multisector collaboration around public health data sharing to improve the timeliness and quality of data to strengthen local decision-making.
- Strengthen capacity, diversity, and ongoing training of the public health workforce to monitor and address health equity, both in the field of public health and through novel collaborations with business, academia, or other sectors that influence health.
- Advocate for and prioritize modernization efforts and data sharing within and across the public health system to ensure that local data can inform emerging public health concerns at the regional, state, and national levels in real time.

**Figure 2.** A modern, equity-oriented public health data system must have the ability to generate outputs in three areas: data, information, and insight



TIMELY. ACCURATE. ACCESSIBLE.  
**THE NEW WORLD OF PUBLIC HEALTH DATA**

CDC is building a digital public health superhighway to accelerate lifesaving prevention and response.

**THE REALITY**



**THE OPPORTUNITY**

**REACTING**  
Always behind when epidemics occur



**PREDICTING**  
Getting ahead of epidemics to **stop them quickly**

**COUNTING**  
Collecting data without the ability to rapidly analyze it



**UNDERSTANDING**  
Rapid data analysis to gain **real-time insights**

**STORING SEPARATELY**  
Siloed systems that restrict data sharing



**SHARING EFFECTIVELY**  
Interoperable, accessible **data for action**

**MOVING SLOWLY**  
Outdated, paper-based systems with multiple points of data transfer

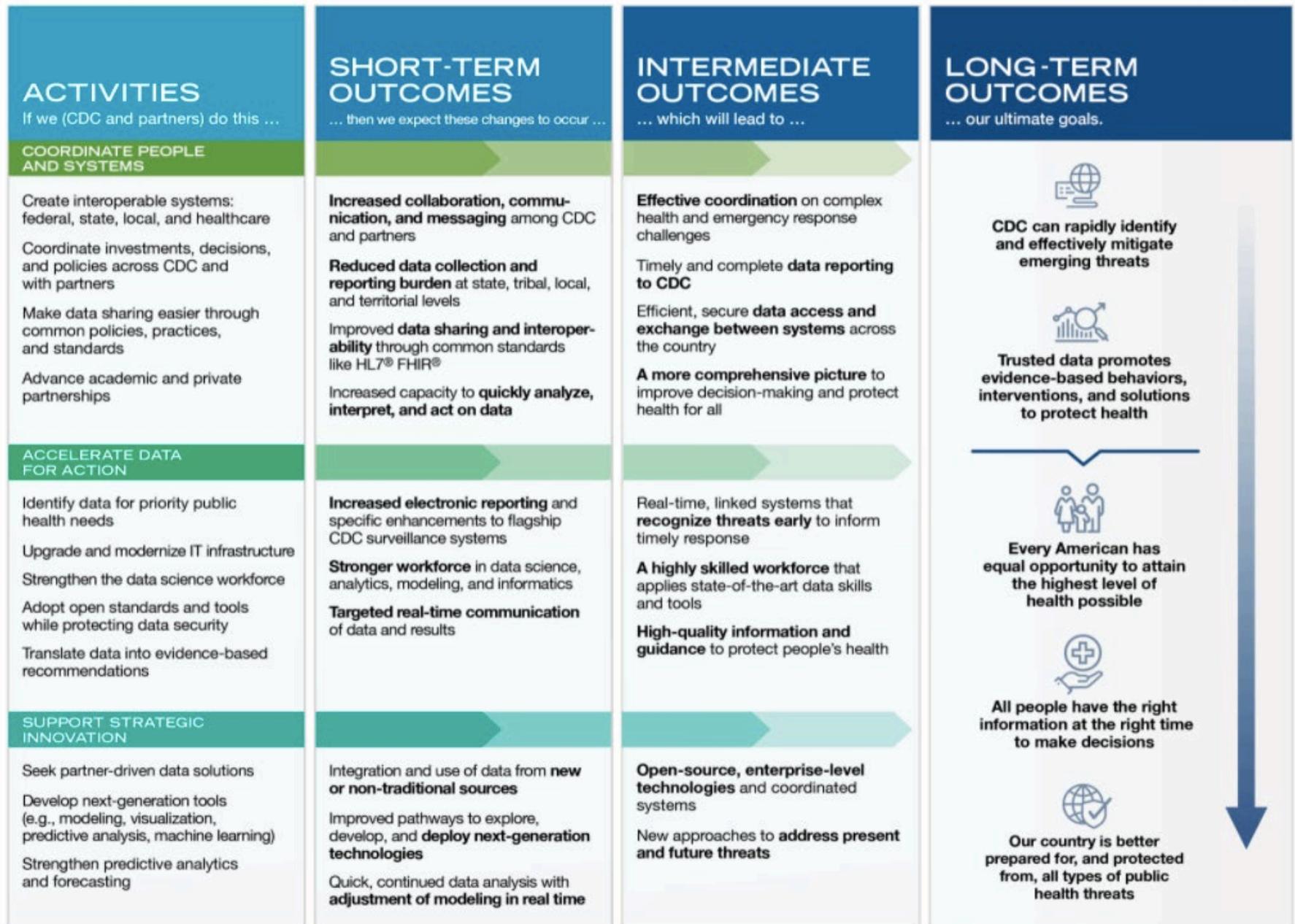


**MOVING FAST**  
A true digital highway to automate **transfer of critical data in real time**

**USING RESOURCES INEFFICIENTLY**  
New resources always required to do new data collection



**CONNECTING RESOURCES**  
Leveraging existing resources and making common **investments for the future**



## Proposed framework and example for Public Health Accountability Metrics

*Under this proposed framework, there are four components to how public health accountability metrics will be collected and reported.*

