**CLHO Healthy Communities retreat July 31, 2015**

**Attendees**:

Janet Jones, Umatilla County; Kris Williams, Crook County; Peter Davis, Marion County; Julie Albers, Clackamas County; Marilynn Sutherland, Klamath County; Adelle Adams, Multnomah County; Matt Davis and Amanda Garcia-Snell, Washington County; Charlie Fautin and Tatiana Dierwechter, Benton County; Morgan Cowling and Kathleen Johnson, Conference of Local Health Officials (CLHO); Kirsten Aird, Karen Girard, Heather Gramp, Kati Moseley, Luci Longoria, Sabrina Freewynn and Leah Fisher, Health Promotion and Chronic Disease Prevention (HPCDP) staff

**Legislative debrief:** Morgan Cowling and Karen Girard

Attached accompanying documents:

* 2015\_HPCDP\_LegWrapUp\_7\_31 15\_PartnerSummary (Word document)
* Legislative update (PowerPoint)
* CLHO Org chart (Word document)

Morgan provided a review of the structure of CLHO. A descriptive diagram is attached to the minutes and available at <http://oregonclho.org/about/>.

Tobacco Prevention Bills:

* HB2546 (e-cigarette bill) was passed and has been signed by the governor. CLHO and additional partners supported this bill. Karen has been invited to speak at national meeting regarding the bill, process, and outcome. HPCDP is convening two rules advisory committees: one committee will address ICAA (due January 1, 2016) and second will focus on packaging and labeling (rules due July 1,2016). The public will have an opportunity to comment at public hearings.
* Other tobacco issues heard this session include raising the minimum age for tobacco use, allowing local jurisdictions to tax tobacco, and licensing tobacco retailers. Many hearings were conducted about tobacco retail licensure. There was language added to a bill which included preemption (disallowing local governments from passing stronger policies). Being able to stop a bill from passing that included preemption was a win.
* A bill to allow fees for licensing smoke shops did not move forward. This bill may return next session. The electronic cigarette advocacy community will likely ask for an exemption for “vape shops.”

Other bills:

* There were a number of discussions and bills related to immunization.
* A number of bills were introduced and heard related to marijuana legalization.

Modernization bill:

* HB 3100, Public Health Modernization adopts foundational capacities and establishes a public health advisory board. Oregon Health Authority (OHA) and Local Public Health Authorities (LPHAs) are directed to assess and deliver the foundational capabilities. The process of public health modernization will be a multi-year process. Therefore, there is a challenge when some LPHAs will be operating under old statutes and some operating under new statutes. See presentation materials for additional details.
  + CLHO will host webinars to discuss the foundational services and provide input, comments, and questions to draft documents currently being created. There is a need for feedback in a short period of time.
* Next Steps: Respond to a forthcoming request for a webinar date and time. Participate in the webinar hosted by CLHO to provide input on draft documents related to health promotion.

**Healthy Communities Program Past and Present: History of Healthy Communities and the work of current Healthy Communities grantees**

History: Kirsten Aird

In 2006, HPCDP began consolidating multiple separate funding streams (e.g., asthma, diabetes, etc.) that went to LPHAs in the form of grants. The topics covered by the separate funding streams largely had common risk factors: physical inactivity, nutrition, and tobacco. They also had the common need to support people who have been diagnosed with a chronic condition.

Previous to consolidating the funding streams, grants were issued separately for each topic. This created peaks and valleys in local funding.

Integration of these programs occurred both through changes in the funding structure to local programs. Additionally, state staffing was aligned to support this integrated approach. The model was built on the successes in Tobacco Prevention and Education Program (TPEP), using a comprehensive approach, and looked at what was going well in each program. This original program was called Tobacco-Related and Other Chronic Disease (TROCD).

HPCDP offered a competitive opportunity to counties in 2008. The successful 12 applicants attended a series of institutes to ground participants in policy, systems and environmental (PSE) approaches. Grantees brought cross-sector teams and completed assessments. The original 12 grantees were funded for four years: one of building capacity followed by three of implementation.

