SHIP SUBCOMITTEE MEETING: Access to equitable preventive health care

Monday, July 27th, 1:00 – 3:00pm

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Vision: Oregon will be a place where health and wellbeing are achieved across the lifespan for people of all races, ethnicities, disabilities, genders, sexual orientation, socioeconomic status, nationalities and geographic locations.

Meeting Objectives:

- Finalize activities and measures
- Recommendations for implementation

1:00 –1:10	**Welcome & agenda overview**
1:10 – 2:15	**Finalize activities and measures**
2:15 – 2:30	**Recommendations for implementation**
2:30 – 2:45	**Honoring your commitment**
2:45 – 2:50	**Public comment**
2:50 – 3:00	**Wrap-up & Next Steps**

Welcome & Introductions

- Share name, pronouns and agency

Technology Reminders

- Enable video if you feel comfortable
- Mute your line when not talking
- You can also use emoticons and chat to engage.

Timeline for developing 2020-2024 SHIP

Aug – Sept. 2019	Sept. – Nov	Nov – April, 2020	May	June	July	Aug.
• Subcommittees begin meeting	• Identify goals and key indicators	• Identify policy, community and individual level strategies and process measures	• Community feedback on strategies • Short term measure development	• Incorporate community feedback & finalize strategies	• PartnerSHIP approves SHIP • Final activities and measure, recommendations for implementation	• SHIP is launched • Implementation begins

Finalize activities and measures

- Review, add, & modify draft activities based on subcommittee discussion and community feedback
- Where possible, make short term measure recommendation

Healthier Together Oregon

IMPLEMENTATION PLAN (Draft)

Access to Equitable Preventive Healthcare

Key Indicators

1. Childhood immunizations (ALERT IIS)
2. Colorectal cancer screening (Behavioral Risk Factor Surveillance System/BRFSS)
3. Adults with a dental visit in the previous year (BRFSS)

Goal 1: Increase equitable access to and uptake of community-based preventive services.

HTO Plan	Strategies & priority populations	Example activities:	Short term measure ideas
WD	Increase patient health literacy	• Share health literacy trainings with providers • Consider trainings available online, both live and recorded, tailored for different audiences, and for different position levels and with cultural considerations.	
HF	Expand reach of preventive services through evidence based and promising practices.	• Pharmacy partnerships to increase access to naloxone. • Vaccination programs - community-based and health system interventions • Syringe exchange programs • Promotion of Long Acting Reversible Contraception (LARCs) • Diabetes Prevention Program • Mental health SBIRT	% of CCOs meeting X incentive metric benchmark in (OHA)

Commented [HCJ1]: Immunizations, well-child visits, oral health

Commented [HCJ2R1]: Effective contraception use

HC	Co-locate support services for low income people and families at or near health clinics. **Low income**	• Onsite childcare • Co-located housing assistance and food banks • Accessible by active transportation	
HS	Expand recommended preventive health related screenings in schools. **Youth**	• Expand currently offered screenings (Blood pressure hearing, vision, dental, height, weight and, posture) to include mental health, social determinants and other chronic medical conditions.	% of school districts that have school nursing service (ODE)
HF	Support Medicare enrollment for older adults through expansion of the Senior Health Insurance Benefits Assistance (SHIBA) program. **Older adults**	• Promote Medicare and Medicare advantage plans • Address transportation barriers	% of low income, rural, and non-native English contacts per total "hard-to-reach" Medicare beneficiaries in the State. (DCBS)

Commented [HCJ3]: Christy will follow up with kristin et al...

Goal 2: Increase equitable access to and uptake of clinical preventive services.

	Strategies & priority populations	**Example activities:**	**Short term measures**
T&I	Support alternative healthcare delivery models in rural areas. **Rural**	• Leveraging pharmacists, community health workers, mid-level dental providers, and other advanced practice providers to address provider shortages in rural areas. • Creation of health care teams that include primary care providers, advanced practice providers, dietitians, traditional health workers, school nurses, and dentists. • Utilizing dental providers to offer blood pressure, A1c, and cholesterol checks.	

