# SHIP SUBCOMMITTEE MEETING

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

**February 24, 2020 | 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, Cable Hogue, Tom Jeanne, Kelle Little, Katie Harris, Patricia Patron, Catherine (Cat) Livingston

**Members Absent:** Senna Towner, Muriel DeLaVergne-Brown, Frank Thomas, Chiqui Flowers, Laura McKeane, Char Reaves, Heidi Hill, Jim Rickards, Danielle Sobel, Tim Svenson, Marty Cardy

**OHA Staff:** Elizabeth Gharst, Krasimir Karamfilov

**Members of the Public:** Ashley Allison (Oregon AIDS Education & Training Center), Dayna Steringer (Willamette Dental Group), Bruce Austin (Oregon Health Authority)

## 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.

Elizabeth Gharst informed the subcommittee that OHA staff have started to operationalize the outcome indicators. The OHA staff who will be responsible for reporting on the indicators every year are meeting to see if they have any questions about the chosen data points. If there are any questions about the indicators, those will be coming back around in April. OHA is not changing directions. It is ensuring that there are systems of accountability in place to track the progress on the SHIP.

Tim Menza explained that the purpose of the meeting was to narrow the strategies to 15 and write the strategies. In March, the subcommittee will apply criteria to the selected strategies to ensure strategies affect priority populations and will finalize the strategies and their wording.

Elizabeth Gharst remarked that the navigation map had been updated. Subcommittee members can see how other subcommittees are wording their strategies.

## Strategy Narrowing and Writing

Tim Menza pointed out that there were six strategy groups in Goal 1 with 1-2 strategies in each group. The subcommittee members agreed to combine the groups Transportation and Built Environment. The

subcommittee combined strategies under each strategy group, discussed the resulting strategies, and arrived at five strategies, one under each group, for Goal 1.

Elizabeth Gharst stated that there were five strategy groups in Goal 2 and the subcommittee had already started combining strategies.

Bruce Austin suggested changing the name of the strategy category Dental to Oral Health. Dental refers to the work that dentists can do, while oral health includes work done by the rest of the team, including dentists.

The subcommittee discussed the strategies under each strategy group, combined strategies, edited the strategies for clarity, and agreed on five strategies for Goal 2.

Tim Menza reviewed the four strategy categories in Goal 3. Elizabeth Gharst noted that the subcommittee could keep the two strategies under the group Electronic Health Record/Technology-Based Intervention because the strategies were distinct. The subcommittee members agreed.

The subcommittee discussed the strategies under each strategy group, edited the strategies for clarity, and agreed on five strategies for Goal 3.

The list of strategies chosen during the meeting is below:
Goal 1

- Reduce barriers to accessing treatment services by co-locating fundamental support services (including childcare and food pantry services) and providing safe and active transportation to services. This would include prioritizing investments in active transportation such as mass transit, walking, and bike infrastructure.
- Assess populations experiencing food insecurity, provide resources to ameliorate food insecurity, and expand access to affordable, fresh, nutritious foods to reduce food deserts and food swamps, particularly among communities of color, tribal communities, and in both rural and urban areas.
- Ensure that every student has access to screening for health barriers to learning.
- More dissemination of health literacy techniques for healthcare providers and pharmacists including academic detailing, online resources, best practices alerts for pharmacists.
- Expand and promote evidence-based approaches to preventive services such as syringe service and harm reduction programs, overdose prevention, vaccination, obesity and diabetes prevention programs (weight watchers), and contraception.

Goal 2

- In coordination with primary care providers, leverage cadres of providers to increase access to and uptake of evidence-based or promising practices clinic services such as leveraging pharmacists, community health workers, mid-level dental providers. For example, to leverage alternative workforce models to expand access in rural and frontier counties.
- Increase access to dental sealant and fluoride varnish programs based in schools. Fluoridated water.

- 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; PeP; Increase knowledge of U=U, HIV treatment as prevention including home-based testing. reproductive health.
- Increasing access to early prenatal care in the Medicaid and CAWEM+ population through reduction of structural barriers.
- Increase culturally responsive care through use of community health workers and peer navigators. e.g. strengthening access to doulas, especially doulas of color, and provide trainings to healthcare providers to develop expertise around caring for people of different race/ethnicities, gender identities, sexual orientations, immigration status, abilities.

Goal 3

- Improving tele-medicine and its infrastructure including access to specialty services, tele-mental health, and health promotion programs. Infrastructure may include improvements payment reimbursement mechanisms.
- Support expanded electronic health record coordination and data sharing between primary care and secondary/tertiary care.
- Promote use of EHR/ EHR to guide health maintenance services: immunizations, colorectal cancer screening, mammograms, HIV/STI/hepatitis testing, A1c, HTN, pap, etc.  Reminders to providers. Include social determinants of health screenings as well?
- 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.
- Support efforts around statewide community information exchange to facilitate referrals between the health sector and social services.

Tim Menza offered to go through and clean up some language and make suggestions on strategies that will need some additional wording choice work. Elizabeth Gharst will post on Basecamp prior to the next meeting in the March meeting materials folder. The subcommittee agreed to review the suggestions at the March meeting as they finalize the strategies.

## Public Comment

Elizabeth Gharst invited members of the public to provide comment or ask questions.

Ashley Allison from Oregon AETD suggested to add *increasing access to PEP* (post-exposure prophylaxis) to the Sexual Health strategy in Goal 2, specifically for individuals who were uninsured and lived outside of urban centers.

Dayna Steringer from Willamette Dental Group suggested adding *mid-level provider development* as a separate strategy under Goal 2. It is a model that will reach out to populations that have the least access to dental care and affect that disparity.

## Next Steps

- Tim Menza will work on wording choice on strategies that were identified as needing additional work.

## Adjourn

Elizabeth Gharst adjourned the meeting at 3:00 p.m. The next meeting will be on March 5, 2020.