SHIP SUBCOMMITTEE MEETING

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

October 28, 2019 | 1:00 p.m. – 3:00 p.m. | Call: (646) 749-3122, Access: 477-873-293

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

Members Absent: Tim Menza (OHA Lead), Char Reaves, Heidi Hill, Jim Rickards, Nina Fekaris, Frank Thomas, Danielle Sobel, Tim Svenson

OHA Staff: Christy Hudson, Krasimir Karamfilov, Marc Overbeck

Members of the Public: Stefan Shearer, Deborah Riddick

Welcome, Introductions, and Agenda Overview

Senna Towner welcomed everybody to the meeting. She informed with the subcommittee that she, Christy Hudson, and Tim Menza discussed the goal of encouraging more voice on the calls and during the conversation and exploring ways for doing that, since the subcommittee is a virtual group. If anybody has specific ideas for that, they should share them in Basecamp. The hope is to get different perspectives from the subcommittee members. It's also one of the process goals for today's meeting. She invited the subcommittee members to introduce themselves and share the name of their equity hero. The subcommittee members introduced themselves.

Christy Hudson remarked that the subcommittee charter had been finalized. In response to subcommittee members' feedback, it is now possible to send a delegate from one's agency or community to attend the meeting, and the consensus process includes a discussion for subcommittee members who voted thumbs sideways or thumbs down on a proposal. The final charter has been uploaded to Basecamp.

Christy Hudson added that another subcommittee business involved work that the Public Health Division will be rolling out to help support sector-specific meetings. There is a great interest from a variety of different partners sitting on the various SHIP subcommittee meetings. Part of a subcommittee member's role is to ensure that whatever actions or decisions that are happening in the subcommittee are getting communicated back to, hopefully, leadership within a member's agency or sector. By the time this plan is released next summer, the partners that are represented should be well-bought into the strategies and recommendations that have been laid out. Public Health Division (PHD) staff are happy and eager to support the subcommittee members in ensuring that those conversations happen. Over the next few weeks, subcommittee members may be contacted by members of the PHD to check what subcommittee members might need to make sure those conversations happen. This could be during existing board

meetings or cabinet meetings or other meetings where leaders gather. The goal is to have 2-3 conversations with agency leaders between now and July 2020, when the plan will be launched.

Follow-up from Last Meeting – Finalize Key Indicators

Senna Towner reminded the subcommittee that the call for action from the last meeting was for a subcommittee to convene and to talk about the indicators that were discussed in September and explore further indicators and flesh out ideas on the proposed indicators. The group met last week and had a robust conversation about the indicators. The hope is to have three indicators, with the possibility of having four. Considering the subcommittee goals, the subcommittee informally agreed in September on the indicators *childhood immunization rates* and *colorectal cancer screening*.

Christy Hudson remarked that in terms of the *primary care home* indicator, which was discussed in a subcommittee meeting last week, she reached out to staff in the OHA's Health Policy and Analytics Division and was informed that Oregon has 600 primary care clinics that are PCMH certified, but we don't have a strong denominator. There are about 800 primary care clinics across the state, but that number comes from a variety of data sources. There's no definitive data source, and definitely not one by insurance type.

Thomas Jeanne stated that, in the past, the subcommittee had been discussing outcome measures versus process measures, with the subcommittee's priority being access to care. One can argue that any kind of measure of something that directly affects access to care is an outcome measure. Since there will be process measures underneath the outcome measures, the subcommittee should try to keep these more directly related to a health outcome. The *childhood immunization rates* and *colorectal cancer screening* indicators are directly related to a health outcome and they are good examples.

Senna Towner addressed Kelle Little regarding a dental-related measure she had proposed and asked her to share her thoughts around it. Kelle Little explained that one of the reasons she put forward an oral health-related measure was because participation in dental care or access to dental care was a different measure than medical immunizations or access to colorectal cancer screening. In the discussion last week, the subcommittee discussed whether there should be a measure that reflected social determinants of health and how economic drivers of healthcare were also embedded in access to care. To her, access to oral health was a measure that was reflective of social determinants of health in a different manner and it captured a different type of data. Poor oral health has been demonstrated to affect one's health, employability, associated economic status, whether or not the individual pursues higher education.

Laura McKeane noted that dental sealants were going away this year. They are not going to be part of the incentive measures for the CCOs. The sealants metric been replaced with a metric that is going to align with the *kindergarten readiness* metric, which is a preventive service for children aged 0-14. In terms of access to fluoridated water, it shouldn't be something that is unattainable. We fight this fight all the time. The subcommittee shouldn't go into it with something it can't achieve. It's going to take a long time to get fluoride in the water. Cavities are an issue. It may be good to have a measure around sealants, varnishes, or some type of screening. There are conversations that oral health will potentially be part of the PCPCH

standards for next year. A screening tool in the offices is in consideration. If the subcommittee looked at varnishes, it is something providers can be taught to do. They can bill for it in their clinic.

