***Welcome to our new EEC format! We are piloting meetings without a roll call. When you are prompted by Adobe Connect for your name, please enter your first name, last name, and state/org (i.e., Lara Kaye (NY)). If you are sharing a screen, please be sure that all in your party add their full names and state into the chat box at the start of the call.***

**CALL IN LINE:** 1 877 273 4202, room **793-903-441. Please mute your line when you are not speaking.**

**ADOBE CONNECT:** [**https://chronicdisease.adobeconnect.com/eec/**](https://chronicdisease.adobeconnect.com/eec/)

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| EEC Leads | Belle Federman (KS), belle.federman@ks.govLara Kaye (NY), lara.kaye@health.ny.govShelby Vadjunec (WI), Shelby.vadjunec@dhs.wisconsin.gov |
| NACDD Consultant | MaryCatherine Jones, mcjones@chronicdisease.orgKayla Craddock, kcraddock@chronicdisease.org |
| Date | March 13, 2019 |
| Time | 11am PT/12pm MT/1pm CT/2pm ET |
| Objective | To provide opportunities for staff working on 1815/1817 epidemiology, evaluation, data and performance measurement to collaborate on their work through the exchange of questions, ideas, insights, and resources with their peers. |

| Time/Discussion Lead | Agenda Item | Discussion | Actions |
| --- | --- | --- | --- |
| 2 minutesShelby | Welcome and Housekeeping | Instructions for joining Adobe ConnectJust like last month, we are testing holding meetings with no roll call. If you didn’t enter your firstname\_lastname(state) when you logged on, please enter it into the Chat using this format. |   |
| 5 minutesBelle | New Member Introductions | EEC is a community of peers and we love to know who is with us, especially those who are new in their positions and new to EEC. If you are new to EEC, please introduce yourself:* Name and state
* Epi/eval role
* Which part(s) of 1815/1817 you work on
* What you hope to get out of this group

*Holly (OH): Epi and eval supervisor for chronic disease, works on both components of 1815 epi and uses external evaluation contractor. Look forward to hearing how data sources are coming together, measuring PM, and what people are evaluating.* | EEC agendas and minutes are sent by email. If you are not on the EEC email list, please add your email address to the Chat and/or email MaryCatherine Jones.  |
| 5 minutesMaryCatherine/Kayla | NACDD Updates | Coming soon: CSTE travel scholarship application for chronic disease GIS users!Members of the GIS Network are invited to apply for travel support to attend the 2019 Council for State and Territorial Epidemiologists Annual Conference, June 2-6 in Raleigh, North Carolina. Application found here: <https://www.chronicdisease.org/page/GIS>EEC exchange webpage* Login required to NACDD site
* Link distributed only within EEC
* All EEC members should have logins, with your username being your first initial and last name (i.e, kcraddock). Reset your password once you are able.
* Members can download and view links
* Only NACDD can upload docs

