

Public Health Advisory Board (PHAB)
February 21, 2019
Meeting Minutes

Attendance:

Board members present: Dr. David Bangsberg, Carrie Brogoitti (by phone), Dr. Bob Dannenhoffer, Muriel DeLaVergne-Brown, Dr. Katrina Hedberg, Kelle Little (by phone), Dr. Jeff Luck, Tricia Mortell, Alejandro Queral, Dr. Jeanne Savage, Dr. Eli Schwarz, Teri Thalhofer, Rebecca Tiel

Board members absent: Eva Rippeteau, Akiko Saito

Oregon Health Authority (OHA) staff: Christy Hudson, Katarina Moseley, Lillian Shirley (ex-officio)

Members of the public: None

Welcome and updates

Rebecca Tiel, PHAB Chair

Ms. Tiel welcomed the PHAB and asked the PHAB members to introduce themselves.

- Approval of January 2019 Minutes

A quorum was present. Mr. Queral moved for approval of the January 17, 2019, meeting minutes. Dr. Schwarz requested a correction of his last name on page 4. Ms. Tiel seconded the approval. The PHAB approved the meeting minutes unanimously.

- OHPB Digest

Dr. Schwarz noted that the digest is done very well and it is helpful in keeping track of the work done by the various subcommittees and workgroups. Ms. Tiel agreed.

Dr. Bangsberg added that the subcommittee discussions are documented well. He invited the PHAB members to speak up during subcommittee meetings so that action items are noticed.

- Legislative Update

No legislative update was provided.



Public Health Advisory Board
Meeting Minutes – February 21, 2019

Update on CCO 2.0

Rebecca Tiel, PHAB Chair

Ms. Tiel reminded the PHAB that the workplan is a living document and invited the PHAB members to review the workplan and ensure that the changes proposed during the January PHAB meeting have been made.

The PHAB members had no questions or comments about the workplan.

Update of CCO 2.0 RFP

Lillian Shirley

Ms. Shirley provided a disclaimer related to the largest RFA for the largest amount of money the state of Oregon has ever put out to bid. She cautioned the PHAB members about talking to external people about the RFA.

Ms. Shirley explained that recommendations went to the Oregon Health Policy Board about a year ago. What came through the PHAB was a question: Can we require a local public health authority voting member position on the CCO governing board? The answer is no, as that is not in the RFA. Oregon Statute 414627 does require of the CCOs to include representatives of each county government on the community advisory council. It is good to remember that CCOs are not-for-profit or for-profit individual corporations. The Department of Justice did not feel that a private company could be required to have certain board members.

Ms. Shirley added that the recommendation was that there would be a CCO voting member position on the local public health advisory committee when there was such a committee in a jurisdiction. That was not included in the RFA, because that is a decision of each local jurisdiction. The serve requirement that the PHAB requested was that LPHAs are compensated for public health contributions towards incentive measures. This has been partially addressed in the RFA and the contract does require CCOs to demonstrate and report on the amount and quality of their pool dollars that are being distributed to the public health and non-clinical providers. That information will be collected, reported, and publicly posted annually.

Ms. Shirley noted that this aligned with one of the goals of the Oregon Health Policy Board (OHPB), namely, asking for increased transparency. That was one of the initiatives to address that, as well as to align the CCO incentive measures with population health priorities to a feasible extent. The OHA believes that the CCOs made progress on that. Recommendation 3 does encourage the adoption of social determinants of health, health equity, and population health incentive measures. The RFAs will be scored on how well any given organization demonstrates that that is part of their plan. Policy work committees, including the PHAB, Accountability Metrics Subcommittee, Metrics and Scoring, and Health Plan Quality Metrics

Committee routinely consult on population health priorities during measure selection processes.

Ms. Shirley pointed out that another wish by the PHAB was to require CCOs to develop shared community health assessments and community health improvement plans with LPHAs and hospitals and require the use of community health assessment and community health improvement planning tools that meet the requirements for LPHAs and hospitals. In the RFA, the answer is yes. The contract requires CCOs to work with LPHAs, nonprofit hospitals, and other CCOs that share a portion of the service area. This is beyond the distribution of a governmental jurisdiction. Some counties had multiple CCOs and they had to come to the table around those priorities. In addition, with the federally recognized tribes in the service areas, CCOs have to include their prioritization and assessments in their final plans. The RFA does require applicants to provide information on current relationships, so the CCOs have to demonstrate that being a CCO is not only aspirational. They have to demonstrate and document their current relationships with the entities in their service area. The RFA also asks the CCOs to identify gaps in those relationships and they will be scored on having plans to address those gaps prior to any awards that are given. Beginning in 2020, after we have had some history of concrete documentation of how we can evaluate these relationships, the CCOs will be required to report the activities they have undertaken annually.

