**March 13, 2018**

**To: CLHO Board**

**Fr: Workshop Participants**

**Re: DRAFT CCO 2.0 Recommendations for CLHO**

Background

Twenty local public health officials from around the state convened in Bend, Oregon to review the Public Heatlh Advisory Board recommendations for Coordinated Care Organization’s 2.0 contracts. During the course of the meeting the group prioritized which were the most important recommendations.

**CCO 2.0 recommendations**

The group discussed ten CCO 2.0 recommendations (nine from PHAB and one from CLHO), and then split into small groups to brainstorm the following for each of the group’s assigned recommendations (2-3 recs per group): 1. Potential health impacts; 2. Additional factors to be considered; 3. Prioritization of each recommendation within the ten (high = 1-3; medium = 4-6; low = 7-10); and 4. Key messages to motivate action

**\*\*Top priority\*\* (full consensus): Recommendation #10**

* Require 1% of the total CCO premium or global budget be invested into evidence-based public health promotion and prevention activities.

Note: Recommendation #3 was selected as an alternative to #10, if #10 is not accepted. Note that a phrasing change was suggested for Recommendation #3:

* Require that LPHAs are compensated for the public health contribution towards incentive measures ~~(e.g., tobacco and immunizations)~~, as defined in the Public Health Modernization Manual.

**2nd Priority (15 votes): Recommendations #5 and #6, combined**

* The group strongly supported Recommendation #5 with some added language, and felt Recommendation #6, as written, was too vague but could be folded into Recommendation #5 with suggested changes.
  + Original Recommendation #5: Require CCOs to develop shared community health assessments and community health improvement plans with LPHAs and hospitals. Require the use of community health assessment and community health improvement planning tools that meet requirements for LPHAs and hospitals.
  + Original Recommendation #6: Require CCOs to invest in shared community health improvement plan implementation
* New, combined recommendation (bold words are new):
* Require CCOs to develop **and financially invest in** shared (**objective health indicator gathering and analysis**) CHA/CHIPs with LPHAs and hospitals. Require the use of CHA and CHIP planning tools that meet requirements for LPHAs’ **accreditation** requirements and hospital **assessments**.

**3rd Priority (a tie, both with 13 votes each and both with suggested changes)**

* Recommendation #1: Require a local public health authority (LPHA**\***) voting member position on the CCO governing board.

\*The group would like to see the “A” in LPHA reference a local public health *administrator (or designee)* and not necessarily the *authority*.

* Recommendation #9: **Within 24**\* **months, implement a mutually agreeable revenue model for** fully reimburs**ing** LPHAs for the full cost of the provision of clinical services, including family planning, sexually transmitted infection treatment and contact tracing, and immunizations~~, whether through FFS or alternative payment methodologies~~.

\*The group of LPHA folks who worked on this recommendation initially suggested a 24-month timeline. Following the meeting, the participant from Multnomah County suggested that 12 months is likely an adequate amount of time. This suggestion is based on Multnomah’s experience with ongoing CCO negotiations around new payment methodologies for public health services.

**Remaining recommendations**

* #8: Include the OSPH Lab as an in-network provider for CCOs (9 votes)
* #7: Support response to public health emergencies, such as participating in regional health care coalitions (3 votes)
* #2: Recommend there be a CCO voting member position on the LPHA advisory committee, when a LPHA has an advisory committee (0 votes)
* #4: Align CCO incentive measures with population health priorities, to the extent feasible (0 votes)