COALITION OF LOCAL HEALTH OFFICIALS

Oregon Health Policy Board
May 1st, 2018
Public Testimony of Tricia Mortell

Chair Smith and Members of the Oregon Health Policy Board:

My name is Tricia Mortell, Public Health Division Manager in Washington County, and I am here today representing the Coalition of Local Public Health (CLHO) to talk with you about opportunities for greater alignment between CCOs and Public Health to meet the Triple Aim goals of better health, better care and reduced costs.

Public health as part of the community health system serves Coordinated Care Organization (CCO) members and non-members in many ways. But collaboration work is not consistent. In the first phase of CCOs the level of partnership work has looked different from community to community. Local public health has had to work county by county to develop partnerships, sometimes at great expense of time and resources.

We can say that there are examples of effective partnerships in place that should be replicated. Local public health has stepped up and chaired Community Advisory Councils, drafted grant proposals, participated on clinical advisory councils, shared in Incentive Pool funding, developed Per Member Per Month (PMPM) structures for prevention work and developed innovative models for shared Community Health Assessments and Community Health Improvement Plans. We believe that the proposals we have available for you today will help ensure stronger, effective partnerships like these are in place across the whole state.

With the passage of HB 4018 (2018) and the CCOs 2.0 contracting period you have the opportunity to require and enforce these effective collaborations between CCOs and local public health. We believe these partnerships will lead to better health outcomes, provide quality services and reduce costs. The goal of CCOs has been to continue to move upstream but unless CCOs meaningfully engage with public health the work will continue to be in a medical model and not break out of the clinical walls.

We know some of the major cost drivers to our health care and hospitals systems – obesity, tobacco use, substance and opioid use and mis-use– are areas where the public health system can and should be an integral partner in every community. Early interventions can also set infants and children on a greater trajectory to health for long-term cost savings.

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The Health Policy Board plays an important role in supporting and advancing Public Health Modernization. Public Health Modernization statutes require agreements and coordination with Oregon's Coordinated Care Organizations. However, if there isn't a similar and corresponding requirement on the health system side we won't be moving together in alignment.

Public health modernization dictates that the public health system do work differently, work across sectors, and use a collective impact approach for health. Opportunities to utilize that approach to reduce health disparities and improve community health can be furthered through CCO 2.0.

In closing, CLHO leaves you with five important recommendations that we hope spark conversation about how and what the relationship between CCOs and local public health can and should be in the next phase of CCOs contracts.

Tricia Mortell

The Coalition of Local Health Officials put forward the following recommendations to ensure there are meaningful and consistent connections between Coordinated Care Organizations (CCO) and Local Public Health Authorities (LPHA) across the state.

CLHO Recommendations	Policy Area of Focus	Community Health Improvement
Require CCOs to develop, financially invest in and implement shared Communication Health Assessments (CHA)/Community Health Improvement Plans (CHP) with LPHAs and hospitals. Require the use of CHA and CHP planning tools that meet requirements for LPHAs accreditation requirements and hospital assessments	Social Determinants of Health/ CHP implementation requirements/ expectations	This recommendation: - Reduces duplication of each sector doing separate CHAs and CHPs - Aligns activities and direct resources between sectors - Builds capacity for collaboration between CCOs, hospitals, and LPHAs
Require 1% of the CCO global budget to be invested in community -based cost-containment strategies conducted by LPHAs through evidenced-based strategies targeting: 1. Reducing rising obesity rates 2. Reducing tobacco use and stopping youth from getting addicted 3. Reducing low-birth weight babies and supporting infants and children for growth and development (toward kindergarten readiness) 4. Reducing opioid and other substance mis-use disorders	Cost Containment & Social Determinants of Health Additional ways to promote CCO use and reporting of HRS	This recommendation: - Aligns with Public Health Modernization in the Foundational *Health Promotion & Prevention* Program - Easily tracks Health Related Services expenditures - Ensures that progress is being made in several of the largest cost-drivers to the health care system - Expands access to important maternal and child health strategies - Moves the health care system upstream in a meaningful way to reduce costs across the whole state to better meet the Triple Aim
Require a % of quality pool to be shared with LPHA for shared work on meeting metrics.	Social Determinants of Health/ CCO community partnership requirements	This recommendation: - Leverages strategies and tactics led by LPHAs that complement the medical approach

		- Establishes and maintains strong partnerships - Aligns clinical and community-based work to achieve the greatest health impact for Oregonians
Require a Local Public Health Administrator voting position on the on CCOs governing board	Social Determinants of Health CAC & Governance connections	This recommendation: - Leverages governing board flexibility offered in HB 4018 (2018) - Adds value and expertise to the CCO governing board by including Local Public Health Administrator expertise in population and community health approaches
Require the creation of Alternative Payment Methodology for LPHA providing quality and culturally appropriate clinical services to high-risk, Medicaid members through specialty clinics and other public health models including services in non-clinical settings and the use of nursing services and traditional health workers that are not easily reimbursable through a fee for service model.	Paying for Value	This recommendation: - Supports quality and culturally appropriate services to Medicaid clients provided by local public health that don't always fit within a Fee for Service Model - Supports the innovative models of reaching community members in the home and community - Increases the identification of new payment methodologies for reimbursing direct care to clients