SHIP SUBCOMITTEE MEETING #3: Access to equitable preventive health care

Monday, October 28th, 1:00 – 3:00pm
800 NE Oregon Street, Suite 900
Portland, OR 97232

OR

Go to Meeting: https://global.gotomeeting.com/join/447873293
Conference call: +1 (646) 749-3122
Access Code: 447-873-293

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 key indicators
- Identify policy level strategies

1:00 – 1:15	**Welcome, agenda overview, and subcommittee business**
1:15– 1:45	**Follow-up from last meeting – finalize key indicators**
1:45 – 2:45	**Identify policy strategies**
2:45 – 2:50	**Public Comment**
2:50 – 3:00	**Wrap-up & Next Steps** • Next meeting: November 25th – Community level strategies

Welcome & introductions

Share name and pronouns

Who’s your equity hero?

Subcommittee Business

- Subcommittee charter finalized
  - Clarified role of delegate
  - Consensus process includes discussion for those who are thumbs sideways/thumbs down
- Supporting sector specific meetings

Finalizing the indicators

- Childhood immunization rates
- Colorectal cancer screening

Getting clear on language

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

Goal: Broad statement(s) of what we're trying to accomplish within a given priority area to achieve the vision.

Outcome indicator: Long term measure that would indicate goal is achieved.

Strategy: Policy, community and individual level interventions needed to achieve the goal

Process indicator: Short term measure that would indicate strategy has been achieved.

Actions: Specific tasks needed to implement strategy

Getting clear on language - Example

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

Goal(s): Improve oral health

Outcome indicator: Percentage of adults who have lost all their natural teeth

Strategy: Increase access to sources of fluoridated water

Process indicator: Percentage of people in Oregon residing in areas served by optimally fluoridated water

Strategy development

- Goal: Identify a total of 10-15 strategies at policy, community and individual level
  - Existing strategies
  - New strategies
  - Interventions needed to make progress towards the goals

- Process
  - Identify possible strategies
  - Apply criteria to narrow strategies
  - Identify approximately 3 – 5 strategies for each layer of framework

Strategy Criteria	
Selection criteria	**Definition**
Proven impact on disparities	• Strategy addresses disparities in priority populations (POC, low income, disability, LGBTQ, rural/frontier)
Will achieve intended outcome	• Right strategy for the goal • Strategy aligns with evidence-based or promising practice
Politically feasible	• Ability to influence and implement a policy change
Resourced or likely to be resourced	• Funding is available or likely to be available • Local expertise exists
Relevant to community	• Strategy is in use in local community • Strategy is realistic and of interest from a local perspective
Alignment with other strategic initiatives (locally or federally)	• Strategy nationally recognized or recommended
Change likely in next 5 years	• Impacts likely to be seen within 5 years of implementation
Addresses lifespan	• Relevant to a wide range of age • Relevant to young children or older adults

Process measure development

- Goal: Identify 1 process measure for each strategy
  - Communicate hoped for changes
  - Short term in nature (change in 1-2 years)
  - Measure progress towards strategy

- Process
  - Identify possible measures
  - Apply criteria to narrow measures
  - Identify baseline and target if available

Process Measure Criteria (short term, 1-2 year change)	
Selection criteria	**Definition**
Promotes health equity	• Measure addresses an area where health disparities exist • Data are reportable by race/ethnicity • Data are reportable by gender • Data are reportable by sexual orientation • Data are reportable by disability • Data are reportable by income level
Respectful and relevant to local priorities	• Data are reportable at the county level • Indicator is already in use at local level
Lifespan	• Data are reportable by age
Acceptable and attainable	• Right measure for the strategy • Measure aligns with evidence-based or promising practice • Measure is sensitive enough to capture improved performance or sensitive enough to show difference between years • It is reasonable to expect improved performance on this measure.
Frequency	• Data is collected annually or every other year at minimum.
Transformative potential	• Demonstrates an innovative measurement approach • Brings forward community voice
Aligned with state measures	• Existing State Health Indicator, CCO Incentive Measure, Public Health Accountability Measure or other state-wide performance measures
Feasibility of measurement	• Data for measure are already collected, or a mechanism for data collection has been identified.

