

## METRIC DISCUSSION AND DECISION NOTES

Public Health and Prevention Metric Selection Workgroup: April 11, 2016 meeting

Attendees: Hailey Akah (HPIO), Beth Bickford (Association of Ohio Health Commissioners), Craig Davidson (Hamilton County Public Health), Brian Fowler (Ohio Department of Health), Michelle Groux (Columbus Public Health), Shaun Hamilton (Premier Health), Jason Orcena (Union County Health Department), Brandi Robinson (Ohio Department of Health), Amy Scheon (Case Western Reserve University), Amy Bush Stevens (HPIO), Becky Sustersic (HPIO), Krista Wasowski (Medina County Combined General Health District)

**Follow-up notes from 3/18/16 meeting**

Notes from 4/11/16 meeting

**Note: Shaded metrics will be addressed at 4/5/16 Public Health Infrastructure and Performance Sub-Group meeting**

Note: Numbered items= recommended items

Subdomain	Metric	Metric description	Discussion	Follow-up Tasks/Decision
Public health system	1. <b>Percent of population served by a comprehensive public health system</b>	Source: National Longitudinal Survey of Public Health (see description in doc sent by CB)	Leaning toward using this, but CB will provide methodology for selection to make sure we are comfortable using this. Pending documentation from UK.	CB Mamaril will provide methodology  Add this metric if methodology is acceptable.  More LHDs will be added for Ohio this summer. HPIO will ask CB when this new data will be available.
Workforce and accreditation	<b>State public health workforce</b> 2. <b>Combined state and local public health workforce (if available)</b>	Number of state public health agency staff FTEs per 100,000 population. Data normalized per 100,000 population. ASTHO data were used to obtain the numerator and the American Community Survey 1-year population estimates for 2011 and 2012 were used for the denominator.	UK may be able to provide combined state and local workforce (and per capita spending for Cost domain)	Keep (but use combined state and local if possible)  CB will follow up with Amy Bush Stevens on the availability of combined workforce data.

Workforce and accreditation	<b>Local public health workforce</b>	Median number of local health department FTEs per 100,000 population	Same as above	Same as above
Workforce and accreditation	<b>3. Accreditation of local health departments</b>	Percent of local health departments that have received accreditation from the Public Health Accreditation Board. PHAB accreditation is a relatively new process; 2013 was the first year that health departments began achieving accreditation. This source is updated periodically throughout the year.		Keep
Communicable disease control and environmental health	<b>4. Chlamydia</b>	Chlamydia rate per 100,000 population.	<p><b>Consider replacing with HIV</b> (public health has no funding to address chlamydia)</p> <p><b>What do national scorecards do?:</b></p> <ul style="list-style-type: none"> <li>• CHR includes Chlamydia as a ranked measure, and HIV prevalence as an additional measure (prevalence).</li> <li>• AHR includes Chlamydia, but not HIV.</li> </ul> <p><b>HIV metric for consideration:</b>  Diagnosis of HIV infection, rate per 100,000  Source: CDC HIV Surveillance Report (same metric/source used by CHR)</p>	<p>Keep</p> <p><b>Feedback from ODH:</b></p> <p>“Both are relevant to public health in Ohio so one is not necessarily “more important” than the other ... However, when reviewing the criteria, while there are many more cases of chlamydia diagnosed in Ohio and nationally in a year than HIV, chlamydia surveillance data is more straightforward, more readily available and more timely in terms of finalizing the data. HIV has more gaps in completeness and finalization of the data both at the CDC and State levels takes much longer as result of the required processes and projects associated with putting out a “final” number.</p>

			Clarify if this is NEW diagnoses?	<p>Given this and the fact that HPIO was already using chlamydia as a metric in their dashboard, it sounds as if it may be best to continue with chlamydia if they can only include one or the other."</p> <p><i>Recommend putting HIV on bike rack list.</i></p>
Communicable disease control and environmental health	5. <b>Foodborne illness monitoring</b>	Proportion of foodborne illness outbreaks reported to Centers for Disease Control and Prevention for which an etiologic agent is confirmed. This metric is included in the National Health Security Preparedness Index. Multiple confirmed/suspected in one food was counted as a single report. So long as it contained at least one confirmed, it was reported as confirmed. Does not include multistate outbreaks.	None	<p>Keep (or replace with better metric if available.)</p> <p>Jason reached out to ODH. Dr. DiOrio has some suggestions. HPIO will follow up with ODH to see if this data is available at the state level for all states.</p>
Communicable disease control and environmental health	6. <b>Child immunization</b>	Percent of children ages 19 to 35 months who received all recommended vaccines (DTaP, poliovirus, measles, Hib, HepB, varicella, PCV)	None	Keep