**Vision:** *Use the vision included in the Public Health Modernization Manual*

**Context:** *Provide background for inequities in disease risks and describe the intersectionality that place someone at greater risk. Describe impacts of social determinants of health. Describe the groups that are most vulnerable.*

**Indicators:** *Include data points/measures that demonstrate the context.*

### **Public health accountability metrics (State and local accountability):**

*Include actionable metrics demonstrating state and local accountability.*

*Involve local public health authorities in developing accountability metrics. Recommendations will come to this committee for discussion and guidance.*

*Based on discussions in this subcommittee to date, accountability metrics may focus on foundational capabilities for:*

- *Assessment and epidemiology (i.e. core functions for ensuring accessible, shareable and useable data).*
- *Community partnerships*
- *Policy*

*Accountability metrics may also focus on programmatic/community-based interventions*

## Communicable Disease Control Example

**Vision:** *Ensure everyone in Oregon is protected from communicable disease threats.*

**Context:** *Discuss inequities in communicable disease risks in Oregon, for example housing stability and housing conditions, food security and access to health care. Discuss vulnerable groups (i.e. people who are homeless; people who inject drugs; men who have sex with men; BIPOC, immigrant, refugee and migrant and seasonal farmworkers). Also frame within the context of COVID-19.*

### **Indicators:**

- *HIV; congenital syphilis, acute hepatitis A/B/C; with proportion occurring among people who inject drugs.*
- *Chronic cases of hepatitis C under the age of 30 years.*
- *Vaccine preventable disease rates such as hepatitis A, hepatitis B and pertussis, with proportion occurring in homeless individuals.*
- *Foodborne diseases (Salmonella, Shigella, STEC, with proportion of cases occurring in homeless individuals.*
- *Vaccine preventable diseases stratified by race and ethnicity.*
- *Foodborne diseases stratified by race and ethnicity.*
- *Proportion of people newly diagnosed with HIV who achieve viral suppression within 90 days of diagnosis.*

### **Public health accountability metrics (State and local accountability):**

*To be developed*

# Discussion

- Is this proposed framework going in the right direction? What changes would subcommittee members like to see?
- Are changes needed to metrics selection criteria in light of today's discussion?