Goals, Strategies, and Measures

GOAL 1: Improve health literacy by simplifying and standardizing health insurance.	
Strategy 1.1A: Coordinate with state agencies (including Kentucky Department for Insurance, DPH, DMS, etc.) to reduce health insurance complexity by making health plans simpler and more understandable for consumers to make informed decisions. **Strategy 1.1B:** Promote continued development of clearer language used to explain health plans for Medicaid enrollees, where possible, by the end of fiscal year 2018. **Strategy 1.1C:** Encourage assessment and coordination among state agencies, private insurance companies, providers and health coalitions, to provide outreach and enrollment assistance. By 2018, LHDs will provide input to assist Medicaid enrollees with a plan to identify where assistance is needed. **Strategy 1.1D:** Support education of Medicaid enrollees about how commercial health coverage works so they can maximize the benefits of their plans. DPH and LHDs will participate in the development of information to educate consumers on health coverage. ***Justification (Strategies 1.1A-1.1D):*** *Kentucky's Medicaid 1115 Waiver includes a goal to increase insurance literacy and improve health literacy in terms of medical consumer knowledge. By becoming better informed, the enrollee is able to make better personal and plan choices.*	**Measure 1.1.1:** Increase number of Medicaid enrollees who understand their health plan **Baseline:** Unknown (2017) **Target:** Establish baseline and increase by 5% (2022) **Data Source:** Medicaid enrollment

GOAL 2: Expand access to health care services within and outside clinical settings using innovative delivery models.	
Strategy 2.1: Encourage higher educational institutions to create health care workforce development strategies that respond to emerging needs in the field (e.g., dental hygienists, community health workers). DPH and other stakeholder will collaborate in the development of strategies and implementation of strategies in each of the eight Medicaid regions. ***Justification:*** *There is a national shortage of health care professionals. Without an adequate workforce (e.g., physicians, nurses, dentists, physician assistants), health access will remain difficult. Additionally, as society becomes more technologically advanced, new ways of providing care should be considered to increase health access.*	**Measure 2.1.1:** Increase number of higher education institutions that have a health care workforce development strategy **Baseline:** Unknown (2017) **Target:** 8 – one in each Medicaid region (2019) **Data Source:** Kentucky Center for Education and Workforce Statistics **Measure 2.1.2:** Increase number of higher education institutions that have implemented a health care workforce development strategy **Baseline:** Unknown (2017) **Target:** 8 – one in each Medicaid region (2019) **Data Source:** Kentucky Center for Education and Workforce Statistics **Measure 2.1.3:** Increase number of students enrolled in a health care professional careers **Baseline:** 33% Certificate, 42% Associate's, 20% Bachelor's, 22% Master's (2010) **Target:** Increase by 10% (2022) **Data Source:** Kentucky Center for Education and Workforce Statistics **Measure 2.1.4:** Increase number of organizations (and county coverage) that utilize Community Health Workers within and outside of clinical settings **Baseline:** 14 organizations covering 36 counties (2017) **Target:** 30 organizations covering 60 counties (2022) **Data Source:** DPH, Kentucky Community Health Worker Advisory Group

Strategy 2.2: Develop and establish training on virtual health services for health service providers (e.g., hospitals, federally qualified health centers, community health centers, and private physician offices) and consumers. Currently, a team from DMS, DPH, the University of Kentucky (UK), and the University of Louisville (UofL) is developing the telehealth strategic plan. ***Justification:*** *Implementation of telehealth mechanisms will improve health care access.*	**Measure 2.2.1:** Increase number of health agencies that receive training on virtual health services **Baseline:** Unknown (2017) **Target:** Establish baseline and increase by 5% (2022) **Data Source:** Kentucky Telehealth Board
Strategy 2.3: Expand the adoption of telemedicine technologies (e.g., remote patient monitoring) to increase access to health care services for people living in rural and other underserved communities. ***Justification:*** *Implementation of telehealth mechanisms will improve health care access.*	**Measure 2.3.1:** Increase number of adopted telemedicine technologies (e.g., remote patient monitoring) **Baseline:** Unknown (2017) **Target:** Establish baseline and increase by 5% (2022) **Data Source:** Kentucky Telehealth Board
Strategy 2.4: Maximize Kentucky Health Information Exchange (KHIE) participation among health care delivery systems. Continue to ensure privacy and security of electronic health information. Support the use of electronic data, measurement and clinical decision support tools, and promote providers using electronic data sources to accurately report health care quality for local and regional use. ***Justification:*** *Implementation of telehealth mechanisms will improve health care access.*	**Measure 2.4.1:** Increase number of health care delivery agencies participating in KHIE **Baseline:** 1,583 (2017) **Target:** 80% of all health care delivery agencies (2020) **Data Source:** KHIE