Emergency preparedness	<b>7. Emergency preparedness funding</b>	Total per capita funding for state and local health departments' emergency preparedness (Public Health Emergency Preparedness). Data normalized to per capita. Base population year was 2012 from American Community Survey. 2013 population base estimates are not yet available.	None	Keep
Health promotion and prevention	<b>8. Cigarette tax</b>	State cigarette excise tax rate.	None	Keep
Health promotion and prevention	<b>9. Tobacco prevention spending</b>	Tobacco prevention and control spending as a percent to the Centers for Disease Control and Prevention-recommended level.	None	Keep
Health promotion and prevention	<b>10. Seat belt use</b>	Percent of front seat occupants using a seat belt.	None	Keep
Health promotion and prevention	<b>11. Sales of opioid pain relievers</b>	Kilograms of opioid pain relievers sold per 10,000 population, measured in morphine equivalents.	<p><b>Consider including an opioid overdoses metric instead. Note that drug overdose deaths are already included in the Population Health Domain.</b></p> <p>Follow-up from ODH about which drugs are included in the Population Health domain's drug overdose metric:</p> <p><b>"We can provide the deaths specific to all opioids (rate) for the state ... but CDC recommends to compare with other</b></p>	Keep

			states to use all drug overdose [deaths].”	
Health promotion and prevention	<b>12. Falls among older adults</b>	Percent of adults age 65 and older who report having had a fall within the last 3 months. Source: BRFSS	<b>This metric has been revised. Previously referred to falls w/in past 3 months, but now is w/in 12 months. Trend data is therefore problematic.</b>	Keep
Health promotion and prevention	<b>Youth distracted driving</b>	Percent of youth who report that they texted or e-mailed while driving a car or other vehicle on at least one day during the past 30 days. Source: YRBS	Vulnerable metric: previously unranked because the data has 10 or more missing states.  If trend data is not available, then move to bike rack. <b>Newer data is not available. YRBSS data for 2015 may not be released due to low survey response rates.</b>	<b>Remove this metric and put on bike rack. If available, replace it with a better distracted driving metric.</b>  <b>Brian will follow up with ODH staff to see if available at state level on distracted driving overall from crash data. Also check with COTS (Central Ohio Trauma System) and Ohio Department of Public Safety.</b>
Health promotion and prevention	<b>WIC at farmers markets</b>	Percent of farmers markets that accept WIC coupons.	Vulnerable metric: previously unranked because the data has 10 or more missing states.  <b>Updated data is not available.</b>	<b>Remove this metric and put on bike rack.</b>  Andy Wapner will look into availability of WIC at FM data. <b>Better metric not available.</b>

### Infant mortality-related metrics for consideration

Health promotion and prevention	<b>13. Safe sleep</b>	Percent of infants most often laid on his or her back to sleep. Source: PRAMS	Vulnerable metric: previously unranked because the data has 10 or more missing states.  Consider replacing with	Keep
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			<p>Low Birth Weight (also replacing with consider Pre-Term Birth Weight, or recommend Pre-Term Birth Weight to Healthcare System domain)</p> <p><b>Info on PRAMS from ODH:</b></p> <ul style="list-style-type: none"> <li>• <b>After 2015, ODH is contracting with GRC to conduct a PRAMS-like survey (rather than having it done by CDC).</b></li> <li>• <b>The intent is to keep the methodology as close to PRAMS as possible to allow for in-state trends and cross-state comparisons.</b></li> <li>• <b>The PRAMS or PRAMS-like measures are still the best available and I recommend continuing them.</b></li> <li>• <b>2014 Dashboard used 2010 PRAMS data.</b></li> <li>• <b>2013 data is now available.</b></li> </ul> <p><b>2014 data will be available "by the end of 2016."</b></p>	
Health promotion and prevention	<b>Home visiting (new)</b>	Percent of women who report a home visitor came to their home before or after their most recent pregnancy to help them prepare for their new baby and/or to help them learn how to take care of themselves or	<p>Vulnerable metric: was not ranked in the 2014 Dashboard. This was a new PRAMS metric in 2013 and the data was not available in time.</p> <p><b>Same issues with PRAMS</b></p>	<b>Put on bike rack</b>