Two years later, the remainder of the counties and the tribes were offered opportunities (and all but two accepted) to participate in the building capacity phase—attending a series of institutes and completing an assessment. This is when the name was changed to Healthy Communities and the CDC Community Health Assessment and Group Evaluation (CHANGE) tool was used to conduct the assessment. These grantees were only offered funds for one year but were then eligible to apply for competitive funds in the future.

In 2012, HPCDP released a second round of Healthy Communities implementation funding as a competitive funding opportunity. The selected cohort of nine grantees is currently starting a fourth year of implementation activities.

Comments:

* This history would be useful to capture on paper. Include information about key outcomes and metrics. There was a report in 2011 about the building capacity phase. A report about the implementation phase would be useful.
* Information about how counties worked together and provided cross-learning to peers will be useful for accreditation.
* Evaluations that counties do or participate in are extremely useful, whether Strategies for Policy and Environmental Change (SPArC), Sustainable Relationships for Community Health (SRCH), or other. These keep informing the model.

Benton County: Tatiana Dierwechter and Charlie Fautin. Materials are attached.

Funding has allowed for stable staffing and capacity to pursue additional funding opportunities. In early years, we did a lot of healthy eating active living work. In the last few years our focus has been more on health care. We are currently focused on worksite wellness (breastfeeding, healthy meetings, tobacco-free, etc.). Chronic disease self-management has grown, creating systems with partners to sustain programming. Benton has been able to take advantage of ARRA funding, partner with a hospital, and successfully apply for the SRCH grant. Similarly, the colorectal cancer work was leveraged into a bigger project with Coordinated Care Organization (CCO), and we now have a potential for CDC money towards this project. Also, Healthy Communities helps touch other counties not in Healthy Communities but in our CCO region, such as Lincoln. Built environment work grew for a few years without Healthy Communities, and we are pleased to see it back in the grant work plan. There is also cross over with the Community Health Improvement Project (CHIP) committee.

Opportunities: partnerships, consistent funding for stability, work leveraged for more funding.

Challenges: policy work is hard, regional partnerships are hard without everyone getting funds, changing program focus makes continuity and credibility with local partners challenging.

Jackson County: Tanya Philips. Handout attached.

The grant has allowed for leveraging concepts to other organizations. For example, Worksite Wellness has expanded from public health to the County Health and Human Services agency, City of Medford, and now to courts and other county buildings. Jackson County was successful by opting to not get a vending machine in new building, and issuing a new contract for vending with roads and parks that includes a requirement for 100% healthy options. Partnerships have been key to expanding the work, such as coordinating with mental health for quit line referrals. Staff have been at the table for the development of the Community Health Assessment (CHA) and CHIP, and the Healthy Communities work is a big part of the CHIP. That this is a consortium grant with Josephine was helpful, especially for CCO collaboration on colorectal cancer screening.

Deschutes: Thomas Kuhn

The Sustainable Relationships for Community Health (SRCH) grant presents opportunities for joint work with the CCO. We focused on increasing referrals to Living Well, getting the Diabetes Prevention Program (DPP) up and running, and creating electronic referrals to the Quit Line. We have made some progress in all of these areas. We are now focused on using the SRCH process to identify sustainable funding. One challenge is that CCO funds tend to not be for pilots or start-ups. We need funding for staffing to conduct the work. We are focused on our region but would like to see something rolled out at the state level. Will be coming back to ask for your support and CLHO support. The new incentive metric for tobacco cessation will give us some leverage next year.

Discussion:

There is such diversity of activities in communities, and in the context of modernization. What practices have you observed that are foundational and should be consistently supported? This question is about what are the core, foundational activities. It is also about the roles for local programs and state agencies. Feedback included:

* Assessment, because despite CCOs emerging as partners, sometimes public health is the only one thinking about disparities.
* Public health knows its partners. Convening community coalitions and advocacy is key.
* Continue to develop a workforce that knows how to conduct policy, systems and environmental change approaches.
* Population focus, again because despite working with CCOs, they can be 1:1 focused.
* Health in All Policies lens is important. We are the only ones looking across non-health sectors, because health is everywhere. Convening is an important role of public health.
* We are the nexus of work between public health, the CCO and hospitals.

