SHIP SUBCOMMITTEE MEETING

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

November 25, 2019 | 1:00 p.m. – 3:00 p.m. | Call: (646) 749-3122, Access: 477-873-293

Members Present: Tom Jeanne, Chiqui Flowers, Kelle Little, Muriel DeLaVergne-Brown, Rebeckah Berry, Laura McKeane, Bridget Canniff, Katie Harris, Tim Menza (OHA Lead), Nina Fekaris

Members Absent: Char Reaves, Heidi Hill, Jim Rickards, Frank Thomas, Danielle Sobel, Tim Svenson, Catherine (Cat) Livingston, Patricia Patron, Senna Towner, Marty Cardy

OHA Staff: Elizabeth Gharst, Krasimir Karamfilov

Members of the Public: Dayna Steringer (Willamette Dental Group)

Welcome, Agenda Overview, and Subcommittee Business

Tim Menza welcomed the subcommittee members to the meeting. He asked the members to introduce themselves. The attending subcommittee members introduced themselves.

Tim Menza reviewed the subcommittee business, which included an introduction to the videoconferencing service Zoom that would be used for the meetings. He informed the subcommittee members that a process evaluation form would be submitted to them this week to get their feedback on how the meetings were working and whether the subcommittee was getting the intended outcomes.

Tim Menza noted that the subcommittee had defined three goals and three outcome indicators. The next step in the process is to identify strategies, which are policy, community and individual-level interventions needed to achieve a goal. They don't necessarily have to be directly related to the outcome indicator. They can be broader. He gave an example of a strategy related to the goal *improve oral health*.

Elizabeth Gharst added that in terms of the process measure connected to a specific strategy, if subcommittee members had a process measure in mind while discussing a strategy, they could tie together the strategy and the process measure. The subcommittee meetings through February 2020 will focus on defining the strategies. If an additional meeting is needed in March 2020 to finalize the process measures, the subcommittee can meet at that time. The goal for the strategies is to come up with 10-15 strategies at policy, community, and individual level.

Tom Jeanne asked whether the strategies that the subcommittee selects have to line up with the outcomes measures or whether they were broader across all three of the goals.

Elizabeth Gharst explained that the strategies lined up with the goals, although some strategies certainly could be chosen to move the needle on the outcome indicators. Each subcommittee is in the process of finalizing their 2-3 different indicators. These are key data points that are measurable, the data source is available, and the indicator can be measured every year to track progress.

Strategy Identification

Time Menza reviewed the selection criteria that the strategies must meet. He reiterated the three goals and invited subcommittee members to contribute strategy ideas. Elizabeth Gharst explained that the subcommittee could approach the strategy selection in several ways. One way is to suggest strategies across the three levels (individual, community, and policy) and three goals. Another way is to take one goal at a time and brainstorm strategies only for that goal.

The subcommittee decided to take one goal at a time, the complete brainstorm of strategies by goal was captured in Basecamp under the Meeting Materials folder.

Tim Menza proposed for the subcommittee to begin with one of the first two goals. Bridget Canniff agreed with Tim Menza. Elizabeth Gharst showed the strategies suggested in Basecamp for the goal *access to community-based preventive services*. Tim Menza asked the subcommittee members for strategy ideas on the first goal.

Elizabeth Gharst remarked that some of the other subcommittees approached the strategy brainstorming by thinking about what existing plans were out there and then thinking about aligning with those plans. Plans can be elevated and highlighted, especially in terms of the strategy criteria. Plans that address the lifespan of young children and older adults and focus on people of color, low income, people with disabilities, LGBTQ+ community, and rural frontier communities could be examined. Some of the other subcommittees have struggled with elevating strategies related to older adults.

Nina Fekaris noted that as a representative of school nursing, she was most familiar with children. She suggested the strategy *safe routes to and from school* for the community-based preventive goal. This strategy could be expanded to *safe routes within the community* that encourage walking and biking. She added the strategies *improving nutrition standards in schools* and *addressing food deserts in racially-segregated communities*.

Tim Menza suggested the community-based strategy *syringe service programs* for addressing the harms related to injection drug use and increasing access to substance abuse treatment services. This strategy is related to the prevention of HIV, Hepatitis C, and bacterial infections related to injection drug use. Muriel DeLaVergne-Brown supported that strategy.

Elizabeth Gharst proposed looking at strategies related to *developing community-based policy-level interventions for smoking or obesity*, one example is developing regulations for multiunit housing. Such policies are often overlooked.

Muriel DeLaVergne-Brown proposed the strategy *hiring youth to promote and implement interventions*. This strategy incorporates children in the preventive work. Crook County has been successful in using youth to support public health work.

Tom Jeanne linked the strategy *safe routes to and from school* to the strategy *active transportation*. He suggested the strategy *adult and pediatric intensive support for preventing obesity*, which was primarily provided in clinical settings, but could be extended to the community. He recommended a diabetes prevention program that was effective against obesity and was often provided outside of the clinic.

Bridget Canniff remarked that the strategy *active transportation* could be included in the cross-collaborative Goal #3. It's an issue for access to community-based services and access to clinical services. A lot of tribal communities have looked at that particular barrier and thought about how to reduce it for access to all services.

Nina Fekaris commented that she would like to see the obesity-related strategy Tom Jeanne proposed under Goal #1. If obesity is left in the clinical setting, a lot of opportunities are missed to address it socially in the community.

