SHIP SUBCOMMITTEE MEETING

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

May 18, 2020 | 1:00 p.m. – 3:00 p.m. | Call: (669) 900-6833, Access: 393-128-009

Members Present: Senna Towner, Rebeckah Berry, Nina Fekaris, Tom Jeanne, Bridget Canniff, Tim Menza (OHA Lead), Marc Overbeck

Members Absent: Kelle Little, Katie Harris, Patricia Patron, Catherine (Cat) Livingston, Muriel DeLaVergne-Brown, Frank Thomas, Chiqui Flowers, Laura McKeane, Char Reaves, Heidi Hill, Jim Rickards, Danielle Sobel, Tim Svenson, Marty Cardy, Cable Hogue

OHA Staff: Christy Hudson, Krasimir Karamfilov

Members of the Public: Danielle Uhlhorn (Eugene Family YMCA), Cathy Wamsley (InterMountain Education Service District), Eli Schwarz (Public Health Advisory Board), Liz Walker (Health Evidence Review Commission)

Welcome & Agenda Overview

Christy Hudson welcomed the subcommittee members to the meeting. She asked the members to introduce themselves. The attending subcommittee members introduced themselves.

Update on Community Feedback Process and Timeline

Tim Menza provided an update on the timeline for developing the SHIP. The subcommittees have identified policy, community, and individual level strategies and process measures. The community feedback helped in making the strategies more succinct. The community feedback process involves the distribution of online surveys by OHA, PartnerSHIP, and subcommittees. Seven community-based organizations and several stage agencies collect feedback from priority populations. The feedback will be incorporated into the SHIP at the June subcommittee meetings. Specifically for this subcommittee, the three outcome indicators include two-year-old immunizations, colorectal cancer screenings, and a dental indicator.

Tin Menza added that the purpose of today's meeting was to develop short-term measures for each strategy. Ideally, the measures will be collected annually, will be measured statewide, and be SMART (i.e., specific, measurable, achievable, relevant, time-bound).

Senna Towner asked if today's work was done under the assumption that the community feedback wouldn't change the strategies so much so that the subcommittee would have to adjust the strategies.

Tim Menza answered that that was the hope. There may be some changes to strategies. COVID-19 has uncovered a lot of differential access to healthcare, and to health in general, in a lot of the priority populations, particularly among people of color and poor people. Some strategies might be changed if the subcommittee felt that COVID-19 has changed the subcommittee's thinking about equitable access to preventive care. Any health emergency will continue to uncover those disparities. If some of strategies change, the outcome indications may have to be changed as well.

Eli Schwarz asked about the baseline year for the measures. Tim Menza answered that the baseline year has not been determined.

Senna Towner asked if all subcommittees were moving in the same way. Christy Hudson answered that four of the five subcommittees would be doing the same work this week. The adversity and trauma subcommittee worked through the short-term measure development last week.

Finalize Key Indicators

Christy Hudson reminded the subcommittee that the key indicators were selected in fall 2019. At the time, the subcommittee landed on a data source, Oregon's Smile Survey, that is taken once every 5 years. Based on feedback from OHA analysts, there was a lot of concern about the data coming out of the Oregon's Smile Survey. The suggestion was for the subcommittee to select a different data source for oral health. OHA staff at the Maternal and Child Health section assisted with identifying 10 possibilities, out of which two possible indicators were proposed: (1) percent of children with a preventive dental visit in the past year (National Survey of Children's Health), (2) adults aged over 18 years with a dental visit in the previous year for any reason (BRFSS). The task for the subcommittee is to pick one indicator.

Nina Fekaris asked about the age of the children for the first proposed indicator. Tim Menza answered that the age for that indicator was 0-18. The age for the second proposed indicator is over 18. At the state level, NSCH occurs every two years, while the BRFSS measure occurs every year.

Eli Schwarz asked for more clarification on the lifespan criteria for the indicators.

Christy Hudson explained that the vision for the SHIP that was set by the PartnerSHIP specifically called for equity across the lifespan. When OHA asked for community feedback when setting the priorities for this SHIP, people specifically called out for attention to be paid to the needs of children and older adults.

Tim Menza clarified that another consideration was to be able to look at the data by race and ethnicity. This is possible for the BRFSS measure. For the NSCH, this cannot be done.

Eli Schwarz remarked that the question was whether there was enough additional information about the children's situation. He was not sure that just measuring if the children had been to the dentist over the last year was a useful measure. In the Metrics and Scoring Committee, there is the Kindergarten Readiness Measure, which captures children aged 0-5 with a dental visit. The Smile Survey doesn't capture dental visits at all. It only looks at the dental carrier situation for the children and whether they have cavities, sealants, and so forth. Dental sealants are also being measured by the Metrics and Scoring Committee. He

wondered if the SHIP outcome measures had to be exclusive, or other measured could be looked at as part of the success with the SHIP.

Tim Menza answered that the more the subcommittee could align measures, the better. He asked Eli Schwarz what a useful measure would be, if the proposed NSCH measure was not useful.