Ms. Shirley remarked that per the PHAB requirement for CCOs to invest in shared community improvement plan implementation, OHA feels that this is in the RFA. The implementation of House Bill 4018 requires CCOs to spend a portion of their net surplus on health disparities and social determinants of health, which includes spending on population health priorities. In the interim, the Oregon Health Policy Board requested that there was a standing committee for health equity, which is a new committee that will be also monitoring CCOs' implementation.

Ms. Shirley stated that there was nothing in the RFA around public health emergencies, such as participating in regional health coalitions. This is because CCOs do not provide services. The regional health coalitions are made up of hospital systems and provider groups. Most of the emergency preparedness work that goes on is directly to that and, a CCO, as a paying entity, is not involved in that planning.

Dr. Schwarz asked how the application would be scored. This is typically stated in a table that indicates the points that each section could receive. There was nothing like that in the RFA. Also, if a CCO applies to operate in a new area, how can it document its relationships with the new community?

Ms. Shirley responded that even if a CCO tries to operate in a new area, it is possible that the CCO has relationships through the providers. In terms of scoring, there are criteria, which will be shared with the PHAB as soon as they become available.

Ms. Tiel clarified that it is a request for application process, not a request for proposal process. Any entity that meets the requirements of the application gets to be awarded. It is more of a Pass-Fail than scoring.

Dr. Savage noted that there are a couple of places on the OHA's website where the RFA contracting section can be viewed. Under [CCO 2.0 Reference Documents](#), there are two documents: RFA Community Engagement Plan Required Components and RFA Community Engagement Plan Required Tables. These documents explain the relationships that CCOs have to develop, even if they don't have them now, when they apply in the RFA. The CCOs have to invest in and document those relationships to get their RFA in.

Dr. Luck asked about the next steps after the Pass-Fail stage. Do entities that pass the RFA get to start negotiating with the OHA about becoming a CCO, or is there another process?

Ms. Tiel responded that the applications are due on April 22, 2019. Prior to that date, organizations have been submitting letters of intent and staking territory. The applications will be reviewed after April 22 until July. There will be public process and the organizations will have to do presentations in their communities.

Ms. Mortell expressed an appreciation of the conversation about other avenues for the important components of what LPHAs would like to do between public health and the health care system. For example, on the meningococcal vaccines – even though the language is not as strong as LPHAs would like, it is a starting point to continue building these relationships stronger and work through the internal systems to be stronger too.

Dr. Savage pointed out that during conversations with the medical directors of different CCOs, there is a discussion about local public health and the benefits and value of the public health system. There is a big appetite amongst the medical directors to have those relationships and to support each other. Everybody understands that nobody can do it by themselves. The medical directors are looking forward to building those relationships, if they don't currently have them. There is a system in how the money is given to LPHAs, and governed, in terms of how LPHAs then spread the money amongst contracts. The hard part about making more relationships isn't the desire to do it. It is the difficulty in trying to balance the money given to PCP and spread it through different areas.

Ms. DeLaVergne-Brown remarked that February 20, 2019, was Exclusion Day (i.e., all children who were not up-to-date or complete on their immunizations were excluded from their school or child care facility). While some communities have more providers, other communities, such as Crook County, have a few providers and they are booked a month and half out. It is impossible for children to get in for the immunizations. The system is built, but in many parts of the state access is still restricted. In Crook County, the providers stayed open and, with the help of extra nurses, they took care of the children and sent them back to school.

Dr. Bangsberg provided comments on the process of things that went well and things that could be improved for CCO 3.0. What went well were the discussions at the PHAB meetings that were brought to the OHPB. The conversations with the CCOs showed that some of the work is being done, in terms of true partnerships with LPHAs. That made it into the 46 policies that were approved. OHA did the contracting language, which went for public comment. After public comment closed on a Friday or Monday, nobody could talk about it during the OHPB meeting the following Tuesday. Some of the reasons for why this couldn't be done, like having LPHAs on the board and requiring the contract, is that it put the LPHAs in veto power. They didn't want to work with a CCO that wouldn't be eligible for contract. Although that seems like a sensible reason, it was not what the PHAB intended. The PHAB wanted to encourage a partnership and it has put in a stronger language to encourage that partnership.