Tom Jeanne proposed the strategy *access to lactation accommodation in workplaces and public places*. Tim Menza added that another strategy, before women got pregnant, could be *strengthening access to doulas, especially doulas in communities of color*. Tom Jeanne pointed out that this strategy tied to the strategy *access to prenatal care*. Tim Menza agreed.

Elizabeth Gharst clarified that doulas were one category of community health worker, which pointed to the strategy *community health worker interventions*. She gave an example with Klamath County, where health workers began providing transportation for patients to appointments, which then expanded to home visiting, nutritional, support and eventually incorporated nurses into the program as well.

Tom Jeanne proposed for the subcommittee to find and review the list of community-based interventions created by the Community Preventive Services Task Force. Katie Harris stated that that was what she did when she looked for possible strategies for each goal.

Tim Menza opened the discussion for ideas around access to clinical preventive services. He asked Tom Jeanne to elaborate on his suggestion related to obesity, this time for clinical-based services. Tom Jeanne answered that the prime clinical service would be the National Diabetes Prevention Program (National DPP). On the community side, there is Weight Watchers, which is evidence-based, and some YMCA programs. The National DPP is often done with a multidisciplinary team in a clinic-type setting or group-type setting and can be viewed as both a community-based or clinical-based service. Muriel DeLaVergne-Brown remarked that the National DPP has been very successful in Crook County. Nina Fekaris pointed out that in terms of obesity, all the work that happens in schools around nutrition education, exercise, and Fit-for-Life programs is community-based obesity prevention. A diabetes prevention clinical service is overlapping Goal #1 and Goal #2.

Tim Menza proposed the strategies *universal testing for HIV (including home-based testing)* and *universal testing for HCV*. Bridget Canniff seconded these strategies. Muriel DeLaVergne-Brown supported the strategies and noted that Central Oregon counties have struggled with taking seriously the strategy *universal testing for HIV*.

Bridget Canniff suggested the strategy *childhood immunizations*. Tim Menza remarked that childhood immunization was one of the three indicators. Katie Harris added that she wrote this strategy under Goal #3 as it opened possibilities for systemic and cross-collaborative changes.

Tom Jeanne shared that he looked at the Vermont State Health Improvement Plan and two strategies that could be applicable to Goal #2 were *developmental screening for children* and *early social emotional development*. He stated that an obvious strategy was *increase the population that has access to services*. This strategy tied into the clinical preventive services and the priority "increasing access to care." It could be enacted as increased Medicaid enrollment, or as Dayna Steringer suggested, reduced wait time on the Oregon Health Plan client services lines. Tom Jeanne suggested to add accessibility, affordability, and availability within access.

Nina Fekaris commented that it would interesting to see if there was any information available in Oregon that showed members of healthcare providers that accepted Medicaid clients and OHP clients. She has heard through school nursing channels that school nurses can't find providers in the rural areas. There is a lack of providers that accept OHP and a general lack of mental health care providers to help service the rural areas. In terms of access to care and equity of care, this is a big red flag.

For Goal #3, Nina Fekaris stated that one of the biggest barriers for cross-collaboration was the difference in electronic health records systems and the inability to share information because of HIPPA and FERPA complaints. It would be great to have one healthcare records system that all community players can access, view, and share. Such systems exist in other states and help access to care. Similar systems include the ALERT Immunization Information System and the EDIE system in emergency departments.

Katie Harris explained that there was federal law that prohibited substance abuse records from being seen by providers. This prevents collaborative work when it comes to substance use and mental health treatment in primary care.

Bridget Canniff noted that her organization (Northwest Portland Area Indian Health Board) has been working with communities to implement ODMAP (Overdose Detection Mapping) to map opioid overdose in communities. The system shows where services are available and allows to do follow-up to identify people who need access to community services or clinical services. The system allows to see the surveillance data and share information.

Cable Hogue asked the subcommittee members if they had read the CMS proposals regarding health data and how they might help in situations of cross-collaborative sharing between hospital systems. The main goal of the proposals is to give the consumer more access to their health data. They can then allow for their data to be shared more freely through hospital systems, clinics, providers, and mental health providers. This way, the focus will be on the patient, as opposed to on the barriers.

Tom Jeanne proposed a strategy related to *telemedicine*. It's technology and increasing access is a big part of it. It also satisfies the equity criteria with rural populations that may not otherwise have access to specialty care or primary care. Elizabeth Gharst added that telemedicine has become important with the transgender population, because finding a provider that is appropriate in their area might be challenging. Telemedicine might be a way to access those services, such as the OHSU's transgender health program. OHSU also houses Oregon ECHO Network launched in 2014 that aims to provide technical assistance in rural and frontier areas. It is modeled after the University of New Mexico's Project ECHO ® (Extension for Community Healthcare Outcomes).

Elizabeth Gharst wondered how an individual knew what services were available to him/her. This question has come up in most community conversations she has been a part of. A systemic intervention is needed to help find out what services are available. This could be an online tool for individuals. Bridget Canniff pointed out that the system not only had to show what services were available and if individuals were eligible for them, but also if the programs had capacity to accommodate these individuals.

Public Comment

Elizabeth Gharst invited members of the public to provide comment or ask questions. There was no public comment.

Next Steps

- Elizabeth Gharst will post the suggested strategies for the three goals on Basecamp. Subcommittee members will be able to edit the documents and add comments.
- Subcommittee members are encouraged to read strategic plans posted in Basecamp or other strategic plans at their respective organizations for strategy ideas.

Adjourn

Elizabeth Gharst adjourned the meeting at 2:34 p.m. The next meeting will be on December 16, 2019.