SHIP SUBCOMMITTEE MEETING

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

September 30, 2019 | 1:00 p.m. – 3:00 p.m. | Call: (646) 749-3122, Access: 477-873-293

Members Present: Tim Menza (OHA Lead), Tom Jeanne, Catherine (Cat) Livingston, Chiqui Flowers, Kelle Little, Muriel DeLaVergne-Brown, Rebeckah Berry, Patricia Patron, Laura McKeane, Bridget Canniff, Katie Harris, Senna Towner

Members Absent: Char Reaves, Heidi Hill, Jim Rickards, Nina Fekaris, Frank Thomas, Danielle Sobel, Tim Svenson, Martin Cardy

OHA Staff: Christy Hudson, Krasimir Karamfilov

Members of the Public: Kristan Jeannis, Deborah Riddick, Dayna Steringer

Welcome, Introductions, and Agenda Overview

Christy Hudson thanked Senna Towner for filling in for Tim Menza with leading the meeting. Senna Towner invited subcommittee members to introduce themselves and share three identities they held. Each subcommittee member and two public members in the room shared their name and identities. Senna Towner reviewed the meeting agenda. Christy Hudson reminded the subcommittee that a digest that summarized the work of all subcommittees was posted on Basecamp. The digest will be updated monthly.

Follow-up from Last Meeting – Finalize Goal

Senna Towner asked the subcommittee members if they had any questions about the presented definitions for vision, goal, outcome indicator, strategy, process indicator, and actions. She remarked that at Lane County, it had been helpful for their team to go back to the MAPP (Mobilizing for Action through Planning and Partnerships) process and look at how the terms were used from the MAPP perspective. There are many ways to define these terms.

Christy Hudson noted that the definitions were following the MAPP framework and the process was consistent with how Lane County approached the definitions. Senna Towner asked Cat Livingston to explain how the subcommittee goals got developed.

Cat Livingston explained that the group that worked on the goals developed three summative goals. The first was dividing up into community-based preventive services, such as use of community health workers, food security interventions, harm reduction interventions, connecting people for social determinants of health or social need screening and connecting them to services. The groups talked about equitable access

to and uptake of clinical preventive services and defined them as the U.S. Preventative Services Taskforce (USPSTF) A&B recommendations, a set of evidence-based clinical preventive services. The third goal the group discussed was creating an integrated, mutually reinforcing relationship between clinical and community-based preventive services to improve the quality, equity, efficiency, and effectiveness of services and interventions. The group discussed at length whether or not *access* and *uptake* should be separate things. It was decided that it was more important to be about people getting the services and that access is a necessary part of that. There was some concern raised that if we had *access* as its own thing, that would guide the metrics to be a certain way that wouldn't result in the yield of people actually getting access to the services. At the end, the group decided that it was okay not to pull it out separately, but to bundle it in, and make sure it was about everybody getting access to those services.

Tom Jeanne asked about the distinction between *access* and *uptake*. Is *access* about whether a service is provided and is it at all feasible or possible to get it for a person? Is *uptake* about long practice and how many people are actually accessing a service?

Cat Livingston answered that the group initially discussed some metrics in the format of "If you wanted to, could you do this?" that would end up being a survey-based tool, or a few people asking whether or not they had access, which ultimately seemed less meaningful than "Are people actually aware of it and taking the next step and using those services?" Most of the discussion was about increasing the number of people broadly who were accessing these services with a focus on equity as well. The group was concerned that it would end up with process metrics about access rather than people getting the services that they needed.

Christy Hudson invited the subcommittee members to vote for the three proposed goals as written by using the thumb-voting method in the GoToMeeting chat box. Thumbs-up means "approved with no changes." Thumbs-sideways means "pending with a lingering question." Thumbs-down means "disapprove with strong reservations." The voting is done in three rounds until a consensus is reached. The subcommittee approved the goals unanimously in the first round.

Identifying Outcome Measures

Senna Towner explained that the proposed process for measure development for the goals was to identify two to three outcome measures for the priority. Tom Jeanne asked if the subcommittee had to identify 2-3 outcome measures for each of the three goals.