Cat Livingston wondered if the outcome measure could be *reduction in cavities rate*, with the process measures being fluoride varnish and dental sealant. Senna Towner stated that there was a strategy in the 2015-2019 SHIP to increase the number of fluoridated public water districts. The subcommittee could carry that strategy over for this particular goal.

Marc Overbeck agreed with Cat Livingston about the reduction in cavities being an outcome measure. There are a lot of variables in terms of cavities that are genetic, and then there are people who are blessed with good teeth even though they don't have the best habits. In terms of fluoride, while there may be some consensus that changes in the fluoridation rates may be hard to come, if it's not listed as an outcome or an indicator, it likely is not going to happen. Just the listing of something as an indicator says that it is important. In terms of what measure the indicator can be set at, that's up to someone else. Whether or not it is an indicator seems to be a value statement of its contribution to the health, and specifically the oral health, of Oregonians.

Laura McKeane clarified that even if the measure might not feel attainable, it should be listed. Marc Overbeck explained that if the subcommittee said, "That is a measure of whether or not Oregonians would have the opportunity for optimal health," the measure should be listed.

Thomas Jeanne noted that at the population level, one could see what the current prevalence of, for example, third-grade with cavities was and set a reasonable target on that. There will be differences in populations in terms of their baseline cavities or susceptibility, but when one looks at large groups, one can certainly aim for lowering certain numbers. It's reasonable to have it as an outcome measure.

Senna Towner asked Marc Overbeck if he felt that it would be better to put the measure as an indicator rather than a strategy and whether it would speak louder. Marc Overbeck answered that the framework he tended to view these types of concepts through was (a) What are the indicators? If the wisdom is that more communities and more populations accessing fluoridated water supplies is an appropriate indicator, then yes. (b) Strategies in the plan would be in some degree a matter of feasibility. If there is a lack of feasibility in having a strategy to increase the number, the indicator can be abandoned. It's always helpful to put out the indicators of the optimal state of what one wants to measure. Then the political experts can discuss how feasible a strategy is to increase the number even a little bit.

Senna Towner remarked that the next possible indicator was *population with health insurance*. The subcommittee discussed it in September and the conversation was around whether that indicator was truly reflective of access. One could have insurance and not get access. This indicator was not a deal breaker. It was one of the discussed considerations. Kelle Little pointed out that American Indians and Alaska Natives were exempt from the ACA (Affordable Care Act) mandate to have health insurance, if they received their services at tribal health clinics. Many of them do. It's something to bear in mind.

Katie Harris stated that there were other measures that were more indicative of access to equitable care. Among rural populations, just because one has health insurance, it doesn't mean that one has access.

There are not enough behavioral and primary care providers. For that reason, this measure is not a good measure. Six percent of the Oregon population is uninsured. In terms of the improvement plan for the state, there are not significant goals behind that measure that the state would seek improvement on and further reduce the uninsured rate substantially.

Kelle Little agreed with Katie Harris that there were other measures more indicative of access, particularly in rural heath communities, which also included tribal communities. Muriel DeLaVergne-Brown agreed with Kelle Little and Katie Harris. Between transportation and everything else, it is hard to measure the uninsured rate in a meaningful way. Chiqui Flowers added that there was still a mandate, but the penalty had been zeroed out, making it ineffective. Health insurance itself doesn't account for full coverage. Coverage in itself is a little bit complicated. It has a wider breadth than just having health insurance. There have been talks about potentially working out a state version, but we are ways away on that.

Patricia Patron agreed with the other subcommittee members that the insurance indicator was not significantly relevant to access to care. Enrollment in a primary care home, however, is a much more powerful indicator, because it will be more inclusive of populations that may not have health insurance and still need access to a medical home. Chiqui Flowers supported the primary care home indicator, especially because *primary care home* is a concept that is supported by both private and public health insurance. Most carriers, private and public, all require some degree of primary care. Thomas Jeanne remarked that the data sources for this indicator were iffy at best. It's hard to have an indicator without a good data source. The same concerns that applied to the population with health insurance apply here. Just because an individual is enrolled in a primary care home doesn't mean that they have full access to the services they need.