		their new baby. Source: PRAMS	<b>above.</b> PRAMS 2013 data is now available, and 2014 data may be available soon.	
Health promotion and prevention	<b>14. Low birth weight (new)</b>	Percentage of live births where the infant weighed less than 2.500 grams. Source: National Vital Statistics System	Used by CHR and AHR. Trend and rank data is available up through 2015.	<b>Add to Dashboard</b>
Health promotion and prevention	<b>15. Teen Pregnancy</b>	Rate per 1,000 births to females 15-19 years of age	Also considered: Number of unintended pregnancies per 1,000 women aged 15-44 Source: <a href="#">Guttmacher Institute</a>	<b>Move teen pregnancy rate to this domain from Social/Economic environment domain</b>
Health promotion and prevention	<b>Contraceptive service needs met by publicly-supported providers (new)</b>	Percentage of the need for publicly funded contraception services met by all publicly supported providers and by Title X-funded clinics Source: Guttmacher Institute (2010 and 2013 data available; <a href="#">see page 28</a> , Table 8)	<b>This metric is unclear.</b>	<b>ODH will follow up to clarify the value of this metric vs. unintended pregnancy, teen pregnancy or other contraception measure.</b>
Equity	<b>16. Low birth weight, by poverty status or race/ethnicity</b>	Percentage of live births where the infant weighed less than 2.500 grams. Source: National Vital Statistics System		<b>Consider using LBW by race/ethnicity or by income/poverty status rather than safe sleep, which was used last time. ODH will follow up with a recommendation based on relative contribution of race and income differences and data availability.</b>

### **Other decision notes from 3/18/16 meeting**

- Decision: Convene public health infrastructure subgroup to discuss metrics from the National Longitudinal Survey of Public Health Systems.
- Decision: Recommend to the Healthcare System domain that they consider adding metrics related to asthma management and preterm birth
- Decision: Revisit infant mortality metrics at the next meeting (contraception, LBW, safe sleep, home visiting)

### **Discussion notes from 3/18/16 meeting**

Amy Bush Stevens noted that America's Health Rankings added a metric about insufficient sleep.

Amy Sheon asked whether the metric decision criteria specify that the metrics chosen for the Health Value Dashboard must "move the needle" in the short term. Although this is an important goal, Amy Bush Stevens noted that the metric decision criteria do not include this specification because it's difficult to see change in health outcomes and health costs in the short term. However, for the public health and prevention domain specifically, this may be an important consideration.

Tim Ingram asked about how "comprehensive public health" is defined in Robert Wood Johnson Foundation's new Culture of Health Action Framework. CB Mamaril noted that it's a composite measure. It is computed at the state level, and he can provide that data for 2014. He will provide Amy Bush Stevens with a document that describes the measure in further detail. CB also suggested adding a metric on public health expenditures. Amy Bush Stevens noted that per capita spending for state public health and median per capita spending for local health departments are including in the cost domain. CB said he could potentially provide merged state and local spending data.

HPIO staff has not found updated WIC at farmers market data. Andy Wapner will reach out to OSU extension for this data. Safe sleep is also vulnerable because multiple states do not participate in PRAMS. However, there is updated PRAMS data since the first *Health Value Dashboard*. 2013 PRAMS data is available, and 2014 data may become available. However, there is significant lag on the data. Michelle Groux recommends replacing safe sleep with low birth weight because there are better data options and that metric is likely more comparable across the country. Amy Bush Stevens noted that low birth weight can often be broken down by race/ethnicity as well. Craig Davidson suggested replacing safe sleep with pre-term birth weight at 32 and 37 weeks. Andy Wapner noted that pre-term birth weight might be a better fit in the

health system performance domain. Amy Bush Stevens also commented that a contraception metric is another possible measure related to infant mortality. She will reach out to Beth Conrey and Maria Gallo about possible contraception metrics. Youth distracted driving is also vulnerable. It is unclear whether new data will be released in time.

Amy Bush Stevens noted that a metric about HIV is on the bike rack. HPIO reached out to experts on HIV and they each recommended the following metric: new HIV diagnosis as a percentage of the population. Amy Shoen noted that diagnosis data could reflect both better testing and higher infection rate. Craig Davidson said that a limitation of the chlamydia metric is that public health is not funded to address chlamydia control, unless HIV or syphilis. Michelle Groux noted, however, that chlamydia metrics are used to represent STI prevalence nationwide and may be a more nationally comparable metric. The HIV metric selected should be similarly comparable nationally.

Amy Bush Stevens introduced the possibility of adding an asthma prevalence measure, either for adults or children. The Public Health and Prevention workgroup could also recommend that the Healthcare System domain include an asthma management measure. Andy Wapner supported recommending a management measure to the Healthcare System domain.