GOAL 3: Strengthen community cross-sector health coalitions.	
Strategy 3.1: Train LHD directors on Public Health 3.0 to serve as the lead health strategist in their communities and encourage cross-sector health coalitions. ***Justification:*** *LHD directors are the most appropriate convener of cross-sector health coalitions because of their unique knowledge and influence within their local community.*	**Measure 3.1.1:** Increase percentage of LHD directors and who have received training on Public Health 3.0 **Baseline:** Unknown (2017) **Target:** Establish baseline and increase to 75% (2022) **Data Source:** Kentucky Oral Health Coalitions, LHDs, Kentucky Population Health Institute
Strategy 3.2: Identify communities that have established cross-sector health coalitions and promote them as "best practices" among other LHDs. Convene LHD directors and community leaders at a "Health Access Workgroup" to present the work of these coalitions, promote collaboration, and facilitate additional support. ***Justification:*** *Communities could discover innovative practices through sharing, networking, and collaborating with other LHDs who have successfully facilitated multi-sector coalitions.*	**Measure 3.2.1:** Increase percentage of LHDs who establish cross-sector health coalitions that include social support services and oral health **Baseline:** Unknown (2017) **Target:** Establish baseline and increase to 50% (2020) **Data Source:** Kentucky Health Department Association
Strategy 3.3: Educate and promote a "Health in All Policies" (HiAP) approach across Kentucky. DPH will conduct seminars and conferences to educate local and state leaders across all sectors and policy areas on HiAP approach and its implications on health. ***Justification:*** *HiAP will assist with showing how non-traditional partners can improve health using their sphere of influence.*	**Measure 3.3.1:** Increase percentage of LHDs and multisector coalitions who are trained on HiAP **Baseline:** Unknown (2017) **Target:** Establish baseline and increase to 75% (2020) **Data Source:** DPH Office of Health Equity

- **School-based dental sealant programs**
  School-based dental sealant programs are an evidence-based practice recommended by the Community Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), and Healthy People 2020. During the 2014–15 school year, 77% of the eligible schools in Oregon participated in a dental sealant program.

Priorities, strategies and measures

Priority targets

Third graders with cavities in their permanent teeth

Target: 14%

Baseline: 15.5% (2012)

Data source: Oregon Smile Survey

Adolescents with one or more new cavities identified during a dental visit in the previous year

Target: (11th and eighth grades): Pending

Baseline: (11th and eighth grades): Unknown, developmental measure (2015)

Data source: Oregon Healthy Teens Survey

Prevalence of older adults who have lost all their natural teeth

Target: 16%

Baseline: 17.7% (2010)

Data source: Behavioral Risk Factor Surveillance System (BRFSS)

Population interventions

Strategy 1: Increase the number of fluoridated public water districts

Justification: Community water fluoridation is an evidence-based practice recommended by the Community Preventive Services Task Force, Association of State and Territorial Dental Directors, and Healthy People 2020 that reduces dental cavities across populations. It is an effective, affordable and safe way to protect children and adults from tooth decay and is recognized as one of the 10 greatest public health achievements of the 20th century.

Measure 1.1: Percentage of people in Oregon residing in areas served by optimally fluoridated water

Target: 79.6%

Baseline: 22.6% (2012)

Data source: Centers for Disease Control and Prevention, Water Fluoridation Data and Statistics, 2012.

Health equity interventions

Strategy 1: Provide dental sealants in schools that serve students at high risk of tooth decay

Justification: School-based dental sealant programs are an evidence-based practice recommended by the Community Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), and Healthy People 2020 that is effective in preventing tooth decay among children. Most tooth decay (90%) occurs in the molars, and school-based dental sealant programs can reduce tooth decay by 50% in the treated teeth.

Measure 1.1: Percentage of eligible schools served (40% Free or Reduced Lunch [FRL] or greater) (target grades 1 and 2 or grades 2 and 3)

Target: 75%

Baseline: 70.7% (2015)

Data source: OHA Oral Health Unit

Measure 1.2: Percentage of eligible schools served (40% FRL or greater) (target grades 6 and 7 or grades 7 and 8)

Target: 20%

Baseline: 7.8% (2015)

Data source: OHA Oral Health Unit

Measure 1.3: Children aged 6–9 years with dental sealants on one or more permanent molars

Target: 40%

Baseline: 38.1% (2012)

Data source: Oregon Smile Survey

Measure 1.4: Percentage of children aged 6–9 years with untreated decay

Target: 18%

Baseline: 20% (2012)

Data source: Oregon Smile Survey

Strategy 2: Enhance oral health services through community clinics, including SBHCs

Justification: Local oral health infrastructure allows for timely access to oral health prevention, education and care. Oral health services by community clinics may be provided on site or at other locations in the community, and may involve partnerships with local dental providers.

