SHIP SUBCOMMITTEE MEETING

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

August 26, 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, Frank Thomas, Kelle Little, Muriel DeLaVergne-Brown, Rebeckah Berry, Patricia Patron, Laura McKeane, Marty Carty (filling in for Danielle Sobel), Tim Svenson, Bridget Canniff, Katie Harris, Senna Towner

Members Absent: Char Reaves, Heidi Hill, Jim Rickards, Nina Fekaris

OHA Staff: Christy Hudson, Krasimir Karamfilov

Members of the Public: Lindsay Atagi (PacificSourse), Trevor Beltz (Oregon Medical Association), Josh (student at PSU)

Welcome and Agenda Overview

Tim Menza welcomed everybody to the meeting. He introduced himself and invited the subcommittee members and meeting attendees to introduce themselves and state why access to care was important to them.

Get to Know Other Members of the Subcommittee

Subcommittee members and meeting attendees on the phone and in the room introduced themselves.

Setting the Stage

Tim Menza explained the subcommittee expectations: (a) develop strategies and measures within health equity framework, (b) maintain vision, values, and direction for the SHIP, (c) facilitate two-way communication about the SHIP with your agency and community, (d) review materials ahead of the meeting and come prepared to discuss, (e) respond to requests in between meetings, (f) make decisions based on consensus.

Tim Menza outlined the ground rules. OHA is in the process of getting Zoom, which will allow the meeting attendees to use web cams and see each other. Some of the ground rules include: explain jargon and acronyms, introduce self when talking, discussions and decisions stay in the meeting, differentiate between speaking for self versus speaking for a group, expect and accept lack of closure, among others.

Christy Hudson reminded the subcommittee members that if they had not reviewed the orientation webinar, held in late June, they should review it, as it provides an overview of the SHIP. As a reminder, the

SHIP Framework details the types of strategies that subcommittee members are expected to create across the five priority areas: institutional bias, adversity/trauma/toxic stress, behavioral health, access to equitable care, economic drivers of health. The strategies or interventions fall into three big categories: (a) social, economic, political, environmental, and cultural context, (b) daily living conditions (e.g., education, employment), (c) individual health-related factors. Within the three areas, focus should be maintained on the priority populations: people of color, people with low income, people with disabilities, people who identify as LHBTQ+, and geographic disparities. Work should also focus on the needs of children and older adults.

Christy Hudson reviewed the proposed timeline and work plan until July 2020. Goal is to have final strategies and measures for SHIP by July 2020. Partnership members on the subcommittee are Katie Harris, Cat Livingston, Jim Rickards, Rebeckah Berry, and Kelly Little.

Christy Hudson listed the subcommittee tools: SHIP website, Basecamp, GoToWebinar and Zoom. Basecamp is a web-based project management tool and contains meeting times and dates, agendas, minutes, materials, and resources.

Tim Menza asked the subcommittee members whether any voices were missing from the subcommittee. Cat Livingston remarked that the subcommittee was missing children and education. Schools could be engaged with the SHIP. A lot of prevention can be delivered directly in schools. Christy Hudson explained that an invitation was sent to the Department of Education (DOE). They have identified individuals for the Adversity, Trauma, and Toxic Stress subcommittee and the Behavioral Health subcommittee, but not for the Access to Care subcommittee. Subcommittee member Nina Fekaris from the Oregon School Nurses Association represents the education voice.

Senna Towner informed the attendees that she worked at United Way, which was the education hub for Linn County. The hub director at United Way may reach out to other United Way hub directors across the state. It might be a good resource. If the directors don't have capacity, they might have a reference in each county.

Tim Menza asked if the subcommittee was missing voices in terms of sex and gender, race and ethnicity, sexual orientation, disability, and immigrant populations.

Tim Menza asked the subcommittee members about their networks for the purpose of sharing information about the SHIP and if the members needed resources to enable information sharing. OHA can help with that.

Frank Thomas answered that sometimes the most effective outreach that can be done is the captive audience on a bus or waiting at a bus shelter. He could reach to providers and make that happen. The counties and tribal systems are already connected with public health or travel health. Stakeholder input can be gathered at the local level as well.

Kelle Little explained that the Oregon tribes and other tribal organizations in Oregon, such as NARA, often have well-established outreach networks. The tribes in Oregon can be reached to provide a feedback for information.

Senna Towner added that United Way is the backbone for the collaborative CHIP and CHA in Linn County. United Way partners with PacificSource and the Public Health Department, among others. United Way can reach out and share out.

