Oregon State Profile: Public Health and Primary Care Collaboration

Background

Oregon's path toward integration of public health and primary care has included innovative Medicaid financing and state legislation defining core public health services. The Oregon coordinated care organization (CCO) Medicaid model launched in 2012. The model includes alternative payment methodologies (APMs) and "incentive metrics" that are traditional population health priorities (e.g., tobacco cessation, immunization, obesity, etc.). Some CCOs are nonprofit, and some are large for-profit companies that prioritize ROI. CCO performance metrics are reported annually and available to view longitudinally by organization or demographic.

In 2013, House Bill 2348 created the Task Force on the Future of Public Health Services, which is responsible for identifying opportunities and providing recommendations on the improvement and modernization of governmental public health in the state. The Oregon Task Force developed a framework of Foundational Capabilities and Programs that should be delivered at the local and state levels in a high functioning public health system. In 2015, the new public health modernization framework was adopted through House Bill 3100 and a statewide gaps analysis was done in 2016 to identify public health needs across Oregon. The public health modernization framework has continued to guide policy priorities and investments in public health at both the state and local levels.

How is collaboration operationalized in Oregon?

Coordinated care organizations

Many of the incentive metrics established by the state for coordinated care organizations (CCOs) target population health priorities, which presents an opportunity for federally qualified health centers (FQHCs) and local health departments to work together alongside Medicaid payers. CCOs have the flexibility to provide a per-member per-month (PMPM) carve out for upstream preventative work, which can go to local public health departments. In these arrangements, the health department must present findings to the CCO board of directors on how the money is being spent, the evidence base for the intervention, and the progress of the work to continue receiving the funds. Importantly, the public health funds from CCO carveouts are flexible.

Oregon has used "Opportunity Conferences" to bring together market competitors to work toward collaboration. These gatherings present occasions for public health leaders to learn about the priorities of physician organizations and CCOs in their county and identify opportunities to work together. In addition to addressing population health needs through upstream prevention efforts, these multisector collaborations can lower costs.

In Lane County, the local health department director has used the CCO model as a foundation to build strong working partnerships with primary care leaders, health systems, and payers to advance public health goals. In a partnership with local public health, the two CCOs in Lane County have focused on decreasing rates of hysterectomies and joint replacements (expensive medical care) through upstream obesity reduction.

Placing local public health leaders on the board of directors for CCOs can establish a working relationship and demonstrate the ability of public health to support primary care priorities. Though there are opportunities for collaboration between CCOs and local public health, CCOs are not required to include local public health leadership

on their boards of directors. This means that the responsibility lies with local health department leadership to make the business case for this type of collaboration with payer organizations.

Health roundtables

Leaders in Oregon have taken creative approaches to strengthening the collaboration between primary care and public health. For example, in Lane County, the local health department director has started a "Health Roundtable" in partnership with health care leaders in the county. Though there may be opportunities for collaboration around specific health initiatives, the roundtable is an informal yet intentional way to build relationships. The focus on building relationships for the sake of building relationships is key to developing trust between public health and health care.

Weekly data sharing

Lane County Public Health provides a weekly, one hour, 1.0 continuing medical education (CME) activity for the local clinical community, including physicians, nurse practitioners, physician's assistance, and naturopaths. These weekly presentations cover important public health topics. For example, during tick and mosquito season, public health leaders present data on the disease burden for Lyme disease and West Nile virus, as well as prevention measures for clinicians to take back to their practices.

Learnings and recommendations for other states

Leaders in Oregon offered suggestions for other states interested in pursuing the approaches taken in Oregon. These suggestions include:

- Share your organization's data (e.g., vaccination rates, communicable disease rates, chronic disease prevalence, etc.) to get your foot in the door with the organizations you're looking to partner with.
- Building relationships just for the sake of building relationships is important; there doesn't always need to be an agenda. If the relationship is established first, it's easier to partner with other organizations/sectors down the road when it matters (e.g., during a crisis like COVID-19).
- In Oregon, there isn't competition between local public health departments/jurisdictions. Regular meetings between local public health leaders in the state allow leaders to share their experiences, provide support, and discuss strategies around collaboration with primary care.