### **Follow-up questions and tasks from 3/18/16 meeting**

**CB Mamaril (UK) and Public Health Infrastructure and Performance Sub-group (Terry Allan, Beth Bickford, Craig Davidson, Michelle Groux, Tim Ingram, Jason Orcena, Joanne Pearsol, Melissa Sever, and Krista Wasowski)**

1. See 3/18/16 email and document for description of metric revisions and replacements under consideration
2. **Thank you to Craig, Joanne and CB for filling out the [Doodle poll](#). It's looking like Tuesday, April 5 at 1:00 works best. If you have not already done so, please fill out this [Doodle poll](#) so we can confirm this time.**
3. CB will check on availability of the following data for us to use in the 2017 Dashboard:
  - a. State-level NLSPH data for all states on percent of population served by a comprehensive public health system
  - b. Combined state and local data on number of public health agency FTEs per 100,000 population (total PH workforce size for each state)
  - c. Combined state and local data on per capita public health spending (total PH spending for each state)

**Patrick Beatty, AIDS Resource Center Ohio**

4. **HIV:** Based on feedback we got from you, Center for Community Solutions and ODH, it looks like **New HIV Diagnoses, rate per 100,000 population** is probably the best HIV-related metric to add to the Dashboard. However, there were still some concerns about what this data actually tell us when we compare Ohio to other states. Does it accurately reflect incidence/prevalence of HIV, or does it really have more to do with how successful we are in getting people tested? If this metric has some validity problems, which metric would you suggest we use instead given our decision [criteria](#)? Please provide a link to where we can find state-level data for all (or most) states.

#### Andy Wapner, OSU CPHP

1. **WIC at farmers markets:** Look into availability of updated WIC at farmers markets data (more recent than 2013, and preferably without so many missing states), and/or find other environmentally-based food metric. One possibility: modified Food Retail Environment Index. Provide link to state-level data for all (or most) states.
2. **Contraception:** Please reach out to Maria Gallo to ask her: If we were to add one metric related to contraception to the Dashboard, which one would you recommend, given our metric selection [criteria](#)? Please provide a link to where we can find state-level data for all (or most) states.

#### ODH (Brandi Robinson and colleagues)

3. **Chlamydia vs. HIV:** We need to decide between including chlamydia (rate per 100,000 population) or HIV (New HIV Diagnoses, rate per 100,000 population). Given our [criteria](#), which metric would you recommend? Which one has better data quality and comparability across states? Which one is most relevant and meaningful to public health in Ohio?
4. **Opioids:** We have two metrics related to opioids:
  - **Drug overdose deaths:** Number of deaths due to drug overdose per 100,000 population (Source: CDC vital stats, via America's Health Rankings)
  - **Sales of opioid pain relievers:** Kilograms of opioid pain relievers sold per 10,000 population, measured in morphine equivalents (Source: DEA, via TFAH)
  - (Note that the Healthcare system and Access domains also have metrics on access to and retention in drug addiction treatment services)

A few questions on these:

- a) For the overdose deaths metric, do we know what proportion of this is from opioids? Is there a more precise measure we should be using that is more specific to opioid-related overdoses? Or is this the best possible metric, given that we need comparable state-level data for all states? What is the most recently-available year for this metric and do you have a link to the most-recent data?

b) Overall, would you agree that these are still good metrics to keep in the Dashboard in terms of what they tell us about the status and trends of the opiate epidemic? If not, what would you suggest?

5. **Contraception:** If we were to add one metric related to contraception to the Dashboard, which one would you recommend, given our metric selection [criteria](#)? Please provide a link to where we can find state-level data for all (or most) states.

### **Discussion notes from 4/11/16 meeting**

The full Public Health and Prevention workgroup expressed concern that the data from the “comprehensive public health system” measure may not be representative of the entire state. Because NSPH samples health departments, it may not represent the wide range of diversity in Ohio. Krista Wasowski and Beth Bickford noted that UK may be adding more local health departments to their analysis, and that data will be collected this summer. It is not clear whether that data will be available in time for the Dashboard, but HPIO will use whatever data is most recent. This measure is being considered for addition to the Dashboard, pending a review of the methodology.

The group decided to keep the Chlamydia metric in the Dashboard in lieu of a metric about HIV. The HIV measure in consideration was from the CDC, and was not recommended by ODH because the Chlamydia data is more solid and comparable across states. For this reason, and because many national scorecards use a Chlamydia metric, the group chose to keep it in the Dashboard.