Marc Overbeck stated that back when PCPCH legislature was originally set up, there was a goal of 75% of all Oregonians to be enrolled in a certified PCPCH by 2015. Oregon has over 700 individual homes. Someone should be able to answer the question of how many Oregonians are members of or participate with PCPCH. He will contact Amy Fischer at OHA's Health Policy and Analytics Division and look into it.

Senna Towner asked Cat Livingston if she led a discussion about access to community prevention program. Cat Livingston answered that she was thinking about what constituted access to prevention on the clinical and community levels. This measure would be a great marker for people who are able to have access to community-based prevention, but it's difficult for them to choose only one. It's hard to see what that priority would be, considering that there are many evidence-based community-based preventive programs. Christy Hudson added that there is a data source issue that needs to be investigated more.

Senna Towner shared that she felt a strong pull from the subcommittee for a dental-related measure. She called for any additional discussions on the first two measures, *childhood immunizations* and *colorectal cancer screening*. Muriel DeLaVergne-Brown noted that from a public health perspective, the *childhood immunizations* measure was a very important measure. Kelle Little added that childhood immunization rates for 2-year-olds in Oregon, Washington, and Idaho decreased in 2018 for the first time in the last 15 years.

Senna Towner invited the subcommittee members to comment on the *colorectal cancer screening* measure. Katie Harris stated that one thing she liked about it was that it provided age variation within the indicators, as it was not focused on children. It also addressed the big disparities in colorectal cancer screenings. It is indicative of receipt of other clinical care. Muriel DeLaVergne-Brown, Kelle Little, and Patricia Patron echoed Katie Harris's support for the measure.

Senna Towner expressed support for the first two proposed measures. She added that in terms of the dental-related measure, the ultimate goal, based on Marc Overbeck's idea, was to have fluoridated water, which would be the indicator, and build feasible strategies for the establishment of a more universal fluoridated water program in Oregon.

Christy Hudson clarified that the indicators did not restrict the strategies. Proposed dental-related strategies do not have to be related to fluoridated water. The indicator is intended to be a communication tool. The higher the indicator and the broader the audience the indicator speaks to, the stronger the indicator. The other goal is that the indicators are things that a variety of people and players can see and identify with.

Thomas Jeanne reiterated that the goal was to focus on more direct outcomes for the indicators. There will be process measures and strategies. Fluoridated water, sealant, and varnishes all make great strategies to support an indicator, such as cavities, which would be better to consider for the dental-related indicator. Fluoridated water is a political topic in Oregon. Although important for dental health, the measure is relatively narrow. There are a lot of other things that affect dental health beside fluoride.

Laura McKeane agreed with Thomas Jeanne and added that the Smile Survey has not been formally released, but it should be released shortly. Early indications of that have shown that rapid decay and kids with cavities have decreased in the past five years. Results are reported every five years. The political part of the topic is worrying.

Thomas Jeanne explained that the data in the Oregon Smile Survey is based on dental hygienists going to schools and classrooms and examining teeth. It's the gold standard, but it's conducted every five years. There is also Oregon Healthy Teens (OHT), which is conducted every two years. OHT has a question, "Have you ever had a cavity?" It's a self-report from 8th graders, 11th graders, and, ultimately, it will be down to 6th graders. The subcommittee needs find the best data source, or sources, for this indicator. Showing change over the 5-year SHIP with the Smile Survey will be possible.

Senna Towner explained that the three targets for the current SHIP included 3rd graders with cavities, adolescents with one or fewer cavities, and prevalence of older adult who have lost all their natural teeth. Christy Hudson noted that the adolescents target got changed with the changes in the Oregon Healthy Teens Survey. The most consistent indicator is 3rd graders with cavities, with the rates improving between 2012 and 2017. Just for reference, in the current SHIP, there are 26 key indicators, and this indicator is the only one that has achieved the benchmark. The other oral health target is among adults and it comes from BRFSS. There will be several others related to 6th, 8th, and 11th grade that will come from the Student Health Survey. Thomas Jeanne clarified that the Student Health Survey was the new name for the Oregon Healthy Teens Survey, which was combined with the Student Wellness Survey, and it will start in fall 2020.

Thomas Jeanne asked if the subcommittee had to pick only one indicator for oral health. Christy Hudson answered that the goal was to build consistency across subcommittees. Subcommittees aren't landing on just one indicator. Thomas Jeanne proposed to have one oral health indicator for children and one oral health indicator for adults for a total of four indicators. Christy Hudson remarked that this was the type of data that OHA includes in presentations to the legislature. Having more than one oral health indicator would not make clear which one is most relevant to oral health. Thomas Jeanne stated that the subcommittee would have to pick either the *childhood cavities* indicator or *adults who have lost their natural teeth* indicator.