Participants who are not funded for Healthy Communities shared the following perceptions:

* Funding is the key.
* We still go back and use our assessment that was developed while we had funding. It’s still important.
* Hard to have one or two people who are not funded for the work continuing to try to foster connections.
* In eastern Oregon, the CCO serves 12 counties. There is never seed money to start this kind of work. We do share the successes of other funded counties, but are unable to get much started locally.
* Hard to even have capacity to quickly understand and apply for the grant opportunities like SPArC.
* Small counties don’t have grant writers available so it’s a capacity issue.
* Even large counties don’t have a grant writer and have to dedicate program staff time to write a grant.
* State has been able to be nimble. Locals have been able to evolve and professionalize work too.

HPCDP is beginning work with Healthy Communities grantees to conduct an evaluation over the course of the July 2015-June 2016 grant year. What evaluation questions are of interest to CLHO Healthy Communities committee members?

* What new partnerships have come out of the grant to help expand the work?
* What other growth opportunities did Healthy Communities seed?
* What initiative was started by Healthy Communities and is now taken on and continued by other local partner (e.g., CCO)?
* Conversely, what partnerships went nowhere?

Are training and technical assistance opportunities meeting your needs, and how do we achieve the right dose of capacity-building?

* Difficult, because state has a wide range, from onboarding new TPEP to grant writing to Policy, Systems and Environmental changes skills. Maybe not all of the right people are here today to discuss that.
* In addition to the training opportunities, HPCDP liaisons are providing assistance to local program to support success.
* Yes needs are being met: the training calendar next year is quality.
* Sometimes people cannot get out to access these, but they learn ideas for other programs. It is helpful to see what others are doing, especially if staff cannot make it to training.

There are a few county health departments who have started to formally work together. For example, Jackson and Josephine counties are a consortium for the Healthy Communities grant. Some SRCH grantees span multiple counties. How is it going?

* Some pieces make sense to collaborate, but it’s hard if the counties are different financial spots or they have less resources and an unequal playing field.
* It makes sense when geographically close together counties work together.
* It’s not always the right fit to collaborate.
* Political diversity can be a challenge for policy work.
* Beneficial for staff to work regionally engaging in mentoring and sharing. For policy advancement they can play bad cop, good cop and be strategic.
* The time required for regional work can take away from local work. Regional work takes time in and of itself.
* The patchwork is hard – one person covers just two jurisdictions, a Council of Governments (COG) covers one area, a county another… etc. There are infinite permutations.
* Large organizations sometimes make assumptions and don’t know what is going on in smaller areas.
* Different counties really do have different disparities and partners and networks, and it doesn’t make sense to be required to or try to roll out the same initiative in the same way.

**Updates and announcements:**

There will be a Healthy Aging and Public Health conversation on September 18 in Portland. CLHO Healthy Communities committee members are invited to participate and contribute recommendations for public health driven actions to address healthy aging and aging in place. An invitation to participate will be sent to all committee members.

**Coordinated Care Organizations, Metrics Primer**: Joell Archibald. Presentation attached.

Joell provided information about metrics as detailed in attached presentation.

When we talked about retreat topics, committee members were not quite sure where metrics came from or what they’re used for. As a result, they were not sure how to leverage metrics to advance their work. Was this conversation adequate to meet the identified need?

* The statewide website looking at each CCO compared to the state is really an eye opening tool.
* Thinking and conversation from state HPCDP perspective is about the value of metrics as a way to start conversation with CCOs about these topics. The stakes get harder and higher, and CCOs are starting to realize that they can’t achieve these independently from public health. This is an opening to population level intervention support for tobacco, diabetes, hypertension, colorectal cancer screening, etc. HPCDP is interested in hearing from this committee what kind of training and technical assistance you need to have these conversations more regularly.
* CCOs will be looking for training opportunities. Is there a statewide list to learn what training resources there are? Joell: Every CCO, because of State Innovation Models (SIM) grant resource, has available 35 hours of technical assistance that they can request. The Transformation Center has a list of trainers and can assist with this matching process.
* The county experience is that one of the CCOs top questions upon entering into any work is “how will this help us meet our metric?” Look at all the metrics closely. The more you can leverage the more interest a CCO may have.