Chiqui Flowers remarked that the Oregon Health Insurance Marketplace (OHIM) does outreach throughout the year and it's a resource that can be leveraged. OHIM has a variety of federal connections with other states that have health insurance exchanges. Unique for OHIM is the Compact of Free Association (COFA) Premium Assistance Program, which provides free health insurance for low-income citizens of the Republic of Marshall Islands**,** the Federated State of Micronesia**,** and the Republic of Palau who live and work in Oregon under the compact of free association, but are not eligible for Medicaid because of a federal law. This is a specific population that can be helped.

Tim Menza asked the subcommittee members if any of them would volunteer to be a co-chair of the subcommittee. Senna Towner expressed interest in the co-chair role. Christy Hudson will follow up with Senna Towner about the role.

Developing a Shared Understanding

Tim Menza presented a data placemat with eight bar charts related to access to equitable preventative health care. He asked the subcommittee members to comment on the disparities that stood out to them. Tom Jeanne pointed out that the access to health care by disability status is a stark contrast, with 19% of disabled people reporting barriers to accessing health care versus 9% for people with no disability.

Frank Thomas remarked that in the chart for uninsured by race, ethnicity, and age, the Latino population was an outlier compared to the other groups. Kelle Little noted that in the same chart, the American Indian and Alaska Native group was the second least insured population. Katie Harris stated that the chart was from 2015 and that although 96% of the population in Oregon was insured and 4% was uninsured, many insured people don't have good insurance, which prevents them from having access to care.

Tim Menza stated that when we look at psychiatric mental health care providers compared to oral health care providers and primary care providers, the population-to-provider ratio for mental health is incredible. Although it varies by rurality, the ratio is above and beyond oral health care providers and primary care providers, which are already too few. The difference for psychiatric mental health providers is even worse.

Cat Livingston added that access to psychiatric mental health seemed to be a critical issue. Whether it belonged in the workforce arena or with the Behavioral Health subcommittee, there is a need and it needs to be fixed. Knowing where it belongs in the SHIP would be important. The ideal data would be on what percentage of the population receives the United States Preventive Services Taskforce (USPSTF) and recommendations. These are evidence-based clinical preventive services that work. It would be good to

know where the gaps are in terms of what everybody should be receiving and what they are actually receiving.

Tim Menza noted that one of the potential sources of information is the All Payer All Claims (APAC) dataset, which was a bit delayed. The 2017 data were recently released. One can look for claims for those particular services. Claims data is a mess, but it is useful. All insurance types are included (i.e., Medicaid, Medicare, all commercial plans), except Veterans Affairs (VA), the federal insurance programs, any insurance that has less than 500 covered lives, and uninsured people.

Defining the Goal

Tim Menza invited the subcommittee members to share big, aspirational goals they wanted to accomplish through the work of the subcommittee. These goals could come from members' daily work, or from problems the state or certain populations are facing, that can be moved forward in this subcommittee. They can be as broad as *improving oral health*, or *improving access to breast cancer or colon cancer screening*, or *using innovative delivery models to take care out of clinical settings*.

Senna Towner proposed the goal of *improving access to behavioral and mental health, including addiction services*.

Frank Thomas remarked that some transit providers are doing a very good job at coordinating with the Eastern Oregon Coordinated Care Organization to put public transit in the preventive health care model, but that was not the norm statewide. Best practices from those providers should be shared with counties across the state. From the outreach perspective, there is a captive audience of mutual constituents who are using bus shelters or stations and riding the busses every day. They will be looking at somebody's advertising on the inside of those buses. He could have public service ads pushed out for free or next to free. Commuters should be looking at our messaging about flu shots, or immunization, or pregnancy prevention, among others.

Tom Jeanne suggested answering the question "What do we mean by equitable preventive health care?" We have disparities by race and ethnicity, by disability, by rurality. Should the subcommittee focus on any one of them? What do we mean by access to care? How can we measure that? How can we improve that?

Cat Livingston stated that if the discussion was about both primary and secondary prevention, each of them can be a separate goal. There are three levels of prevention. Primary prevention is about improving health so that diseases don't develop (e.g., places to play outside, clean air, clean water, healthy food). Secondary prevention is about finding a disease early on before it can manifest (e.g., color cancel screening). Tertiary prevention is when somebody already has a disease, like diabetes, and you try to improve the diabetes care so they don't have to have an amputation.

Patricia Patron agreed with the approach proposed by Cat Livingston. Christy Hudson explained that the primary prevention goal might rub with the goals of the Economic Drivers subcommittee, such as housing, transportation, living wage, employment, education, among other social determinants.