Measure 2.1: Number of SBHCs that provide routine access to a dental provider on site.

Target: 17%

Baseline: 7% (2014)

Data source: PHD School-Based Health Center Program

Strategy 3: Ensure that Oregon has an adequate number of oral health professionals

Justification: Of Oregon's 36 counties, 33 are designated as a Dental Health Care Provider Shortage Area (HPSA). This illustrates both a shortage of qualified and trained dentists and dental hygienists, and a lack of access to oral health care among low-income, rural and other underserved population groups. To meet the oral health needs in Oregon, workforce capacity must be improved to retain and equitably distribute oral health care providers across Oregon.

Measure 3.1: Number of expanded practice dental hygienists practicing in Oregon communities

Target: 300

Baseline: 213 (2013)

Data source: Oregon Board of Dentistry

Strategy 4: Reduce the number of dental-related visits to emergency departments.

Justification: Emergency department visits for dental conditions reflect lack of access to dental care. Uninsured Oregonians and Oregon Health Plan enrollees are more likely to visit the emergency department for dental problems.

Measure 4.1: Number of emergency department visits for nontraumatic dental problems

Target: 7,500 ED visits annually

Baseline: 15,000 ED visits annually (2013)

Data source: Hospital database

Health system interventions

Strategy 1: Create incentives for private and public health plans and health care providers to improve oral health

Justification: Incentive measures and alternative payment methodologies ensure health plans and health care providers are working on a common set of priority areas designed to improve care and access, eliminate disparities and contain health care costs. The measures currently focus on public health plans, but measures will be expanded to include private insurers as data become available.

Measure 1.1: Number of public health plans that receive an incentive or shared savings payment for improved oral health outcomes

Target: 16 CCOs, PEBB and OEBB carriers

Baseline: 0 CCOs, PEBB and OEBB unknown (2015)

Data source: OHA Metrics and Scoring, PEBB and OEBB contracts

Measure 1.2: Number of public health plans that incorporate oral health in alternative payment methodologies for contracted providers

Target: 16 CCOs, PEBB and OEBB carriers

Baseline: Unknown, developmental measure (2015)

Data source: CCO Transformation Plans, PEBB and OEBB contracts

Strategy 2: Increase early preventive care for children

Justification: Despite being preventable, tooth decay is the most common chronic disease in children in the United States. Increasing access to preventive services can reduce the needless pain and suffering that many children in Oregon experience, as well as decrease the health care costs of oral diseases.

The American Academy of Pediatrics suggests children who are at risk of tooth decay visit a dentist by age 1. The U.S. Preventive Services Task Force and the American Academy of Pediatrics recommend primary care teams provide fluoride varnish to all children aged 0–5 and prescribe a fluoride supplement to all children whose water supply is not optimally fluoridated.

Measure 2.1: Percentage of children who received a preventive dental visit during their first year

Target: 10% increase from baseline

Baseline: Unknown, developmental measure (2015)

Data source: Medicaid administrative claims data

Measure 2.2: Number of children less than 7 years old who receive oral health risk assessment and intervention during the well-child visit

Target: 10% increase from baseline

Baseline: Unknown, developmental measure (2015)

Data source: Medicaid administrative claims data

Measure 2.3: Children aged 0 to 5 with a dental visit in the previous year

Target: 10% increase from baseline

Baseline: Unknown, developmental measure (2015)

Data source: Medicaid administrative claims data

Strategy 3: Include oral health in chronic disease prevention and management models

Justification: There is a link between poor oral health and chronic diseases. Tooth decay in childhood has been linked to increased risk for future decay, and chronic oral infections are associated with an array of other health problems such as heart disease, diabetes and unfavorable pregnancy outcomes.

Measure 3.1 Increase the number of adults aged 18 years or older with diabetes that had a dental visit in the previous year

Target: 61.2%

Baseline: 56.6% (2012)

Data source: Behavioral Risk Factor Surveillance System (BRFSS)

Strategy 4: Ensure dental benefit packages cover care and treatment to ensure optimal oral health maintenance

Justification: Dental benefit packages that align with preventive goals and provide adequate care ensures optimal oral health maintenance and equitable outcomes across the lifespan.