Christy Hudson clarified that the subcommittee needed to identify 2-3 outcome measures in total that supported the three separate goals. She added that the measures should be high-level measures and may not be directly connected to the approved goals. She recommended formulating the measures as "if/then" statements and thinking about them as key indicators that are not necessarily tied to the goals. The criteria the subcommittee should use when considering the measures are (a) addresses a health disparity, (b) it is the right measure of the issue and it is easy to understand by community members, (c) feasible (i.e., the data is already collected).

Tom Jeanne stated that the available state health indicators, which could be considered for measuring the goals, are part of the state health assessment, which is done every five years. All these indicators address a disparity and are feasible and could be good measures. Three indicators that stood out for him included *population without health insurance*, *prenatal care in the first trimester*, and *childhood immunizations*.

Senna Towner questioned the suitability of the measure *population without health insurance*. Patricia Patron agreed with Senna Towner and suggested that the measure *population to provider ratio* was more appropriate in terms of access to care.

Kelle Little asked if these were the only indicators that would be available through the state. Christy Hudson answered that these were the primary indicators that were identified during the state health assessment process, which was community-driven and determined by a steering committee and a subcommittee. When the state health indicators were identified, they were intended to be the primary indicators from which the SHIP indicators would emerge. However, if there are indicators outside of the state health indicators that would be better for the proposed goals, they would be considered.

Kelle Little noted that the list of indicators included a few National Survey of Children's Health (NCH) indicators and only one adult preventative health indicator (i.e., late stage colorectal cancer diagnosis). If the subcommittee decided on an NCH indicator, such as *childhood immunizations*, the subcommittee should consider adding a measure for adult access to preventative care, such as *late stage colorectal cancer diagnosis*.

Cat Livingston asked if there was an opportunity to create new metrics that wouldn't be that difficult, maybe from APAC (All Payer All Claims database), or some other source. For example, one not very hard metric is *Do you have access to health insurance*. What is more important is *Do you have access to health insurance that covers, by federal law, USPSTF A&B recommendations*. In other words, do you have access to health insurance that is going to provide individuals with the preventive services that the subcommittee wants people to have. This may be relatively straight forward by figuring out all insurances available to Oregonians and checking if they are offering these services.

Tom Jeanne agreed that for this priority area (i.e., access to preventative services), this measure would be more refined, as opposed to the general *Do you have health insurance*. For a plan like the State Health Improvement Plan, the subcommittee needs to ensure that the measures are general enough and accepted enough.

Muriel DeLaVergne-Brown remarked that she and Rebeckah Berry are involved with the CCOs in Central Oregon and there are a few metrics that they measure, such as the public health metrics, based on the Public Health Advisory Board. She asked how it was all coordinated, because if the subcommittee is choosing different things all the way across, it seems disjointed.

Christy Hudson answered that in terms of alignment with the public health accountability metrics and the CCO incentive metrics, alignment was sought in the past SHIP. When the state health indicators were developed, OHA looked toward alignment of the public health accountability metrics. As per the CCO incentive measures, OHA used the SHIP priorities to help inform the metrics that came out of Metrics and

Scoring in the Health Plan Quality Metrics Committee. OHA would continue to use the SHIP to inform the proposed measure sets that it brought forward for those committees.

Tom Jeanne suggested that the measure *childhood immunizations* should be considered as an access to care measure, as it is also one of the eight public health measures local public health authorities track. If one was to assess the impact of all preventive services, immunizations are at the very top. Muriel DeLaVergne-Brown agreed. When Central Oregon counties did their priority setting with all partners, immunizations rose to the top.

Senna Towner invited the subcommittee members to vote on the first measure. The measure *childhood immunizations* was approved unanimously. Tome Jeanne added that a specific measure included in the SHIP was *2-year-olds who are up-to-date on immunizations*. That's a good data source that OHA has, and it's a key age for getting kids immunized. Christy Hudson pointed out that the measure is also on the 2020 incentive metrics for CCOs.

Cat Livingston remarked that she wanted kids to have access to preschool. In terms of preventative services, having access to preschool and head start is associated with a lot of improved health indicators. Although outside of the box, this is a community preventive service. It also deals with the economic drivers of health.

