SHIP SUBCOMMITTEE MEETING

☐ **Bias** ☐ **Trauma** ☐ **Economic Drivers** ☒ **Access to Care** ☐ **Behavioral Health**

January 27, 2019 | 1:00 p.m. – 3:00 p.m. | Call: (669) 900-6833, Access: 393-128-009 | Meeting Recording

Members Present: Rebeckah Berry, Bridget Canniff, Tim Menza (OHA Lead), Nina Fekaris, Senna Towner, Cable Hogue, Tom Jeanne, Kelle Little, Muriel DeLaVergne-Brown, Marc Overbeck

Members Absent: Frank Thomas, Chiqui Flowers, Katie Harris, Laura McKeane, Char Reaves, Heidi Hill, Jim Rickards, Danielle Sobel, Tim Svenson, Patricia Patron, Marti Cardy, Catherine (Cat) Livingston

OHA Staff: Elizabeth Gharst, Krasimir Karamfilov

Members of the Public: Tenea Hall (Frontier Nursing University)

Welcome, Agenda Overview, and Subcommittee Business

Elizabeth Gharst welcomed the subcommittee members to the meeting. She asked the members to introduce themselves. The attending subcommittee members introduced themselves.

Liz remarked that due to the number of members present, the strategies would be discussed in the larger group rather than going into breakout rooms. She reminded the subcommittee members that the May meeting had been rescheduled for May 18th, as May 25th is Memorial Day. Liz reviewed the timeline and noted it is being shifted so that all subcommittees will have the March meeting to discuss and finalize strategies. However, as the PartnerSHIP is meeting on March 16th, the meeting date for the March meeting will need to be moved to earlier in the month so the draft plan can be finalized for review. A Doodle poll was sent out as an email and posted as a link in Basecamp. Subcommittee members will be notified of the new chosen date. The April meeting can be utilized to discuss process measures.

Elizabeth Gharst explained that the draft plan will go the PartnerSHIP in March prior to the community engagement period in April. OHA has grant agreements in place with seven different organizations that will be vetting strategies in their communities. At the same time, the draft plan will go to different sectors so that OHA can get feedback from implementation partners. For example, if there are transportation strategies that are not drawn from an existing ODOT transportation plan, ODOT leadership can review. The other place OHA will be getting feedback from is the OHA and Public Health Division impacted programs and sections. In May subcommittees will incorporate the feedback and then finalize the plan prior to the PartnerSHIP convening again on June 1st. The SHIP will be launched July 1st.

Tim Menza reiterated the aim for the meeting is to identify 10-15 strategies at policy, community, and individual level—3 to 5 under each goal. Tim Menza stated that the strategies under each goal have been

grouped by topic area. The current process is to narrow the strategies the subcommittee brainstormed by removing some, condensing others, or putting together strategies that deal with a specific topic.

In March, the subcommittee will look at areas of overlap or duplication with other priority areas. Any direct overlaps with the strategies of the Economic Drivers subcommittee will reveal themselves. For example, in the case of housing, when OHA went out for community feedback to narrow down the priorities, access to safe and affordable housing was the number one priority for six out of the seven communities and number two for the seventh community-based organization. So strategies related to housing might appear in multiple SHIP subcommittees, but it would be looked through different lenses depending on the priority area. Some level of strategies related to the social determinants of health will appear across subcommittees.

In March, the subcommittee will also apply the criteria broadly to ensure there are strategies affect priority populations and finalize choices and wording. Instead of going through every single strategy and applying the criteria, the intent is to look at the criteria in a more general view. For example, for strategies for the lifespan, the draft plan should have strategies for youth and older adults both.

Strategy Narrowing

For the sake of grouping the topics, some strategies were moved from their original goal to another goal. Depending on what final strategies are chosen, some of them may move between goals depending on the focus. Marc Overbeck suggested to the subcommittee members to pick their top 5 strategies per goal, and then a second tier of five strategies, with the thinking that when the subcommittee chooses the final five strategies per goal and other subcommittees have duplicated one or more strategies, the subcommittee can move strategies from the second tier up to the first tier, so that each goal has a solid set of five strategies.

Elizabeth Gharst pointed out that, so far, very few strategies have directly overlapped among subcommittees. Nina Fekaris commented that some of the strategies were narrow (e.g., diabetes prevention program) and asked if they could be examples under a broader category. Elizabeth Gharst responded that one approach is if there were strategies specific to the priority populations, the strategy could be written “starting with” to indicate what specific programs or culturally responsive interventions should be prioritized. That level of detail is useful for those who will implement the plan.

