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MINUTES

South West Regional Health Collaborative Advisory Board

9/7/2018 12:00 PM to 2:00 PM

Time	Item	Desired Outcomes	Presenter
12:00	Welcome and Introductions; Lunch; Agenda, Minutes	Welcome members, new and old. Working lunch. Confirm the topics of today; review the work at the last meeting; approval of last meeting minutes. Brian welcomed everyone, and introductions were made. Two new members were announced: Lisa Mielke, the new Assistant Health & Human Services Administrator for Community Health of Coquille Indian Tribe Community Health Center; and Tanveer Bokhari, the new Director of Quality Improvement for Umpqua Health's CCO. Lisa was not able to come, but the Coquille Indian Tribe was still represented by Dennita Antonellis-John. Tanveer joined by phone. Dennis Eberhardt with the Cow Creek Clinic tried to join by phone, but the call did not work. Other members in attendance were Anna Warner, Advanced Health; Ben Cannon, Public Health Administrator for Curry County, Florence Pourtal-Stevens, Public Health Administrator for Coos County, Bob Dannenhoffer, Public Health Administrator for Douglas County; Christin Rutledge, Bailey Burkhalter, and Brian Mahoney, staff of the Douglas Public Health Network. Guests included Bert Cramer, contractor for modernization, and Michelle Hicks, staff from Curry Community Health. The agenda was reviewed with no changes. The minutes from April 30 were reviewed with no changes. The Advisory Group Charter was edited to reflect the new members.	Brian Mahoney
12:15	Activity 2.1, the CD Regional reporting	Presentation of CD reporting survey: major findings, next steps, timeline, and training plan. Update on proposed reporting requirements discussion between LHD and state, and about possible access to Electronic Health Records. Ask members for guidance on	Bailey Burkhalter Dr. Bob

	survey and training plan	best methods to offer and provide training with CCO and tribal providers.	
		Bailey gave a presentation on the data gained from the Communicable Disease Reporting Survey that was conducted regionally in August. We met the interview goals (number of targeted interviews) with 44 medical providers, 4 hospitals, 3 nursing or assisted living facilities, a jail and a tribe represented. The locations, professional levels, specialties represented, and years of practice were all in a balance among the counties. The results show that only about half of all providers know how to find reporting requirements (some referred to CDC). More than three quarters listed lack of knowledge as a barrier to reporting. Most said basic provider education would help. Many said they do not know "who" public health is or have not communicated with them. Providers would like increased communications with public health. What interaction with public health that there is has been positive. However, there is no one best method for communications; the split is among phone, email, and fax. Contacting the office manager is the most efficient practice. Nearly all providers said they would participate in training about CD reporting, if offered. We developed proposed steps from the survey: 1) distribute posters to providers *with contact information*; 2) work with the state to clarify what we truly want from providers (to increase calls about non-lab/suspect cases; whether if labs report, do we want physician reports; and improve communications with providers); 3) develop an educational training covering what, when, to whom to report & desirable reporting items, includes training local office staff and CD staff; 4) public health outreach to local providers, including giving feedback on results of case reporting and follow up. We interviewed three laboratories. Labs are following reporting requirements. They can supply information on missing data and can alter reporting interfaces to include additional data requirements. We interviewed LHD CD workers from each county. Primary reports are from labs and ELRs. OB/GYNs report the most, and most cases are STDs. LHDs have capacity issues, that is a lack of FTE to support CD/STDs. A discussion among members ensued based on the presentation. There are several issues: outreach and training, funding, capacity, manpower, and coverage. Sharing work via ORPHEUS is practical. Bert said that reporting was not a job for some physicians, but that staff handle it. They can be leaders and support the staff work that do it.	

| | | For instance, physicians can bring Social Determinants of Health concepts into patient interviews and get useful information and front office staff can gather demographic, REAL-D (race, ethnicity, language, and disability), and occupational data. However, we need to know how each clinic works and what works for each clinic. Tanveer asked if there was access to Electronic Health Records. Bob said DPHN told no by the CCO. Some counties have access to some records, and Curry may have a Health Information Exchange in the works. They need more providers to participate, and somehow the hospital would be involved. Florence said that Coos County has started to share, "if you ask nicely." It takes a business associate agreement to work. There are many EHRs in the region and would take learning how each works. Access is generally "read only." Bob will meet with state staff (Stephen Ladd-Wilson and Paul Cieslak) to discuss the previously mentioned reporting requirements and whether legislative work to allow public health access to EHRs will be undertaken; or it may be rule changes that need to be made. Florence suggested that reporting results of case reports and case investigations back to providers may help them appreciate that what they do helps the public. Their reports result in actions, and this could be added to the training. Give feedback to providers with the context of the case investigations. How do you reach providers with feedback? Coos County has Everbridge notification system (like HAN?). Outreach meetings with providers and groups, such as pediatrics and OB/GYNs. Tribes would also appreciate communications with them. Anna says Advanced Health has two staff who go visit providers, take them information, and gather information from them. Making connections with face-to-face meeting and knowing people by name works. Bob explained the training plan. Bob, Bailey, Bert, and Brian met in Elkton to discuss the planning. Bob said the training should have specific reporting requirements and case presentations. Describing cases reported and cases found or prevented because of reporting will help reporters to value reporting and the work that goes into case control efforts. The training will provide CME/CEU through Bay Area Hospital. There can be several kinds of training using different methods for different audiences, and for different purposes. Again, we need firm reporting requirements. How will training results be measured? What are successes? The training event itself will be evaluated (it is a CME requirement). A pre-test and post-test on knowledge can be used. For training impact on | |