Dr. Bangsberg concluded that the lesson here for CCO 3.0 is that the step between developing the policy and the contract language is a very complicated step. There are unanticipated blocks that the PHAB didn't think of, or the OHPB didn't think of, that are recognized in the final drafting of the contract. It would be nice to have an iterative step somewhere in the process. For CCO 3.0, it would be good to read the contract, then touch base with OHA, and see if there are other ways to do the contract language. This way, we could be 90 percent of the way there.

Ms. Thalhoffer asked Ms. Shirley and Dr. Bangsberg if it was intended for the geographic boundaries to change every five years.

Ms. Shirley responded that it isn't an intention to do that. There's nothing to stop that from happening.

2020-2024 State Health Improvement Plan

Christy Hudson

Ms. Tiel reminded the PHAB that the PartnerSHIP is a group that has been coming together at the community-based steering committee for developing the next state improvement plan. The group convened on February 12, 2019, to finalize the priorities. This is important to the PHAB because this work falls into the public health block grant and the PHAB is the advisory committee to that group.

Ms. Shirley noted that Ms. Hudson has done an amazing job. She has been a public health warrior around this and deserves credit for that.

Ms. Hudson thanked Ms. Shirley and shared with the PHAB that OHA just completed a significant community engagement effort and this presentation would be about what we heard and learned from communities. The last time Ms. Hudson presented to the PHAB was after the PartnerSHIP had its second meeting at which the partners were tasked with identifying 12



Public Health Advisory Board
Meeting Minutes – February 21, 2019

issues that they harvested out of data that OHA had put out in the State Health Assessment and the State Health Indicators. The communities landed on 14 issues. Because we couldn't have 14 priorities, we asked the communities for additional feedback and to further prioritize these issues.

Ms. Hudson stated that there were three avenues for getting input: (1) Online survey in English and Spanish, (2) Mini-grants to community-based organizations, (3) Other community forums (e.g., letters, emails, comments on Twitter and Facebook). Over 2,500 people provided feedback. The sample was racially representative, more women than men responded, people with less education were underrepresented, disability and LGBTQ community was represented, areas outside of the I-5 corridor were represented, and youth voice (under 18) was not present.

A PHAB member asked whether the 2,500 participants were known, to which Ms. Hudson answered that the survey was anonymous. In the OHA survey, participants were directed to sign up for a SHIP listserve, so that OHA could stay in touch with them. For individuals who engaged through the community-based organizations, OHA intentionally made their contracts go through the end of September. This aligned with the block grant, which funds that work, but we also wanted a mechanism to ensure that we had a communication route back to communities. Part of their contract is ensuring that communication gets back to individuals who participated.

Ms. Hudson presented a summary of the data collected from seven communities: Eastern Oregon Center for Independent Living (150 participants), Micronesian Islander Community (65 participants), Northwest Portland Area Indian Health Board (215 participants), Q Center (219 participants), Self-Enhancement Incorporated (54 participants), Next Door (137 participants), Unite Oregon (164 participants). In terms of priorities, the top five included housing (77%), mental health care (69%), adversity, trauma, and stress (55%), living wage (48%), substance abuse (44%), and access to care (42%).

Dr. Schwarz asked if Ms. Hudson could unpack the category Access to Care. Ms. Hudson responded that when these issues came out of the PartnerSHIP, OHA asked the organizations what they meant by "access to care." There was a short description in the survey about what it was meant by "access to care," which included access to medical care and oral health care. This category was separate from Mental Health Care. The PartnerSHIP really wanted to look at Mental Health Care as a separate category from Access to Care.

Ms. Hudson added that other topics that were important to the community participants included education, transportation, older adults, social cohesion, chronic pain, oral health, social services, and vaccinations. In terms of priorities by education (high school diploma, GED, or less than high school), 91 participants indicated the top five priorities, plus food insecurity. For priorities by sexual orientation, 332 participants indicated the top five priorities, plus institutional bias. For priorities by youth, 17 participants indicated climate change, suicide, and

institutional bias as three of the top six priorities. Interestingly, American Indian/Alaska Natives (65 participants) indicated adversity, trauma, and stress at their top priority (68%).