Rebeckah Berry suggested the strategy *increasing access and engagement to community-based preventative programs, such as diabetes prevention program, living well, cooking classes, among others.* Another strategy could be *breaking down transportation barriers by finding alternative solutions based on geographic areas*. These strategies were posted on the SHIP Access to Care webpage.

Christy Hudson clarified that the language on the webpage was drafted based on the conversation that happened in the PartnerSHIP meeting when they landed on this priority, as well as some of the more common themes that OHA heard from the community feedback process.

Rebeckah Berry added that the subcommittee should consider those strategies because of how they were developed. Senna Towner asked if the goal of the subcommittee should go beyond the original discussion that informed the formation of the subcommittee. Maybe looking more deeply into the shared data would help in defining the goals.

Cat Livingston proposed the following three goals: (1) Access to an uptake of community-based preventive services (i.e., primary prevention), (2) Access to an uptake of clinical preventive services (i.e., secondary prevention), (3) Addressing social determinants of health barriers to both primary and secondary preventive services.

Tom Jeanne stated that the different levels of prevention don't map perfectly. Community interventions are mostly primary prevention, but there's also primary prevention that happens in the clinic (e.g., when a clinician is helping a patient to improve diet or lifestyle). Regarding the economic drivers and some of the social determinants, a lot of them are what would be considered primordial prevention, which is upstream from primary prevention, because it's trying to prevent risk factors in the first place. A lot of what we are talking about in access to care is a little bit separate; certainly closely tied to economic drivers and social determinants, but it's a different level and a different lens to look at it.

Christy Hudson asked the subcommittee what communities experienced health inequities, based on the data that each member has seen. Senna Towner answered that it was all communities in the SHIP framework. The subcommittee agreed.

Tom Jeanne articulated the goal statement: *The goal is to improve access to an uptake of both community-based and clinical preventive services by [strategies]*.

Tim Menza remarked that the subcommittee would come up with strategies to improve access. If particular populations are called out, they can be weaved into the strategies. Tom Jeanne noted that the goal statement might be focus enough for the overarching goal and then have more concrete objectives underneath it.

Cat Livingston shared that community-based preventive services seem different than community-based programs or policies. Tom Jeanne agreed and proposed the phrase *community-based preventive efforts*.

Tim Menza asked where public health preventive services, such as ordering a kit to test for HIV/STI at home, fit in the model. Cat Livingston agreed and proposed that the language could be left open by not

defining the services separately. Tom Jeanne added that those services could be included under community-based services, because the program is acting with the community.

Christy Hudson suggested two options for moving forward: (1) Leave the goal statement as it is and have subcommittee members leave comments and suggestions in Basecamp, (2) A small subgroup of subcommittee members could meet before the next meeting and finesse the language of the goal statement and come back with a proposed goal, or two, or three.

Rebeckah Berry liked option (2) and volunteered to be part of the subgroup. Cat Livingston and Tom Jeanne agreed to join the subgroup. Christy would coordinate the meeting and post the goal statement on Basecamp. Subcommittee members are welcomed to join the subgroup meeting, if they wish.

Cat Livingston suggested to post the article The 3 Buckets of Prevention by John Auerbach on Basecamp. The goals can be formulated with that framework in mind.

Public Comment

Tim Menza invited members of the public to provide comments or ask questions. There was no public comment.

Next Steps

- Christy Hudson will follow up with Senna Towner about the co-chair role.
- Subcommittee members will look at the working goal statement and provide comments
- Rebeckah Berry, Cat Livingston, and Tom Jeanne will meet before the next subcommittee meeting to define the goal statement. Heather Owens will schedule the meeting.
- Subcommittee members will post any relevant data that could benefit the group
- Christy Hudson will post the article by John Auerbach on Basecamp.
- Krasimir Karamfilov will move the meeting in December to December 16, 2019.
- The proxy representation issue will be brought to the SHIP Core Group and the other subcommittees for consideration.

Christy Hudson invited the subcommittee to comment on what went well in the meeting.

Chiqui Flowers asked whether a subcommittee member could designate a proxy to attend a meeting in the event that the subcommittee member could not make the meeting. Christy Hudson answered that the charter did not include information about delegates. Tom Jeanne stated that as long as the proxy was somebody from the same organization and was on the same page and could represent that organization's opinion or voice, or the actual subcommittee member's opinion or voice, a proxy should be allowed to attend a meeting. Christy Hudson agreed.

Adjourn

The meeting adjourned at 3:01 p.m. The next meeting will be on September 30, 2019.