Marc Overbeck wondered if there was a connection between the child oral health indicator and the adult oral health indicator. Thomas Jeanne pointed out that it was difficult to answer, because there was a big time lag. Individuals who have lost their natural teeth would tend to be older adults. What happened to a child decades ago probably isn't relevant today, as things have changed so much. Marc Overbeck explained that perhaps an improvement in the childhood indicator might foretell an improvement in the adult dental care. Thomas Jeanne speculated that there must be data that supported the hypothesis that a fewer cavities a child had, the more likely they were to have good teeth as adults. Laura McKeane remarked that that was a fair assumption, although there were many variables involved. There are people with no cavities, who have lots of periodontal problems from which one can lose teeth, and then there are people with no periodontal problems or gum disease, who have a ton of cavities.

Senna Towner asked if the dental-related measure could be thought of as a community-based preventive service. Laura McKeane asked Senna Towner if she was concerned with the community-based services going away because of the sealant measure. Senna Towner clarified that in looking at the indicators and finalizing them, the subcommittee hadn't discussed the community-based prevention programs as an indicator. If the subcommittee wanted to combine the dental-related measure and use a community-based prevention program as that dental-related measure, the subcommittee could tackle both of them at once.

Cat Livingston shared that oral health was a great example of a lot of things that could be done in a community, whether that was sealants or fluoride varnish in schools. It would be good to have some variability in the opportunity to provide different types of interventions in different communities. For some, they might be focusing on sealants, while other might be focusing on improving fluoride varnish. Her highest priority for this indicator was to try to encourage patients to receive those services.

Senna Towner suggested that regardless of which indicator the subcommittee focused on, the adult one or the child one, the variation across communities could be achieved through strategies. Marc Overbeck stated that there was real value in having a single indicator that may allow for multiple community or regionally-based approaches to achieve the desired levels for that measure, maybe even region by region, to help roll up to a statewide average. Based on his 30-year experience in the public sector in Oregon, the culture in Oregon tends to be outcome-based, which is positive. People are very honoring of communities and diverse strategies in communities and not mandating how XYZ is done in the community. The state is not well-served if the state says that every community can set whatever outcomes they want to set. The state is well-served when the state says that this is a measure and an outcome that we want to achieve for

all of Oregon and allow communities to choose how to achieve that outcome. It is also critical that measuring takes place, so that it can be assessed whether the strategies are working for the given outcomes.

Thomas Jeanne added that maybe it would make sense to choose the childhood cavity measure, because most of those strategies, such as fluoridated water, dental sealants, varnishes, and general access to dental care all feed into children, but several feed into adults as well, such as fluoridated water and access to dental care. If the subcommittee chose the outcome measure for the children, that would allow for the possibility of all these strategies, with some of the strategies helping everybody, not just children. That would be a practical way forward. Senna Towner, Katie Harris, Laura McKeane, Muriel DeLaVergne-Brown, Kelle Little, Patricia Patron, Chiqui Flowers, and Cat Livingston supported Thomas Jeanne's proposal.

Senna Towner summarized that the subcommittee had informally agreed on three measures: (1) 2-year-old childhood immunizations (ALERT IIS), (2) colorectal cancer screening (BRFSS), (3) 3rd graders with cavities in their permanent teeth (Oregon Smile Survey). She suggested for the subcommittee to stick to these three indicators. Thomas Jeanne noted that two of the indicators were age-specific – one for children with the immunizations and one for adults with the colorectal cancer screening. The third measure indirectly includes some of the community-based preventative services. The first two indicators are clinical indicators, the third one is a community-based indicator, and the whole lifespan is included. These indicators cover the subcommittee's goals and the whole population. They also cover infectious disease, chronic disease, and oral health.

Cat Livingston remarked that she missed the indicator *access to PCPCH (Patient-Centered Primary Care Home)*. Thomas Jeanne stated that the measure could be included, but only if it had a good data source. Marc Overbeck explained that the closest the subcommittee would be able to get around access to PCPCH at the moment would be for the Oregon Health Plan (HP) population, not for the population at large.

Senna Towner asked the subcommittee if a few members wanted to convene later and discuss the PCPCH measure. In addition to the data source, the members should consider if the measure was reflective of access to care. Alike the health insurance measure, even if people were enrolled with PCP, they may not be accessing care. Cat Livingston expressed interest in convening later. Christy Hudson stated that the subcommittee should keep exploring this measure, which could be a solid process measure to consider. Senna Towner proposed to keep the measure in mind and not convene for a discussion.