HS	Increase access to dental care that is offered in schools, such as dental sealants and fluoride varnish. **Youth**	• Promotion of Alaska model utilizing mid-level dental provider. Current pilots in tribal communities and Willamette Dental. • Expand dental sealant and fluoride varnish programs in schools • Consider use of mobile clinics, and opportunities to outreach to home-schooled or out of school students	% of eligible schools offering dental sealants (OHA)
HF	Increase access to pre and postnatal care for low-income and undocumented people. **Low income and undocumented**	• Promote awareness of pre-natal care available for undocumented women through CAWEM + • Expand Perinatal Care Continuum (PCC) model • Strengthen access to doulas, especially doulas of color.	% of CCOs meeting postnatal care timeliness incentive metric OR % of CAWEM+ clients receiving prenatal care in first trimester (OHA)
HF	Improve access to sexual and reproductive health services.	• Improve wrap-around services • Expand funding models for sexual health, including insurance coverage of pharmacist-delivered PrEP and PEP and Medicaid coverage for EPT • HIV pre and post exposure prophylaxis (PrEP and PEP). • Partner services for HIV/STI. • Expedited partner therapy. • Long-active reversible contraception and abortion.	% of adults ever tested for HIV (BRFSS) OR Effective Contraceptive use OR STI incidence

WD	Increase the cultural and linguistic responsiveness of health care through use of traditional health workers and trainings. **POC, LGBTQ+, disabilities**	• Improve payment mechanisms for traditional health workers. • Provide sexual orientation and gender identity trainings to different levels of clinic staff. • Expand cultural competency and culturally responsive trainings. • Oregon Health Care Provider Incentive Program • Healthy Oregon Workforce Training Opportunities	# of Traditional Health Workers employed by CCOs (OHA)

Goal 3: Implement systemic and cross-collaborative changes to clinical and community-based health related service delivery to improve quality, equity, efficiency and effectiveness of services and intervention.

	Strategies & priority populations	**Example activities**	**Short term measures**
T&I	Expand use of telehealth especially in rural areas and for behavioral health. **Rural**	• Expand Project Echo. • Improve payment mechanisms for telehealth. • Use of telehealth for health promotion programs • Includes telehealth for behavioral health services	% of providers in each rural county that provide services using remote technology (APAC)
T&I	Improve exchange of electronic health record ~~coordination~~ information and data sharing among providers.	• Between primary, specialty and hospital care • Between tribal health care and other health care systems • Between correctional and community-based settings	Rates of health information exchange (HIE) use for care coordination among contracted physical, behavioral, and oral health facilities OR Rates of access to and use of hospital event notifications among contracted physical, behavioral, and oral health facilities

Commented [HCJ4]: This would be preferred, as it includes the second measure. Could look at Medicaid providers only or most providers for denominator.

T&I	Use healthcare payment reforms to support the social needs of patients.	• Use health care payment reforms such as CCO health related services and hospital community benefit spending • Use regulatory levers such as health insurance and health system regulation, health care organization, and workforce licensure. • Create incentives and encourage flexibility to support access to food, housing and transportation.	Average CCO spending on health related services per member per month (OHA)
T&I	Use electronic health records to promote delivery of preventive services.	• Expand use of EHR alerts for preventive services, like immunizations, cancer screenings, etc. • Use EHRs for social need screenings as appropriate~~s~~	Rates of electronic health record (EHR) adoption among contracted physical, behavioral, and oral health facilities
T&I	~~Create~~ Support~~a~~ statewide community information exchange to facilitate referrals between health care and social services.	• Ensure closed loop referrals • Coordinate with 211 info as appropriate	% of closed referrals

T&I – Technology & Innovation

WD – Workforce Development

HC – Healthy Communities

Commented [HCJ5]: Doesn't get at intent of strategy – HPA looking into other options related to alerts

Commented [HCJ6R5]: Also looking into public health data (like ALERT e.g.) that speaks to EHRs.

Commented [HCJ7]: From Unitas and Aunt Bertha to capture statewide data.

Healthier Together Oregon

IMPLEMENTATION PLAN (Draft)

HF – Healthy Families

HS – Healthy Students

H&F – Housing & Food

Recommendations for implementation

- Role of PartnerSHIP
- Community Health Improvement Plans
- State agency partnerships
- Possible resources
- Other opportunities?

How do you suggest we move the strategies forward?

How do you see your agency or organization being involved in implementation of the SHIP?

What would you like your role to be?

Honoring your commitment

Public Comment

Next Steps & Final Thoughts

Healthier Together Oregon launches in September – help us spread the word!

Please complete subcommittee process evaluation – your feedback is important to us!