Tom Jeanne added that in terms of diabetes prevention program, it is a great evidence-based program, as well as Weight Watchers. Maybe the strategy can be generalized as *intensive community-based behavioral counseling* and the DPP can be an example or the starting point.

Muriel DeLaVergne-Brown stated that looking at the list of strategies, one has to think about how they apply across the state. Just because an example worked in an urban area doesn’t mean that it would work in smaller counties. Many of these topics are included in the CHIP, which Crook County just completed. She agreed that the strategies should be a mix of upstream and direct interventions. It is necessary to also look upstream at some of these strategies in order to move the dial.

Rebeckah Berry remarked that it was hard for the State Health Improvement Plan to be inclusive and consider such differences in the state. It is doable if the subcommittee honed in on the primary, secondary, and tertiary prevention components in a way that meets the needs of the different geographic areas and populations.

Kelle Little echoed Muriel DeLaVergne-Brown's comments on the rural communities in Oregon, which include many of the tribal communities. The strategies need to be applicable to differing systems, not just urban, large public health departments. Tribal public health services and tribal health services are often inter-dispersed and shared between a local health division and tribal public health. Flexibility and applicability to different systems is important. Some of the proposed strategies tend to be more applicable to very urban populations. She liked the primary, secondary, and tertiary approach as a way to think about it systemically.

Elizabeth Gharst noted that as the work moved forward over the next couple of months, the challenge was to make sure that there was a mix of general and specific strategies. There are strategies specific to rural areas in most of the subcommittees. The idea is for the strategies to be generally broad and applicable in different contexts, however there may be strategies that are specific enough to affect disparities in priority populations. Examples could be given to help guide how the strategies could be implemented in different parts of the state or for different populations.

Tim Menza pointed out that one of the themes across the goals was decreasing barriers. In thinking about using virtual and community physical spaces, the subcommittee needs to figure out how to get to where people are, because people are getting tied to their homes. There could be an overarching strategy across the goals named *barrier reduction*. Barrier reduction might look different in different places and for different populations. This may include interventions for barrier reduction such as telemedicine and colocation of services and ancillary services.

Muriel DeLaVergne-Brown remarked that she would fight for reproductive health services for her teams and others who needed those services, because it was challenging at times. Another strategy that stood out for her was prenatal care, as maternal child health strategies are very important.

The strategies to move forward under goal 1 were as follows:

Transportation

- Expand the availability, safety, convenience and appeal of places for people to be physically active – with priority on helping people who are physically inactive become more active by walking or rolling. This would include prioritizing investments in active transportation such as mass transit, walking, and bike infrastructure. This could also include prioritizing parks and trails that are well-maintained and accessible to every community.

Food insecurity

- Food deserts in communities – expand access to fresh and nutritious foods especially with consideration to disparities in communities of color.
- Colocation of food pantry services at clinics, community-based organizations, and schools.

Built environment

- Co-location of services - Increase embedded behavioral health providers in primary care.

- Reduce barriers to accessing treatment services by ensuring programs provide ancillary services, such as childcare and transportation, or by making referrals to other community agencies

School-based interventions/Youth interventions

- Developmental screening for children

Community-based prevention

- Syringe service and harm reduction programs
- Community policies and norms - Evidence based approaches to promote preventive services
- Vaccination programs: combination of community-based and health system interventions to increase vaccination rates in targeted populations. Recommended, with strong evidence, by the community guide.
- Identify health strategies and how to targeted preventive message if we are able to reach those who we want to share those messages with the population; tailoring the preventive approach to reach people where they are at; have community be at the center, e.g. Diabetes prevention program - possibility also for community-based preventive services

Tim Menza reviewed the groups of strategies for Goal #2.
Cable Hogue commented that when we look at strategies such as *raising the price of sugary drinks*, this penalizes low income people, the alternative approach of reducing the cost of healthy food is probably a better impact.

Tim Menza explained that when looking at groups such as Dental providers or Pharmacy-based providers, we are looking at leveraging people other than primary care physicians or MPs or PAs to do the work of prevention. One of the strategies that can be used is *leveraging professionals other than primary care providers for access and uptake of clinical preventive services*. That could be a goal that includes the first two groups under Goal #2, but it is flexible for different regions and areas that might have more interest in dental providers versus pharmacy providers.

Muriel DeLaVergne-Brown remarked that when the subcommittee thinks about access, she completely believed in the primary care home. Lots of time people can't get in. Another strategy that could be either pharmacy-based or dental is about opening access so that people can be treated. There are a lot of barriers, some of them structural, around that. She also added that many public health departments in the rural areas provide clinical services. It should be considered how the public health departments are paid for the work they are doing to support the health system.