CCO metric conversation will align with public health metrics. How will this translate to public health functions, and how do we tie this to funding?

* As we move through modernization work, there is concern that in our wanting to be at the table we undersell the value we bring.
* Frame conversations with CCOs in a business plan to make sure that LPHA costs are met, and CCOs are awarded appropriately for their efforts.
* We need contemplative time to think about how we approach a different culture about how we bring value, and what we expect back in a formal contractual relationship. A required output of SRCH is a business agreement between CCOs, community-based organizations, and LPHAs about who is doing what, and how it gets paid for in a sustainable manner. How do you translate costs of community-based organizations to CCO language?
* We also need to think about the risks that we bear in these relationships.
* Finding tangible opportunities for quantifiable contribution will open the door to conversations about advancing healthy communities.

What is needed to bridge us between now and modernization?

* During the Building Capacity process, there weren’t CCOs, CHIPs, etc. We now have significant health planning occurring and don’t need to redo that work separately. Instead, we’re in the current paradigm of public health and we’re trying to get to modernization. What is needed to get us there?
* HB 3100 currently has no money attached, so no means to build the foundational capabilities. Legislators have kicked this question back to advocates to find the money. Can we play this conversation differently and not take from transportation, education, safety and other partners to try to fund modernization? The length of this transformation is longer than a business cycle, longer than a legislative cycle. The business community is looking at quarterly, maybe yearly cycles. Public health thinks in generational lengths of time.
* Public health can ask for resources from community benefits to cultivate the awareness that these things can be paid for. Additionally, tobacco and sugary beverage taxes can be advocated for by others than public health; similarly ask for more Tobacco Master Settlement Agreement (TMSA) funds dedicated to prevention.
* Healthy Communities has different funding streams and we have less control of the funding priorities than we do with TPEP because of the requirements that come from CDC. Having a state controlled funding pool for healthy communities would be a game changer. Benton County example: the CCO partnered on SPArC, so they had an interest in the TMSA budget conversations this session. The CCO provided supportive testimony. Hearing from a non-public health person and a high profile Medicaid-linked person was important to legislators.
* The local level needs more and more language about how and why CCOs need to invest in population level tobacco prevention and other priority prevention topics.
* CCOs are starting to recognize that raising the price of tobacco will be important to their ability to meet their metric. They need to advocate, but also need to be putting the resources to comprehensive tobacco prevention activities throughout the state.
* Develop a system to share grant opportunities with local public health partners so that they have a chance to apply, and diversify beyond just state funding.

Seems like people outside of public health are starting to believe that we do things that are important. What’s working and what’s not working?

* Part of the shift is internal; we’re starting to think about ourselves differently. We have more staff with degrees in public health these days; the workforce is professionalizing. Partners are getting more diverse, part of which comes out of Healthy Communities and TPEP’s focus on settings (e.g., housing). The more we connect with these kinds of partners, the more people are looking at us more seriously.
* Public communication tools such as Facebook and Smokefree Oregon have made a huge positive difference for public health because of the increased public and decision maker awareness of the importance of these issues.
* Accreditation is going to help advance the visibility of public health. We don’t tell our story very well yet. Accreditation will help demonstrate transparency, a system, and a business model that will be more evident. Within public health we are building a better understanding of our essential functions, and acknowledging that health systems do some things better that we don’t need to duplicate.

Joelle- there are examples of collaborative innovation networks to achieve public health goals. A necessity element is a fluid model of leadership alternating which group or individual is leading at a given time. This is not a rigid hierarchy. It takes the networking and weaving of people stepping in and out of leadership while maintaining a common goal.