Tom Jeanne liked the proposal by Cat Livingston. Looking at the state health indicators, most of them are clinically based. Preschool is not a clinical indicator and it aligns with the goal of increasing equitable access to and uptake of community-based preventive services. Another metric on the state health indicators list that could be possibly used as a community-based metric is *childhood developmental screening*.

Cat Livingston shared that her problem with any screening test was that if there was no follow-through and a good connection to the resources that improve it, it is not going to yield high outcomes. The concern with using a process measure is not knowing if those kids are getting the services that they need.

Tom Jeanne pointed out that all state health indicators were process measures. Are they outcome-y enough to meet the goal, or should new goals directly tied to access be found? Access to healthcare is a process. We can still try to have these measures be more about who is getting the services as opposed to who has access to the services. For example, with colorectal screening, we have a proportion of people who got that screening. That's not access to the screening, it's an actual uptake of the screening.

Tom Jeanne asked the subcommittee members if anybody had knowledge of preschool and what kind of data sources could be used to measure access to preschool. Senna Towner suggested the use of Preschool Promise data, which would paint a partial picture. Christy Hudson added that the Early Learning Council released a strategic plan last year, Raise Up Oregon, that covers 2019-2023, and it would be a great opportunity to align with another state plan. Senna Towner volunteered to explore the plan more deeply, as well as look for other indicators that could be useful.

Cat Livingston suggested for the subcommittee to focus on adult preventive care. Tom Jeanne advanced the case for colorectal cancer screening as a measure, because it involved the adult population and colorectal cancer was one of the most common cancers. This measure would balance the children's measures the subcommittee was considering. Kelle Little agreed with Tom Jeanne's recommendation. Rebeckah Berry wondered if that measure would address the entire adult population in accessing preventative services.

Kelle Little added that the measure was an A recommendation of the USPSTF. It's one of the most effective means for preventing colorectal cancer through early detection and screening, and it is an indicator that is available and used, and it could be well measured and compared. It doesn't cross the full spectrum of adulthood because the age recommendation for the first screening is 50.

Tom Jeanne clarified that the measure comes from the Behavioral Risk Factors Surveillance System, which is a phone survey. It's specifically asking if a person is in the 50-75 age group. This measure should not be confused with the *late state colorectal cancer diagnosis* state health indicator, which is more of an outcome and comes from the Oregon State Cancer Registry. The goal is to find measures that cover the whole lifespan for both children and adults of all ages. Unless the subcommittee can find measures that cover the whole lifespan for both the community-based and clinically-based services, the subcommittee will need at least 3-4 measures to capture the whole lifespan.

Christy Hudson explained that the vision reads "across the lifespan," but the community feedback specifically emphasized children and older adults. Tom Jeanne noted that the discussion is about indicators, but indicators are a type of measure. There is a whole subset of all possible measures that are available on this topic and that's a large number of measures. Indicators are a communication tool like highlights to check on work progress. They are not going to be comprehensive and will not cover all ages, or all types of healthcare, or all types of health and disease. Unless the subcommittee selects 20 indicators, the chosen indicators will not cover everybody all the time. The indicators should be representative and not leave out a huge group or some type of health issue.

Cat Livingston stated that OHA already has the data for diabetes prevalence. That would be another potential option. Tom Jeanne could not see how diabetes prevalence is directly tied to access to clinical services. It's indirectly tied, but it's measuring a health outcome that's downstream of what the subcommittee is looking at. Cat Livingston added that there is a push in Oregon for the Diabetes Prevention Program (DPP). With access to DPP across the state, that would prevent people from developing diabetes. Diabetes prevalence could be tied to obesity prevention and become a unifying force for community-based pieces and clinically-based pieces. Tom Jeanne expressed a concern that there were many other factors than those programs that affect the obesity and diabetes rates. It's unclear how precise a measure diabetes prevalence is for what the subcommittee is trying to measure.