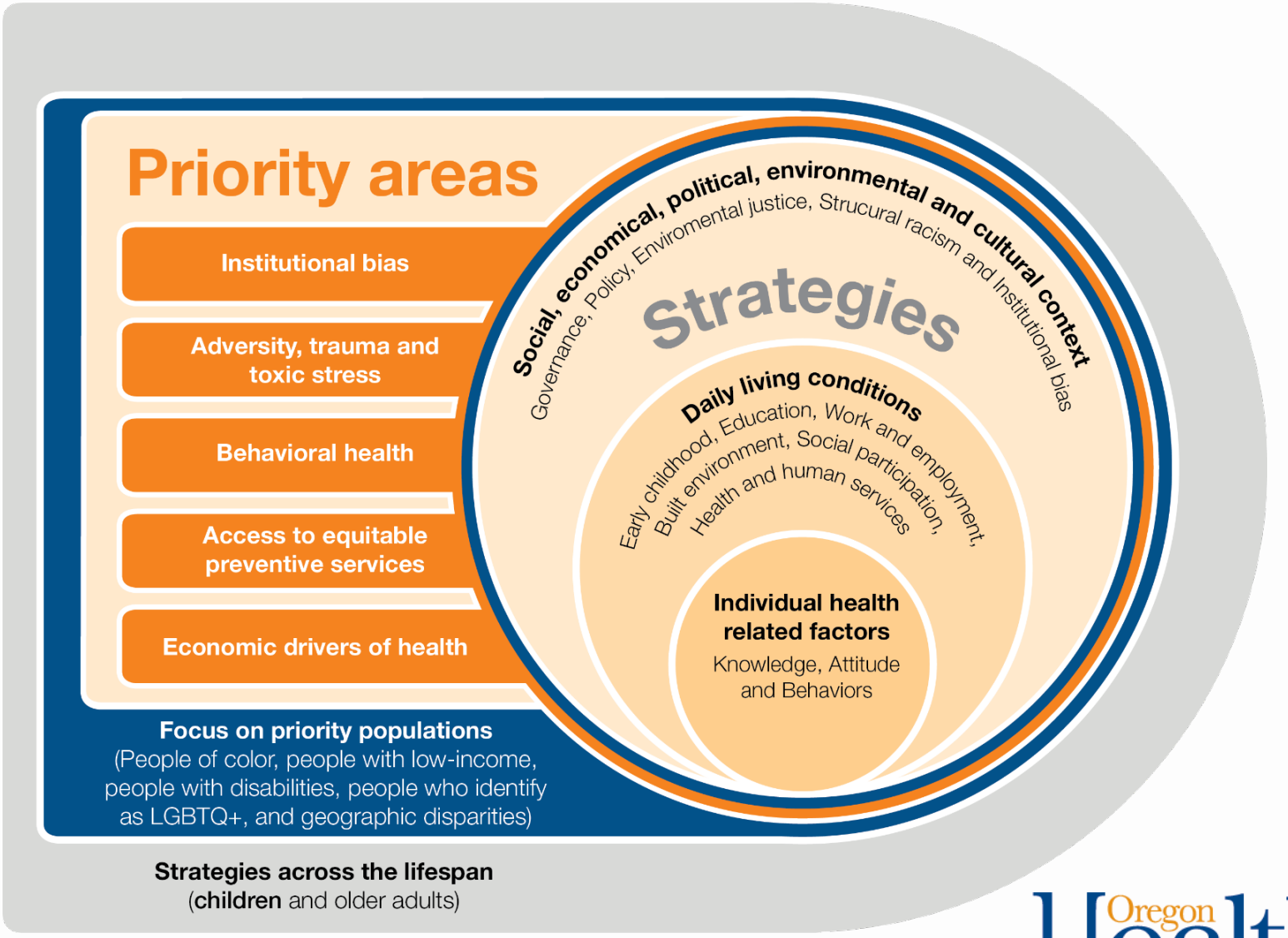
Measure 4.1: Number of adults with any dental visits in the past 12 months

Target: 70.4%; male: 66%, female: 73.7%

Baseline: 63.8%; male: 60%, female: 67% (2010)

Data source: Behavioral Risk Factor Surveillance System (BRFSS)

2020 SHIP Framework



Oregon Health Authority

Strategy brainstorm – What strategies are need to advance our goals?

- Increase equitable access to and uptake of **community-based preventive services**
- Increase equitable access to and uptake of **clinical preventive services**
- **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 interventions

Public Comment

Next Steps & Final Thoughts

-+/Delta feedback review

- Next subcommittee meeting is November 25th

-Homework: Continue to contribute and familiarize yourself with strategic plans, data and policy documents in basecamp.