The strategies to move forward under goal 2 were as follows:

Overarching

- Leverage cadres of providers other than primary care providers for access to and uptake of clinic services.
- Reduce barriers to accessing clinical preventive services, e.g. <<include examples>>

Dental

- Open up new mid-level dental providers model (Alaska)
- Yearly dental exams, yearly wellness exams, fluoride varnish
- Dental care as a mechanism to do BP, A1c, cholesterol checks.

Sexual Health

- STI intervention: Universal testing for HIV. Including home-based testing; Expand provider knowledge of HIV/STI partner notification; Expand provider knowledge of EPT for GC/CT; Increase access to PrEP; Increase knowledge of U=U, HIV treatment as prevention.
- Universal access to free RH services

Prenatal care

- Pre-natal care - cross with clinical and cross-collaborative.

Provider availability

- Provider availability for rural/frontier counties. Provider availability for mental health providers. Provider availability for OHP/Medicaid.
- Strategies to increase uptake and sustainability for more providers in rural health areas- TBD Nurse Corps Program, National Health Service Corps

Increasing culturally responsive care

- Strategies around CHW, peer navigators. e.g. Strengthening access to doulas, especially doulas of color
- Improve clinical expertise around race/ethnicity, gender identity, sexual orientation, immigration status, ability

Tim Menza reviewed the groups of strategies for Goal #3. He explained that Goal #3 was set up a systems goal rather than individual goal, so it is appropriate to have more community and policy-based strategies. Nina Fekaris noted that all groups were important. Cable Hogue remarked that the groupings represented four good goals and a ton of examples on how to get to those goals. Senna Towner agreed that there were four clear groups of strategies, and that one could be chosen under each.

Elizabeth Gharst stated that for Telemedicine, the strategies could be easily condensed, while for Electronic Health Records, the strategies were disparate. Bridget Canniff noted that collapsing the strategies into one would lead to losing some of the detail. The subcommittee needs to find out what is feasible at this point. It's a question of interoperability and/or some way to do data sharing outside of interoperability. The issue of how providers use EHR in their practice is very different than the strategy for sharing information between clinicians and public health.

Elizabeth Gharst added that thinking about the broader strategies, one of the things that some systems (FQHCs) have started doing is screening for social determinants of health, which is then put into the electronic records system. That is something that can be included within that – promoting the use of EHR to guide health maintenance services and connect individuals to social support.

Elizabeth Gharst remarked that one thing to think about before next meeting is what can reasonably be condensed, such as when examples can be included in how the strategy is written. This is versus strategies that need to be specific to move the needle on disparities—is it going to happen unless it is written more specifically, especially for culturally specific interventions.

The following strategies were moved forward under goal 3:

Telemedicine

- Improving tele-medicine and its infrastructure including access to specialty services

Electronic Health Record/Technology-based interventions

- Strategy around interoperability among systems (EHR) between primary care and secondary/tertiary care. And/OR Support expanded coordination and data sharing between primary care (IHS/tribal/urban health clinics) and secondary/tertiary care outside the ITU Indian healthcare system
- Promoting the use of EHR to guide health maintenance services: immi, colorectal cancer screening, mammo, HIV/STI/hepatitis testing, A1c, HTN, pap, etc. Reminders to providers. Include social determinants of health screenings as well?

Financing

- "Healthcare incentives and flexibility - Use healthcare payment reforms and regulatory levers to create incentives and encourage flexibility in using healthcare resources to support access to food, housing, and transportation." (See Vermont SHIP)

Referrals/Eligibilty

- Produce a community-based preventative services database hub. Online tool? Or A strategy in itself could be funding for an EBA to increase health and insurance literacy. Database could possibly include: What screenings/assessments can help us understand, What screenings/assessment are provided by insurance/ACA? Connection to library books program, summer food programs, WIC, housing, utilities, other community services
- Initiate "prescription" in clinic, directive from provider for a community-based prevention program (clinic-community connection) Reduce barriers to care by improving information sharing systems.
- Every clinic with an avenue (SW, online portal, navigator) to community services

Public Comment

Tim Menza invited members of the public to provide comment or ask questions. There was no public comment.

Next Steps

- Narrow down the strategies under group Referrals/Eligibility in Goal #3.
- The meeting in March will be rescheduled.
- Elizabeth Gharst will post the next version of the strategy spreadsheet.

Adjourn

Elizabeth Gharst adjourned the meeting at 2:43 p.m. The next meeting will be on February 24, 2020.