**ACDP’s Proposal for Equity-Based Metrics**

Our process has involved thinking about particularly vulnerable populations affected by a wide range of communicable diseases, and our focus and metrics will address three groups: 1) persons who inject drugs; 2) the homeless; and 3) BIPOC, immigrant, and refugee communities. For each of these groups, there are a number of infections that could be reduced through community-based interventions. We have proposed several infections that counties could choose to track, although some are not prevalent enough that changes could be seen from year to year at the county level, although we would have sufficient numbers at the statewide level.

For each population, we will additionally draft process-based measures after we have had more time to engage with LPHAs, community-based organizations, and representatives from the communities involved. The draft proposed process measures listed below reflect several foundational capabilities outlined in the framework for public health modernization: health equity and cultural responsiveness, community partnership development, assessment and epidemiology, policy and planning, and communications.

Given the range of diseases and proposed activities, ACDP plans to work very closely with our partners in Immunization and HST to develop these metrics in collaboration with affected communities, provide a broad range of technical assistance to LPHAs and regional coalitions that want to work towards these goals, and collect and analyze data to produce annual assessments.

**Proposed Metrics**

1) Increase access to harm reduction services like SSPs, wound care supplies, and medication for opioid use disorder (MOUD) to reduce infections related to injection drug use

* Metrics
	+ Disease
		- 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 (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
	+ Process
		- County-specific data on
1. **Syringe access** **and reuse estimates** by
	1. Outlet type: Syringe Service Program, pharmacy, syringe dispensing machines.
	2. Level: primary, secondary
2. **Syringe reuse estimate:** An estimate of the (mid-point, upper and lower) proportion of injections that are covered by sterile syringe access among “unique” PWID participants of SSPs that track with unique ID.
3. **Harm reduction supply access** estimates
	1. Locations: By county and organization type
	2. What purchases supplies are used to support: overdose prevention, safer injection, safer smoking, naloxone and wound care
	3. Distribution volume of specific supplies: syringes, smoking pipes, smoking foil
	4. Number of program hours per month,
4. **Distance to access syringes**
	1. Average travel time to SSP distribution sites
	2. Percentage of county residents within 50 miles of at least one SSP distribution site in their county
5. **Access to MOUD**
	1. Number of SUD treatment referrals made by programs.
	2. Number of medical care referrals made by programs.
6. **Access to immunizations at harm reduction program locations**
	1. Evaluation of capacity of county or partners to offer Hepatitis A and B vaccination services at SSP and other harm reduction service locations
	2. Percent of days per month that Hepatitis A and B vaccination is provided at SSP locations
	3. Number of Hepatitis A and B vaccine administered through harm reduction programs
		* Could also use data collected by Addictions Treatment, Prevention and Response unit(Behavioral Health section of HSD) on clients accessing substance use disorder treatment using the Government Performance and Results ACT [(GPRA)](http://):
			+ Participant demographics (not at REAL-D level)
			+ Substance and nicotine use behaviors – including last 30 days, route, use of equipment and water after someone else, overdose
			+ HIV, HCV testing, use of PrEP
			+ If HIV, HBV, HCV tests were reactive/positive was person linked to treatment
			+ Respondent’s living conditions, arrests/criminal justice system status, insurance, health, QOL, social connectedness, child welfare status,
			+ Evidence based Intervention participation

2) Decrease infections related to poor sanitation among homeless

* Metrics
	+ Disease
		- County levels of rates of HAV and various foodborne bacteria occurring in homeless from Orpheus; with proportion occurring among homeless
	+ Process
		- County level of volume of supplies dispensed (soap, disinfectant wipes, alcohol-based sanitizer); distance to public restrooms or availability of portable toilets to homeless camps, availability of handwashing stations
		- Access to immunization services associated with LPHA hygiene and sanitation programs for homeless individuals.
			* Capacity of LPHA or partners to provide Hepatitis A and Hepatitis B vaccination services in association with LPHA hygiene programs
			* Number of Hepatitis A and Hepatitis B vaccines administered in association with LPHA hygiene programs

3) Increase cultural competence and level of community engagement/outreach that LPHAs have with marginalized communities (such as BIPOC populations, immigrants, refugees) to improve prevention and control of vaccine preventable diseases, particularly when associated with vaccine hesitancy

* Metrics
	+ Disease
		- Rates of vaccine-preventable diseases (focus on acute hep A and B, pertussis, measles, mumps) stratified by race
	+ Process
		- Vaccination rates stratified by race
		- Completion of cultural competency workforce training; implementation of approaches to development of summary report of census tract demographic and SVI data to delineate populations at risk; establishment of links to CBOs and faith-based groups providing services to identified groups; identification of trusted messengers for each identified group; capacity to create plain language information flyers on health topics and provide in appropriate languages

4) Increase cultural competence and level of community engagement/outreach that LPHAs have with marginalized communities (such as BIPOC populations, immigrants, refugees) to improve prevention and control of foodborne diseases

* Metrics
	+ Disease
		- Rates of foodborne diseases (acute hep A, STEC, salmonella and shigella) stratified by race
	+ Process
		- Completion of cultural competency workforce training; implementation of approaches to development of summary report of census tract demographic and SVI data to delineate populations at risk; establishment of links to CBOs and faith-based groups providing services to identified groups; identification of trusted messengers for each identified group; capacity to create plain language information flyers on health topics and provide in appropriate languages