A metric new around epidemiological capacity is still being considered to replace foodborne illness monitoring. Jason Orcena reached out to ODH and they had several suggestions (via email). For all reported infectious disease cases (excluding Hepatitis, HIV, TB and STDs) provide the following:

- % of cases with attempted interview
- Median days from case report to interview attempt
- % of cases with complete demographic data
- % of cases with exposure history (e.g., travel history for Zika case; food history for individuals with gastrointestinal illness)

There was concern among group members that this data would not be easily available nationally and that the way these metrics are measured may change over time, depending on the grant for which they are being reported. HPIO will do some additional digging and hopes to find a metric that gets at epi capacity and is still related to foodborne illness.

Although there was a slight change to the “falls among older adults” metric, the group decided to keep it in the Dashboard. BRFSS changed the measure from “falls within the last 3 months” to “falls within the last 12 months.” We will not be able to see trend data in this iteration of the Dashboard, but we can rank this measure and trend data will be available in the future.

The group would like to replace “youth distracted driving” with a new metric because YRBSS may not be available for Ohio this year. Amy Sheon noted that police report whether distracted driving occurred in the police report following an accident, and this data is released to the public, at least on an individual level. There is some concern about whether this information is aggregated on the state level, but ODH will look into it. Michelle Groux also mentioned COTS or the Ohio Department of Public Safety as possible sources of this information. HPIO will follow up on this.

Because the “WIC at farmers markets” metric has been removed, and because UK can potentially provide data for a combined state-local workforce metric, there is room to add a few more metrics related to infant mortality and child/adolescent health. Given the discussion in the last meeting, and the measures commonly used in other national scorecards, the group chose to add a measure on low birth weight. The group also decided to keep the “safe sleep” metric as opposed to replacing it with “home visiting.” Safe sleep would provide trend data and is an outcome measure (as opposed to home visiting). Although there are concerns about the PRAMS data (e.g., data lag), the group wanted to have a measure around safe sleep practices.

The group also discussed adding a metric related to contraception. The two options presented to the group were (1) unintended pregnancy rate and (2) Percentage of the need for publicly funded contraception services met by all publicly supported providers and by Title X-funded clinics. The group was unclear on what the second metric actually measures, and they preferred a metric on teen pregnancy over the unintended pregnancy rate measure. Teen pregnancy is an objective measure on every birth certificate, as opposed to a survey question trying to measure “intention.” The social and economic domain has a measure on teen pregnancy, but the group thinks it fits better in this domain.

Finally, the group discussed which metric to use as the domain's equity metric. The equity metric will be broken down by a characteristic, such as race/ethnicity or income. The possible options included chlamydia, falls, safe sleep, low birth weight, and teen pregnancy. The group decided that low birth weight would be the best option. ODH is going to check whether the data on low birth weight can be broken down by income or poverty, but it should be available by race/ethnicity. There were also questions around whether income makes the biggest contribution toward low birth weight, or whether race is a bigger factor. HPIO will follow up with ODH to provide additional information on this.

### **Follow-up questions and tasks from 4/11/16 meeting**

#### **CB Mamaril (UK)**

Metric: Comprehensive Public Health System

- When will the updated NLSPH data be available that includes a larger sample of Ohio LHDs being collected this summer?
- Please provide description of methodology and sample size for Ohio.

Metric: State and local public health workforce

- Please provide data on the total number of state and local public health agency staff (combined) per 100,000 for all states. (combining data from ASTHO and NACCHO for the two most recently-available time periods)

#### **ODH (Brandi Robinson, Brian Fowler and colleagues)**

Metric: Foodborne illness monitoring

- Mary DiOrio provided Jason Orcena with a list of potential metrics from Food CORE (see page 11). Please let us know if data for any of these measures is available at the state level for Ohio and for other states. Please provide a link to the data and let us know which one you would recommend as the best metric to represent public health capacity and performance in this area.

Metric: Distracted driving

- We have decided to remove youth distracted driving from the Dashboard because of problems with the YRBSS data. We would like to know if there is another metric related to distracted driving for which we could get state-level data for Ohio and other states.
- Is there some other source, such as police reports or other crash data, on distracted driving that is aggregated on the state level? If so, please send a link to the recommended data.

Metrics: Percentage of the need for publicly funded contraception services met by all publicly supported providers and by Title X-funded clinics; Unintended pregnancy; and Teen pregnancy (see page 12)

- Please clarify what the “percentage of the need for publicly funded contraception” means.
- What are the strengths and weakness of these three metrics relative to our [metric selection criteria](#)?
- Is there a different metric related to contraception that you would recommend? If so, please provide a link to where we can find the state-level data for Ohio and other states.

Metric: Low Birth Weight by race/ethnicity or income/poverty

- Is state-level data on LBW available by race/ethnicity, income level, and/or poverty status? Please provide a link to the state-level data.
- Which factor makes a bigger contribution to LWB: income or race?

Thank you for your help!