Kelle Little remarked that one of the points she didn't raise in supporting the colorectal cancer screening as a measure for access to clinically-based preventative services was that it was not just an indicator of whether or not an individual has had that screening, but it was an indicator of all the other age- and gender-appropriate screenings and preventative measures that would accompany it in a preventative visit. Although those things are not measured, they are implied, and that's why it is a central measure for what

the subcommittee is trying to accomplish. Tom Jeanne agreed that if an individual has done a colonoscopy, the provider has done some of the easier screenings too.

Christy Hudson led the discussing back to the goals. When OHA asked the community about access to care, 40% of the received comments were about people accessing preventative healthcare. Qualitatively, a lot of the comments were about affordability. The need for culturally and linguistically responsive services also came up often.

Katie Harris expressed her support for the diabetes prevalence measure, because it does speak to both community prevention efforts and access (e.g., nutrition access), as well as clinical. It also crosses the age spectrum, with more children and adults getting diabetes. Rebeckah Berry agreed with Katie Harris. Tom Jeanne shared that having both colorectal cancer screenings and diabetes prevalence is a viable option. The colorectal cancer screening measure is very specifically focused on who is getting the preventive service. The diabetes prevalence measure is a long-term, downstream measure with many community-based and clinically-based factors that are affecting it.

Senna Towner suggested to include the colorectal cancer screening measure and the diabetes prevalence measure as potential measures, with the subcommittee exploring the measure *access to preschool* as a fourth measure at the subcommittee meeting in November. Subcommittee members can communicate in Basecamp about the early education indicators.

Cat Livingston added that the subcommittee should look at people with access to health insurance that covers A&B recommendations. It's about figuring out all health insurers in Oregon and seeing which one provides A&B with no cautionary and coinsurance and getting us as close as 100% as possible. The information would come from policies.

Senna Towner invited the subcommittee to vote on including the colorectal cancer screening measure and the diabetes prevalence measure as access to care measures. The subcommittee approved the colorectal cancer measure unanimously. The diabetes prevalence measure did not receive full consensus.

Cat Livingston made another case for the measure *diabetes prevalence*. The measure offers a lot of variety of different interventions to decrease diabetes prevalence that are both in the clinical and the community setting. Kelle Little remarked that she only questioned the validity of the measure, in terms of its responsiveness, for access to clinical services. Insurers don't cover diabetes prevention programming, nutrition therapy, and exercise therapy. These services are important, but most people don't have access to them, depending on social status or where they live. DPP is only covered by Medicaid.

Tom Jeanne suggested for the subcommittee to explore if there was a feasible measure for DPP or related types of programs. Cat Livingston added that she cared more about Oregonians having less diabetes than whether or not people had access to DPP. Tom Jeanne responded that less diabetes was not a shared priority area. This framework is a way to look at the processes we use to get to those outcomes. We need to measure the processes the best way possible to achieve those outcomes.

Public Comment

Christy Hudson invited members of the public in the room to provide comments or ask questions. Deborah Riddick, the government relations director at the Oregon Nurses Association, commented that the only thing that gave her pause during the discussion was the population-to-provider ratio being only rural-to-urban, in terms of the focus. If that's being done, the minority populations within either would be washed out. If there's a ton of access along the I-5 corridor, that doesn't necessarily mean that the folks who really need the care and service are getting it, because of the desperate numbers. For example, if the minorities are 2% and white people are 98%, it will look like we've covered everybody, and everybody has equal access. The measure needs to be tweaked to be able to elicit that information, so we are not losing the people who ultimately will be the most costly, because of what happens when individuals don't get care and have access a lot sooner. Christy Hudson promised to follow up with OHA staff who collected that data and ask them if they had that data.

Next Steps

- The subcommittee will research and explore the measure *access to preschool* as a fourth measure.
- The subcommittee will look at people with access to health insurance that covers A&B recommendations.
- Kelle Little, Rebeckah Berry, Cat Livingston, and Tom Jeanne will discuss a feasible measure of DPP or related types of programs for the measure *diabetes prevalence* and report back.
- Future discussion topic: Vaping and cigarettes

Adjourn

Christy Hudson adjourned the meeting at 3:01 p.m. The next meeting will be on October 28, 2019.