		the job, an assessment of whether reporting non-lab reported diseases occurs can be used. Unduplicated (not from labs) reports will be useful. Would like to focus on immediately-reportable diseases, but those are extremely rare. There are other possible measures, such as the number of contacts made with individual providers; process measures, such as timeliness and completeness of reports; and others. We discussed logistics of training and CME needs. There are a variety of training methods including didactic and distance learning. Trainers will need locations, times, training materials, registration and advertisement. There are new Triennial Review requirements for data that will need to be included: demographics, risk factors, occupation, etc. Bob will follow up with the requests from the state. Tanveer said he would look into the data-sharing issues and manner of reporting.	
12:50	Activity 3.1, the Regional CD Health Equity Assessment of PH staff and community collaborators	Introduce the BARHII survey and present the work plan for the survey. Ask the Advisory Group to identify community partners for the collaborating partner survey, and to provide guidance on the conduct of the assessment. Brian gave presentations on the Bay Area Regional Health Inequities Initiative (BARHII) Health Equity Assessment material. First, he gave a background overview, and then he presented a Health Equity Assessment draft workplan for the region. The BARHII Health Equity Assessment comes from a collaboration among county health departments in the San Francisco area. The toolkit contains several surveys and other assessment tools. The purpose of the surveys are: 1) to capture baseline measures of capacity, skills and areas to improve health equity-focused activities; 2) identify research-based organizational and individual traits that support health equity-focused work; 3) use the results to develop strategies that improve capacities; and 4) use as ongoing assessment of progress towards identified goals. We will survey LHD staff in one survey, and we will survey community collaborators with a second survey. The LHD survey goes out the week of September 10. The community collaborator survey will go out in early October. Some of the recommended collaborators to take the survey include: hospitals, HIV Alliance, groups that represent Social Determinants of Health sectors, social service groups, Head Start, CCOs and CACs, education and school districts, breastfeeding coalitions, Hispanic councils, perinatal and prenatal groups, and others. Bob asked if there were any results of impact available because of work done with the BARHII. We have not found much information	Brian Mahoney

		on the "outcome" of changes based on plans and policies developed as a direct result of BARHII surveys, but there are reports with recommendations for community engagement based on results of surveys. A suggestion was to add an open-ended communicable disease question to the BARHII. There was not consensus on the need nor on the question. The two surveys will be completed by the end of October. A draft report will be available by the next Advisory Group meeting. The state requires a final report by December 31. A regional action plan based on the surveys is due to the state March 31.	
1:25	Activity 4.3: Improve 2-year-old immunization rates	Provide results of "root causes" workshop. Provide data on AFIX participation in region, timeline, and results of outreach. Provide overview and timeline of effort to create a Boost Oregon project; ask members to identify providers who can be champions, identify venues for workshops, and ask about the best ways to advertise the workshop—to get the word out. Present data from the key informant interview. Findings are tied into future public health policy around health inequities and social determinants of health.	Brian Mahoney
		Brian presented details from the June 22, 2018 Child Immunization Root Cause Workshop. Root Cause Analysis is applied to methodically identify and correct the root causes of events, rather than to simply address the symptomatic result. Sixteen people from eight clinics representing the three counties attended. By the conclusion of the workshop each clinic had produced a six-month action plan for addressing root causes of low immunization rate within their clinic. Follow-up communications will be conducted by the Oregon Immunization Program at the end of this year. Action plans included: 1) developing reminder/recall processes; 2) giving incentives for well-child visits; 3) starting a parent coalition; 4) improving scheduling procedures; 5) learning about ALERT IIS; and 6) designating an immunization champion for the clinic.	
		Brian introduced Michelle Hicks from Curry Community Health who is working on her Master of Public Health degree. She is using a capstone project to plan a BOOST OREGON-type of project for the region. The project would plan for provider-led and parent-led educational events in the region. The BOOST OREGON program is based in Portland, but it is looking for state-wide partnerships. Bert also introduced planning around implementing AFIX in the region. Currently, Vaccine for Children clinics are asked to participate in AFIX	

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		to review clinical immunization rates and make changes to policies and practices that are evidence-based to improve rates. A fully developed AFIX program has incentives and exchanges among the various clinic. That is a way to share clinic data among clinics, challenge providers to improve, and learn from one another what works and what does not. Michelle will be the coordinator for the AFIX project for Coos and Curry Counties. Sara Kiely from OIP will train Brian, Bailey, and Michelle to conduct AFIX assessments. We will need to identify incentives, perhaps with support from CCOs. Clinic representatives may meet on a quarterly basis to share rates and practices. Tribes can be involved. The person from OIP who works with tribes is Jody Anderson. We will contact Jody for her input. Communications with providers in the counties is important for creating and sustaining an AFIX collaboration.	
1:55	Set Next Meeting	Date and times for quarterly meetings for 2018 and 2019 Determine appropriate dates Advisory Group to meet. The next dates are October 26 (?), January 25 and April 26. The venue is the same (Bandon Community Health Center), and the times will be from 12 noon to 2 p.m. We agreed as a group that we would meet once more before the end of the year but would not meet October 26. We will send a Doodle Poll to find a time in early December to meet. We will have results from both Health Equity surveys to share at that meeting.	Brian Mahoney