Public Health Advisory Board (PHAB)
August 10, 2011
Portland, OR
Meeting Minutes

Attendance:

Board Members Present: Thomas Aschenbrener, Shawn Baird, Betty Bode, Tom Eversole, Tran Miers, Mike Plunkett, Alejandro Queral, Bob Shoemaker, Steve Westberg, Liana Winett

Board Members Absent: Kathleen O'Leary, Bill Perry, Rick Stone

OHA Public Health Division Staff: Katherine Bradley, Katrina Hedberg, Katy King, Laura Saddler, Brittany Sande

Members of the Public: Morgan Cowling, Coalition of Local Health Officials; Beryl Fletcher, Oregon Dental Association; Janet Hamilton, Project Access Now; Sandra Hernandez, The TREE Institute; Amy Hojnowski, Planned Parenthood; Ryan James, Oregon Medical Association; Cindy Langhorn, Caring Ambassadors Lung Cancer Program; Gary Oxford, Multnomah County Health Department; Christen McCurdy, The Lund Report; Laura Sand, Caring Ambassadors Hepatitis C Program; Carol Van Horn

Materials distributed to board members in advance of the meeting:

- Oregon Health Policy Board meeting materials from July 12, 2011 meeting
- "Better health and lower costs: Improving Oregon Health Plan services"
- "Coordinated Care Organizations: Frequently Asked Questions"
- Agency for Healthcare Research and Quality's (AHRQ) Care Coordination Measures Atlas: http://www.ahrq.gov/qual/careatlas/
- "A Very Brief Description of Developmental Origins of Health and Disease" by Kent Thornburg, Ph.D., Oregon Health & Science University
- "Oregon's health system transformation legislation: A summary of OR House Bill 3650"
- The Institute for Healthcare Improvement's Triple Aim Measures: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/MeasuresResults.aspx
- "Effect of In Utero and Early-Life Conditions on Adult Health and Disease" by Peter D. Gluckman, M.D., D.Sc., Mark A. Hanson, D.Phil., Cyrus Cooper, M.D., and Kent L. Thornburg, Ph.D.
- Workgroup rosters and draft charters
- "A Case for Equity" – Northwest Health Foundation (distributed at the meeting)

Opening:

Chair Eversole called the meeting to order, welcomed board members and invited introductions. He stated that this special meeting would serve as a work session for the board and no public comment would be taken. The purpose of the meeting is to make recommendations for the workgroups set up by the Oregon Health Authority around health services transformation.

Announcements:

- Chair Eversole shared with the board the concern of Les Ruark, a member of the public, regarding the late notice for the meeting. Mr. Ruark felt that the late notice limits the public's ability to attend or participate in public meetings. Mr. Ruark stressed the importance of staff taking the necessary steps to avoid this happening again in the future and urges the board to think twice about holding special meetings on substantive issues without providing notice to the public. Chair Eversole stated that he appreciated Mr. Ruark's comments and although sufficient public notice of the special meeting was given according to the Public Meetings Law, this serves as a good reminder to send out meeting notices as far in advance as possible even if the agenda isn't set.
- Jeremy Vandehey with the Director's Office, Oregon Health Authority gave a five minute overview of the workgroups and provided information on how to present the PHAB's recommendations.
    - HB 3650 required a public process in three particular areas (one was also added by the OHA) through Governor appointed workgroups:
        - CCO Criteria
        - Global Budgets – contain healthcare delivery system within a global budget
        - Performance metrics – outcomes, quality and efficiency
        - Medicare – Medicaid Integration of Care Services (added by OHA) – opportunity to better coordinate care for dual-eligibles and how to make sure that's included in CCO
    - The workgroups aren't set up for receiving public comment, but public comment will be set up through the Oregon Health Policy Board. Workgroups will provide feedback to the OHPB after meetings each month for four months.
    - More information on the workgroups (charters, rosters) is available online: http://health.oregon.gov

Discussion:

Board members engaged in discussion about the four workgroups (Coordinated Care Organization (CCO) Criteria, Medicare-Medicaid Integration of Care and Services, Outcomes, Quality, and Efficiency Metrics, and Global Budget Methodology) set up by the OHA around health services transformation in order to come up with some recommendations for the workgroups:

Overarching Themes: Four overarching concepts or messages reflect PHAB's general advice to guide the design of CCOs and Health Service Transformation (HST). Each of these themes is elaborated in the workgroup-specific sections that follow:

1. PHAB members recommend that public health services cannot and must not be replaced by preventive medicine delivered in clinical settings. Achieving the triple aim's healthy population goal requires comprehensive public health promotion (i.e., disease prevention & policy) efforts organized in partnership with communities using an ecological health model.
2. The HST goal of lowering cost requires increased access to and use of community based prevention solutions with less reliance on high end, long duration hospital interventions. Appropriate, regular and successful use of health services often requires assistance from community health workers, health navigators, etc. This is especially true for the most costly users of services. Emergency departments and hospitals should be used as a last resort with the shortest advisable stays.
3. Partnerships between CCOs and their communities to conduct primary disease prevention (health promotion) activities and achieve health equity should be a uniform expectation in services for all users of health services, especially persons dually eligible for public health insurance (Medicaid and Medicare).
4. Public health should have an active role in overseeing budgets that affect population health through allocation of public funds.