Eli Schwarz explained that in terms of real outcomes, a disease-related measure was most informative. OHA is already reporting to CDC the percentage of children with cavities. We know that Oregon is 47th in the county for dental disease in children. Because oral health or fighting oral diseases is not a priority in this SHIP as it was in the previous SHIP, just measuring the dental visits might not be a useful measure for the children population. When he was on the Metrics and Scoring Committee, the committee refrained from measuring that, because the committee didn't think the measure gave any response or indicator of how well the children were doing.

Tim Menza clarified that going for a preventive dental visit didn't mean that there was decrease in untreated decay.

Eli Schwarz remarked that when we measure whether a child had been to the dentist over the last 12 months, we don't know whether the child came in because it had an abscess or because the child came in to get tooth cleaning. If we don't describe it further qualitatively, the measure, in itself, doesn't reveal nature of the visit.

Nina Fekaris agreed with Eli Schwarz. She suggested that measuring attendance as it related to dental disease might yield data, or measuring a decrease in the number of children seen with dental disease. In other words, something that measures what a dental visit entails and whether those instances increase. She preferred a measure that targeted the oral health of school-age children.

Tim Menza asked the subcommittee if measuring dental visits in the previous year for people over 18 captured what the subcommittee wanted.

Eli Schwarz stated that the BRFSS measure provided information. If we are addressing access in this age group, it is clearly a measure of access. That's why he asked earlier about the baseline year. We probably know the situation for Medicaid and un-Medicaid populations for 2019. If 2019 is the baseline year, in 2020, we will find a huge decline in the number of visits due to the pandemic. When we add to it the social determinants of health, we would have some very useful information about the adult population. We could also be held against the national statistics, because the Dental Association in Chicago is covering that area for the entire country. That would be a very useful statistic to have.

Tim Menza asked if the measure *percentage of enrolled children in Medicaid who received a preventive dental service during the measurement year* captured preventive services.

Eli Schwarz explained that preventive dental services was a particular code. It is clearly possible for Medicaid. This is already run out of Medicaid as statistics. In that regard, it will be interesting to see what proportion of children are getting preventive and full services. There are national statistics looking also at

commercially insured children. In Oregon, many more commercially insured children are getting a preventive service during a year than Medicaid covered children. It's all about putting several levels of measurements together, in order to get a total picture.

Tim Menza added that, in addition the Medicaid data, we had APAC (All Payer All Claims) data. That would allow us to look at those who are commercially insured and those who are on Medicaid for preventive dental services. The APAC is lagged (the latest data is for 2017). The goal then of the short-term measures is to provide a complete picture. These measures are the bigger beacons as to whether we are reaching the goal with the overall strategy of increasing equitable access to preventive services.

Tim Menza showed the selected strategies. He remarked that the process measures had been renamed short-term outcome measures, as the focus was on short-term progress on the three larger outcome indicators. He invited the subcommittee members to review the strategies and suggest edits, given what was known through COVID-19 work.

Marc Overbeck pointed out that for strategy #9, *support alternative healthcare delivery models in rural areas*, a process measure had not been identified. He recommended as the owner for this strategy the research data unit at OHA's Health Policy & Analytics division, which runs the healthcare workforce reporting program.

Nina Fekaris asked whether the term "promising practices" in strategy #3, *expand reach and preventative services through evidence-based and promising practices*, should be added to the list of definitions. This is almost like a model in and of itself. It is based around practices without evidence that sounded like they would be okay.

Tim Menza answered that the phase would be defined during the writing of the final SHIP. There are things that communities do that don't have the typical evidence-based foundation. The epistemology of who is the expert is different from the scientific and academic communities. This allows for communities to dictate promising practices or evidence based on community expertise.

Christy Hudson defined "promising practice" as a practice that reported positive outcomes despite lack of scientific evidence.

Eli Schwarz asked whether the increase of services or the provision of services would be written in the process measure. For example, language such as "ensure that there is a provider within a certain amount of minutes from these areas." This is the supply side of the access of equation.

Tim Menza confirmed that language like this would be included in the short-term measure.

Identify Short Term Measures

Tim Menza stated that the short-term measures that had been brainstormed before the meeting were for the strategy *increasing access to affordable healthy and culturally responsible foods for people of color in*

all communities. A possible measure could be fast food or convenience stores within a half mile from schools. The metric could be the number of farmers markets in particular communities.

Tom Jeanne remarked that while the fast food and convenience store measure was loosely corelated to access to affordable healthy food, it was a different measure. It wouldn't be the best measure for that strategy. Something around grocery stores and farmers markets distance, or density per square mile or population, would get a better measure.

Christy Hudson clarified that if the subcommittee couldn't think of a potential measure, it would be helpful to think about who would be a potential owner of data.

The subcommittee discussed a short-term measure for each strategy.

Public Comment

Tim Menza thanked the subcommittee members. He invited members of the public to provide comments and ask questions. There was no public comment.

Next Steps

- An OHA research analyst will work on data visualization, benchmark data, and proposed target for the key indicator *Adults aged over 18 years with dental visit in the previous year for any reason*.
- Subcommittee members will continue to share the SHIP survey to their networks
- Christy Hudson, Tim Menza, and OHA staff will work on solidifying a short-term measure for each strategy

Adjourn

Christy Hudson adjourned the meeting at 2:56 p.m. The next meeting will be on June 29, 2020.