What about the grants that require CCO and LPHAs to apply together? Those have been helpful in bringing them together with both agencies accountable to reach grant objectives together. Right now, these opportunities are coming from the public health side, but not the CCO side.

Is there a timeline for metrics to be developed?

* CCOs are getting frustrated with the measures and the time it is taking to get baseline numbers. The goal is to have baseline measures out by January 1.
* It may take longer to get to 2017 and 2018 metrics. We can talk about things under consideration, but they may not happen right away.
* Consider where we have leverage: LPHAs or health officers that have relationships with CCO representatives on the Metrics and Scoring Committee.

Congestive heart failure is the number one reason for hospital readmission within 30 days of discharge. Public health can help with that.

Where are we in terms of achieving state-level goals?

* HPCDP has a five-year plan that extends through 2017. We are on track for tobacco and colorectal cancer measures. PHD plan and state plan have similar measures and objectives.

**What’s next for the CLHO Healthy Communities Committee?:**

Committee members are interested in discussing these topics in the coming year:

* Report on HPCDP and state strategic plans; provide baseline and current status.
* What is environmental health’s five-year strategic plan? Does it exist?
* What is happening at the state level to reach strategic plan priorities?
* Share state health profiles- how do counties compare to the state?
* HPCDP staff are considering hosting brief data calls on one or two data points. These would be open to LPHAs and partners.
  + This idea is of interest to committee members.
  + Give the LPHA departments enough time and keep it short.
  + Tape them as well for those who cannot attend live.
* Explore relationships between public health and land use. Public health sits at the intersection of land use/transportation and CCOs. How does public health position itself as the translator?
  + Possible glossary for planning/transportation and public health.
  + Consider a brief survey on how LPHAs are working on this topic.
  + We are at the tool building stage. It can be daunting to look at big outcomes when people still may just need to tools to start the conversations.
  + Conversations have so many different levels. Some counties have moved from early conversations to beginning to develop formal policy agreements.
  + There is more work to do to bring CCOs and transportation/land use together and public health can have a role.
  + Conversely, CCOs and land use/transportation may not be ready for work together. Perhaps starting conversations around areas like housing and mental health where both can see a clear role will be more engaging.
    - Planners use data. Data that they don’t have access to is of interest.
    - Share data between the different groups.
    - Data is there- but funding is not.
* Discuss preemption and what that means for health. This is an important topic for tobacco prevention and for other public health topics.
  + Maybe there is a short list of additional policy issues. The committee can help the state develop language, training, and host future conversations.
  + Information about how counties and incorporated cities interact is also important.
* Healthy community outcomes and modernization – what communications and resources are needed about what was learned through Healthy Communities that could be useful in discussions about modernization? What could HPCDP develop or brand to help support that communication? What can help for conversations with CCOs and other partners? Is there a need?
  + Healthy communities map and other visuals. Community partners like to see where they fit in.
  + Test our current materials with partners and see if it makes sense.
* Healthy aging efforts. How does that fold in and not get lost? How do we ensure we work across the life span?
* Environmental Protection Agency Sustainable Communities Initiative: this group is doing many of the same thing as healthy communities with same goals, but each is funded from a different federal agency. Environmental justice grants: addressing health disparities. Same goals, but different language.
* Modernization and environmental health are tied. Environmental health goes beyond regulatory and while that was uncomfortable for a lot of traditional environmental health folks, view it as an opportunity to talk.

**Meeting evaluation:**

What worked well:

* Helpful to have the CCO discussion.
* State planning, examples from others, modeling and discussing the future.
* Daunting because of all the work we have before us. What will public health look like in a very short timeframe?
* Great that we could all get together in person.
* Depth of thinking was beneficial. It was worthwhile exploring ideas that we don’t have answers to.
* Starting at 9:30 was acceptable.

What could work better:

* Air conditioning

**Announcement:**

Registration for Oregon Public Health Association (OPHA) will open in a couple of weeks. Those who submitted abstracts will receive notices soon. Senator Merkley and Senator Steiner-Hayward plan to be in attendance. There will be a focus on policy issues and equity.