Minutes

draft

## 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**](http://?)

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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. |
| **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.  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.  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.  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.   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 camps are 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 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. |
| **Subcommittee business**   * Next meeting scheduled for 11/17 |
| **Public comment**  No public comment was provided. |
| **Adjourn** |