Ms. Hudson summarized that based on this feedback, the PartnerSHIP identified five 2020-2024 priorities: (1) institutional bias, (2) adversity, trauma, and toxic stress, (3) economic drivers of health (i.e., housing, living wage, food insecurity, transportation), (4) access to equitable, preventive health care, (5) behavior health (including mental health and substance use).

Dr. Schwarz asked if the economic drivers were the social determinants of health. Ms. Hudson responded that social determinants also include environmental health and education, among others. Dr. Bangberg added that the economic drivers are a subset of the social determinants of health. Dr. Schwarz noted that, for him, social determinants of health are very conceptual unless the concept is broken down by the actual issues. This is what the participants have reported. Education, for example, is not listed anywhere. This means the people do not think that education is a barrier.

Ms. Hudson explained that education was not one of the original 14 priorities. It did come up in the comments. Education was brought in as an issue for consideration with the PartnerSHIP last week. The structure of the subcommittees that are going to be stood up to inform the strategies that get developed will include representation from Department of Education. We will likely see education threaded throughout as a factor that will be involved. Education might appear as a factor when the economic drivers of health are discussed.

Ms. Thalhoffer remarked that she is a member of the Early Learning Council, and the council just released the state strategic plan for early learning system, called Raising Up Oregon. The plan is cross-walked with several plans, including the Oregon Health Authority's and the Governor's priorities. The similarities between the plans are huge. The issues that impact how we prepare kids for school are the same as the PartnerSHIP priorities. Education has become a subset of the chaos families have to live through. We have gotten so far down on the hierarchy of needs that things that we used to take for granted, such as housing and living wage, are gone. Families can't think about education because it is the next step.

Ms. Thalhoffer added that it is sad to see this happen to working families in our lifetime. We have lost a middle class that worked hard and had prosperity. We are at the point where families are trying to get housed and they can't think about education yet. We have taken a giant step backwards.

Dr. Dannenhoffer praised the process for collecting the feedback. However, compared to the last SHIP, none of the eight priorities in the last SHIP made it into the new SHIP and none of the new SHIP priorities were in the last SHIP. It will be interesting, in retrospect, 20 years from now, to know which one was more correct, the previous one or this one. The last plan also had very specific bullets underneath it, such as improve immunization rates. With the new priorities, we

could be having a harder time getting the directly measurable bullets underneath. The list of the new priorities looks a bit simplistic, which could be a better way to go, but it will be interesting to see how we get there.

Ms. Hudson explained that the new priorities are grounded in the community voice and that they will get us in the right direction. These priorities also align with some other efforts, such as Governor Brown's policy priorities, as well as with the priorities in the recent Trust For America's Health report [Promoting Health and Cost Control in States](#).

Ms. Hudson concluded that subcommittees are being formed with PartnerSHIP members, subject matter experts, cross-sector partners (i.e., partner state agencies), and people with lived experience. The groups will start convening later this Spring and will continue working until early next year. They will identify strategies, measures, and action steps, as well as solicit additional feedback from the community later this summer.

Dr. Schwarz commented that there have been other PHAB presentations, which showed what people were dying of, and how long people lived, and how the life-expectancy has come down in America due to various factors. In the Australian model just presented, life expectancy and mortality rates at the top. These are more objective metrics, which would say something about the health of the community from a more objective point of view. The question is: How do we get intentions and wish lists aligned with the problems as they are documented by the epidemiological data?

Ms. Shirley pointed out that the State Health Improvement Plan is our direction. The priorities do not reflect what people want. It is felt need rooted in the community. The priorities give us a way to organize our work and figure out the priorities that are driving us to change those outcomes that we obtain with our regular, epidemiology metrics. Epidemiology tells us what is happening. These priorities are helping us think through what we can do about what is happening. We should include this for any further presentations. This is aligned with the Early Learning Council's strategic directions. In terms of socializing this particular process, which is a Public Health best practice, we are trying to get people to understand that this is a state health improvement plan. It is not a public health department improvement plan. We still have all our outcomes and measures and business practices for which we are still accountable.

Ms. Thalsofer remarked that she saw the presented priorities as the subjective part of the plan. Epidemiological data is needed to support this subjective work before an assessment is made. Data that backs this up is most likely available at the Public Health division and other community partners. This information must be part of the plan, because we know that tobacco usage and obesity are still killing lots of Oregonians and we can frame them under the new priorities. We need to continue pointing that out with the data we know about what is harming Oregonians and how that is happening.