Cat Livingston shared that one thing that was missing was the idea of access to equitable preventive care, which meant, "Do people have a place to go? And when they go, do they speak the same language? Do they have the ability to communicate? Do they have to ability to get there?" This hasn't been the focus of the subcommittee. The focus has been on the clinical side of things. If these questions are something to be considered, either as an indicator or as process measures, they are really critical when the subcommittee thinks about access.

Senna Towner stated that the conversation was getting to the next step of identifying policy strategies related to the indicators. If it seems during that conversation that the subcommittee is not addressing the issues brought up by Cat Livingston, the subcommittee will revisit the indicators. Thomas Jeanne proposed

that the subcommittee accepted the three final indicators and, if a workgroup wanted to explore the PCPCH, that's great, as long as a data source was identified. The subcommittee could potentially add it as a fourth indicator, but it might be better to add it in the process or the strategy stage. If a data source is found, the subcommittee will decide later where the indicator belonged.

Senna Towner asked the subcommittee members if they should vote on the three proposed indicators. Christy Hudson suggested that, for consistency with the other SHIP subcommittees, members should indicate their preference with thumbs sideways or thumbs down. Thumbs sideways means that a member needs more conversation and discussion; thumbs down means that a member rejects the proposed indicators.

Cat Livingston expressed a disappointment with having only three indicators. She wished for ten indicators to make access to care broader. Thomas Jeanne added that that was always the challenge with indicators, because they represented highlights. It's impossible to capture the whole scope of a population's health. The goal is choose metrics that, even though they may be relatively specific, they include a lot of the other considerations and factors that go into health. Even though those other factors are not measured, the chosen indicators would correlate highly with the indicators that the subcommittee would like to have. Cat Livingston shared that her biggest disappointment was that there were no indicators related to physical activity and healthy eating, which have huge impact on cardiovascular disease, hypertension, diabetes, and stroke, among many other diseases. Christy Hudson assured Cat Livingston that these factors would be picked up by other SHIP subcommittees.

Marc Overbeck asked if the subcommittee had spoken about provider-to-population ratios as an indicator of access to care. Thomas Jeanne answered that the subcommittee had discussed those ratios a little bit. That indicator is part of one of the current state health indicators. Marc Overbeck stated that OHA's Health Policy and Analytics division had the data, if that was determined to be an important indicator of access to care.

Cat Livingston was the only subcommittee member who voted thumbs sideways. The proposed three indicators were approved by the subcommittee.

Identifying Policy Strategies

Christy Hudson informed the subcommittee members that over the next few meetings, the subcommittee would get into what was needed to be done about the proposed indicators. The subcommittee's task over the next three meetings is to identify 10-15 strategies at the policy, community, and individual levels. The task is not about inventing new work. It's about aligning what's already happening at the agencies and in the sectors where members work, or with related strategic plans, or national standards. The task could include coming up with new strategies and looking for interventions needed to make progress towards the goals. The proposed process involves a group brainstorm to identify possible strategies. There is a set of 8 criteria to use for narrowing the strategies. The end result should be 3-5 strategies, or 10-15 across the priority area, that also speak to the health equity framework. For every strategy, the subcommittee will develop a process measure and use 8 criteria for narrowing the indicators.

Katie Harris recommended that, over the next month, the subcommittee members should think about strategies. These strategies could be sent to Christy Hudson prior to the next subcommittee meeting, so that the subcommittee had something to start with and talk off of. Thomas Jeanne agreed that doing some homework would be helpful. Christy Hudson proposed to create a document in Basecamp where the subcommittee members would write their strategy ideas, framed by the goals. Ideally, there should be 3-5 strategies at the policy level, 3-5 strategies across the daily living conditions, and 3-5 strategies related to individual health-related factors. The strategies have to align to the three goals related to the increase of community preventative services, increase of clinical preventative services, and the implementation of systemic and cross-collaborative changes.

Thomas Jeanne clarified that the strategies the subcommittee was trying to identify were for the three general goals. They don't necessarily have to feed directly into the outcome indicators. The outcome indicators are a small subset of everything that is related to access to care. The focus could be much broader than childhood immunizations, colorectal cancer screening, and oral health. For any of the strategies, the subcommittee could choose a process measure that was directly related to the outcome measure.

Public Comment

Deborah Riddick commented that she appreciated the deliberateness and the caution with which the subcommittee approached the discussed concepts, whether those were strategies or outcomes. She was looking forward to seeing what priorities emerged strategically.

Next Steps

- Each subcommittee member will identify policy strategies that align with the three goals.
- Christy Hudson will set a firmer timeline for the strategy contributions in Basecamp.

Adjourn

Christy Hudson adjourned the meeting at 3:00 p.m. The next meeting will be on November 25, 2019.