Itemized Recommendations:

- ✓ **Coordinated Care Organization (CCO) Criteria**

  THEME 1: Public health cannot be replaced by preventive medicine
  - Design the structure of the CCO entities to enhance population health through partnerships with public health
  - Delivered services must include outreach, health system navigation and patient supports in communities
  - Criteria to qualify as a CCO should include working relationships with

community partners in health care, prevention and promotion. CCOs should have a history of successful community partnerships and collaborative planning. To that end the local public health authority must have an active role in CCO governance and CCO engagement with community health programs. Evaluation metrics must demonstrate effective partnerships that improve individual and community health through a variety of means, including:

  - Patient access to comprehensive services, including for example: mental health, oral health, physical health, comprehensive women's health
  - Single setting (integrated health home)
  - Access to supportive services: pharmacy, lab, translation, enabling services
  - Successful referral and feedback loops that link services to larger systems
  - Patient choice of CCO
  - Both CCOs and public health agencies should be active participants in workforce development

- Organizational structure should support successful outcomes. There may be variability in organizational structure, but metrics about the structure should be in place to define allowable variations (flexibility).
- Since new CCOs may need to build capacity to meet all criteria, compliance with all criteria could be phased in with appropriate milestones and evaluation.

✓ **Outcomes, Quality, and Efficiency Metrics**

THEME 2: Shift utilization toward community based prevention solutions with hospitals as the service of last resort

- Define good health as per World Health Organization (WHO) and design metrics to include the WHO's broad understanding of health.
- CCOs should be evaluated based in part on their relationships with community based access points for comprehensive health services including: physical/mental, dental care.
- CCOs should enhance and be interconnected with settings that increase access to care including: school based health centers, rural and community health centers, and other existing structures that serve large populations in public health context.
- OHA should design and implement a system that holds CCOs accountable to the public. An appropriate range of sanctions is

necessary to assure compliance and effectiveness, including:
    - Financial disincentives for non-compliance
    - Panel for patient complaints with sanctioning power (public accountability as alternative to litigation)
    - Public service models for health quality assurance
- Avoid becoming "No Healthcare Left Behind" due to metrics without context

✓ **Medicare-Medicaid Integration of Care and Services**

THEME 3: Primary prevention

- Rather than focus on dual eligible patients (Medicare-Medicaid), the language should be inclusive of all vulnerable populations
- Define the role of governmental public health in supporting CCOs
    - Provide mechanisms to fund public health for its share of this work
- Principles and activities of public/community health will be assured to this population by the CCO in order to achieve/sustain health equity. CCO's success in achieving health equity among patients will be evaluated.
- CCO quality improvement programs should provide data about vulnerable populations, as well as costs and effectiveness of innovative business/service models

✓ **Global Budget Methodology**

THEME 4: Oversight and resource allocation

- Discrete functions should be identified in the broad role of CCO. The budget should support those functions and desired health outcomes.
- Responsibility to provide public health services (versus public medicine) and responsibility to achieve desired population health outcomes should accompany any public health resources moved into a CCO's global budget.
- Public health resources that serve the entire population (environmental health, family planning, communicable disease prevention and control) should not be redirected to serve only those with insurance served by the CCO. That is, don't create new cracks for people to fall through. Shifting public health resources to CCOs could further marginalize Oregon's most vulnerable residents.
- Consider and account for the role of public health in the system
    - Any changes should enhance Oregon's ability to receive and

leverage (maximize) federal public health revenue
- Functional relationships between CCOs and public health agencies should be supported to strengthen public health system capacity.
- CCO role in public health should be evaluated based on population health outcomes

The previous themes and bulleted points were sent to Dr. Bruce Goldberg, Director, Oregon Health Authority from Tom Eversole on behalf of the Public Health Advisory Board members in a letter dated August 16, 2011 (attached to these minutes as Exhibit 1).

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

Friday, September 23, 2011
Portland State Office Building
800 NE Oregon Street, Room 1A
Portland, OR
9 a.m. – 2 p.m.

If you would like these minutes in an alternate format or for copies of handouts referenced in these minutes please contact Brittany Sande at (971) 673-1291 or brittany.a.sande@state.or.us.