Dr. Luck suggested that the PHAB should reconsider the proposed Health Equity framework. The Health Equity Committee agreed on using a framework developed by the Robert Wood Johnson Foundation that talks about historic inequities leading to health disparities. Perhaps the SHIP should look at that framework as a way to align its work with what OHA is doing and what the federal government is doing. While the concepts are similar, the more we can have shared health equity concepts and definitions, the better our chance at realizing Ms. Shirley's vision of this being a state plan that everybody works toward.

Incentives and Funding Subcommittee

Alejandro Queral

Mr. Queral informed the PHAB of the subcommittee's discussion during its meeting on February 12, 2019. At the center of the discussion was a question: How do we move forward with the available funding for Public Health Modernization investments for 2019-2021, if funding remains at the \$5 million level (\$3.9 million to LPHAs)? Dr. Dannenhoffer proposed to continue as before for the start of the new biennium. If additional funding is available through new tobacco tax revenue or increased General Fund investment, a new structure should be developed to account for the additional money. During the subcommittee meeting, Dr. Dannenhoffer suggested three principles of the funding: 1) to encourage regionalization, 2) to fill gaps in funding so personnel is not lost, and 3) to fund successful projects that have great promise for the future.

Ms. Thalhofer suggested that there needs to be some evaluation of how those county-to-county cross-jurisdictional relationships have worked. These cross-jurisdictional relationships can be country-to-CCO, country-to-FQHC. It may work better if the jurisdictions are not LPHA-to-LPHA, but LPHA-to-something-else. That may be more applicable in some areas than it is in others. We should not force one model across the state because it is square peg-round hole.

Ms. Mortell echoed Ms. Thalhofer's remarks by noting that it is regional approaches, or regional projects, or regional configurations. The regional in epidemiology is different than cross-jurisdictional sharing of everything. The principle of regionalization is a principle of regional approaches, or regional systems, or centers of excellence.

Mr. Queral stated that the conversation highlights the importance of having some amount of dollars available for an assessment of the different models. Not to compare them necessarily against each other, but to understand where the partnerships are leading to real success. The assessment will help us explain why certain models are working better than others.

Dr. Schwarz asked when we will know how much funding we get from the legislature. A few PHAB members responded that we will know in July.

Ms. Moseley added that the subcommittee should be contemplating the best directions to go, based on what happens in the next three months. If we are looking at having a very large investment come through in the last six months of the biennium, what is the best way to prepare the system to succeed in using that toward outcomes.

Mr. Queral responded that the answer is yes. The subcommittee is approaching it by looking at different scenarios and how to prepare for those two alternatives.

Accountability Metrics Subcommittee

Teri Thalhofer

Ms. Thalhofer informed the PHAB that the subcommittee met on February 13, 2019. It reviewed a draft of the public health accountability metrics report. The subcommittee gave some input on what it would like to see in the executive summary. The subcommittee also went through each of the outcomes and process measures and gave input and asked for clarification. The report was reviewed at the CHLO meeting this morning. The report will be presented to the PHAB in March.

Dr. Schwarz asked about CHLO's comments.

Ms. Thalhofer stated that the CHLO gave extensive feedback on the report. The important thing to remember is that even though this report is prepared for the legislature, the modernization funding is not yet reflected in the data that the subcommittee was able to put in the report. The changes in outcome metrics are not a reflection of the investment of the legislature. Overall, the report shows that public health is making a difference, but we cannot say that it is because of the investment. Although the report is for the legislature, most of the local public health administrators are using it with local commissioners and CCO partners, among others. The users of the report must be well-versed in what the report is saying and how to talk about things, such as gonorrhea rates going up, because we are discovering more of it. We are still having providers in our communities that are surprised that gonorrhea is back. It takes some education to bring people up to speed.

Public Comment Period

Ms. Tiel asked if members of the public on the phone or the webinar wanted to provide public comment. No public comment was provided.

Closing

Ms. Tiel thanked the PHAB for their time and adjourned the meeting.

The next Public Health Advisory Board meeting will be held on:



Public Health Advisory Board
Meeting Minutes – February 21, 2019

**March 21, 2019
2:00-5:00 p.m.
Portland State Office Building
800 NE Oregon St Room 1B
Portland, OR 97232**

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Krasimir Karamfilov at (971) 673-2296 or krasimir.karamfilov@state.or.us. For more information and meeting recordings please visit the website: healthoregon.org/phab