We have removed the older webpage version and replaced it with one that is restricted to members. You will have an NACDD account. If you don’t have one already, Kayla will create one and send it to you. We will start posting EEC minutes here as well as any documents/resources that you would like to share with colleagues. Try visiting the site at (may require log-in to NACDD site): <https://www.chronicdisease.org/page/CVH_EEC>We’ll take feedback on how we can make it useful to the group. | Contact Kayla for assistance with accessing the page and/or submitting documents to share (kcraddock@chronicdisease.org).  |
| 10 minutesShelby/Kayla | 1815/1817 Grantee MeetingStaffing Survey | CVH Network get together Tuesday, 3/26, 4:45-5:45pm. Everyone working with Category B strategies is encouraged to attend! EEC get-together Wednesday, 3/27, 5:15-6:15Fun and activitiesCome and meet your friends1815/1817 staffing surveyWe want to understand how staffing around eval, PM and epi is organized. How many personnel are dedicated to this? What is their funding (in-kind, 1815, etc.)? This will help us provide better TA and learning opportunities. We also want to capture what strategies have been seleted for the overall grant. This will be coming out soon.Other Update for grantee meeting:Brittany (UT): At the grantee meeting, on Tuesday night, we are having a CVH Network ancillary meeting at 4:45. Everyone that works on Category B activities or is related to Cat B is welcome.We are looking forward to seeing everyone in person! | Come have some fun with us during March ancillary sessions!  |
| 25 minutesBelle | 1815/1817 Discussion | Any comments, highlights, or questions from the Fireside Chat on Cholesterol Management (2/28)?Lara: I was very disappointed not to attend. Were there highlights or a brief summary that folks want to share?Tiffany: I was on it and took notes. It was very clinical. Not sure who the real audience was supposed to be.Kayla: We have heard that it was very clinical, but usually we do a virtual roundtable for people to come back together and discuss this. We didn’t do that this time because there will be a Part II of this topic at the grantee meeting. On the grantee agenda, there is a cholesterol session. I would encourage everyone to attend. This should be less clinical and more programmatic.MaryCatherine: All feedback is valuable and helpful toward future planning.Kayla: NACDD normally provides a summary document because the Part II will be helping at the grantee meeting, it has not yet been developed. You can view the recording on the CVH website and access handouts provided during the chat. <https://www.chronicdisease.org/page/CVHWebinars>Belle: Sounds like good things to come. We can circle back to cholesterol management after the grantee meeting.Lisa Kocak (TN): How are states working with FQHC associations getting buy-in from clinics to collect data for performance measures (esp. BP, chol, referrals to self-management, etc.)? Our FQHC association is asking what they can do to provide “evidence” or “support” to leadership and people who run the show there to include other types of patient tracking in EHR systems. They have HRSA and federal funding that require a minimum level of tracking outcomes but with 1815 there are extra ones that are not in the funding they’re receiving to incorporate into their health records. They’re reluctant to add new alerts, prompts, etc. to be able to track outcomes associated with BP measurement and control, if providers are tracking referrals, etc. Rachael (NY): We are working with our community health careassociation that oversees FQHCs (CHCANYS), and our contract with them included funds for them to program in measures specific to 1815 to a data warehouse platform they have that FQHCs are connected to (Azara). We can support connection to FQHCs that are not yet connected. We are recruiting practice sites from the FQHCs who are connected to it to have access to the PMS as well as clinical decision-support tools based on those measures.We also have developed our own performance monitoring system(Catalyst) that our eval and program teams will use to support a practice facilitation model with our individual sites, which will collect quarterly information on referral to programs (ie., cholesterol referrls, diabetes referrals) among other site-level policy and practice changes. This gives us 2 different ways of trying to track the required measures.California: Clinic can track # of patients referred to NDPP or lifestyle change program, but how do you ask them to monitor and make sure that the referred patient attends/completes the program? Is this part of what’s tracked in NYS? Kayla: When I was with VA and working in a clinic setting, you’d need to have a relationship with the program that they’re referring out to and that organization would need to provide the feedback.Emily (MN): As far as getting buy-in for tracking chol PMs (Long-term), because HRSA will be requiring that they report this as 2019, we offer to look into it this year to get them off on the right foot before they start having to report to HRSA. Lisa (TN): We framed it this way, too. Carrie (OH): We’re also working with our state FQHC association. The association has licenses to AZARA (pop health mgmt. software), so they will be building reports that will be available for the practices that participate.Ariene (MI) – similar to OH and working with primary care association - trying to expand.Mojde (NV) – working directly with FQHC – do not go through association. We are using ICD codes and working with the managers to get data (data agreements in place for this exchange).Lisa: Do you have a data agreement that you can share so I could see verbiage or how to set one up? Mojde: I will check on this and get back to you.Belle: This could go on the EEC webpage, too.Mojde: I will find out.Allie (KY): We are doing a project under 3.7, bidirectional referral pilot project. We’re working with FQHCs on IT system. We’re working with community referrals to DSME, SMBP to FQHCs where we can get the feedback from the community to the providers. No answers yet, but we’re working on it.Lisa: Thank you for your ideas!Belle: Have states modified their health system assessment of team-based care since we have gotten finalized performance measures that ask about team-based care for hypertension and high blood cholesterol separately? We had developed an assessment but had a lot of discussions with our contractor around what the questions mean if asked separately for both HTN and chol. How do other states/cities deal with this?Rachael (NY): We haven’t taken our assessment to our program team yet, but in terms of TBC, we have sites that will be working on DM and preDM and those that will be working on HBP and chol. We’re not splitting out the TBC questions out. We’ll be able to tease some of it out but expecting the approach to be inclusive of HBP and HBC. We’ll track referrals separately using our performance monitoring system.Belle: We had been going this way. Are others using this approach?Tiffany: We are doing the opposite—specifically tracking them differently. ND health systesm are not working on chol as they have been with HBP. We want to track which team member are part of HTN and TBC and what if any team based care is happening. We will be tracking them separately within separate questions in our health systems assessment.What last minute questions do you have before submitting the 1815/1817 EPMP on April 1st?Brittany (UT): I am struggling with this. With the guidance being finalized so recently, how are people doing this?Dierdre (SD): We are not on track. We are just beginning, do not have contracts in place, will do our best to create this but can see the need for modification. Not sure how we can do this.Debra (AL): Also having this problem. We are struggling with contracts, it’s overwhelming. The timing of the grantee meeting is unfortunate given the deadlines.Emily (TX): One thing we are doing in terms of contract and execution: we are doing a lot of research to make accurate estimates of baselines and targets using publicly vailable data sets or proxies for this information. Our CDC rep told us that it’s not acceptable to write “TBD.” Emily (MN): I’ve been working on the PM plans for 1815 and 1817, all components. I feel like we’ll be sending in a lot of bare tables, we don’t have a lot of partners in place yet, because we’re still contracting with grantees, who need to identify the partners. There will be a lot of data that we will be adding in when we are able.xX (CA): We also have this problem. We are having a projection for our targets. We project what the targets will be. This is a living document and we have the opportunity to circle back and can change information. Adrian (MI): We struggle too but there’s always an opportunity for technical review and resubmitting.Jackie (PA): We are struggling to prepare a document for 4/1. A lot of the baselines we know what the data sources will be but aren’t far enough along with working with the health systems to get accurate baseline data. We will try to use some of the information from 1305 to try to give pretty good esitmates ot targets.Tiffany (ND): We are done with our EPMP. We included notes about the baseline for the data. We did put “TBD.” We have a pharmacy assessment in progress. We are happy to explain why we wrote TBD. We know that this is a working document. For Cat A presentation, the order of the evaluation categories, we brought up that the B template is different from the NOFO. We learned today that the 5 topics can be in any order (efficiency, effectiveness), or the Category A that follows the NOFO. We have overlapping strategies. We need to have the questions in the same order. Rachael (NY): We will have everything together but it has been challenging to pull all the pieces together. We’ve used the approach of taking 1305 and 1422 data where possible. In terms of eval approach, we are being more general in some of our questions rather than too specific knowing that some details need to be worked out with contractors. We’re being a bit more broad. Mojde (NV): I thought it was just me struggling with Cat A. I’m very behind.Mengyi (KS): We’re struggling with Cat A evaluation form. For Cat B there is one core area to address for each year. How are you all capturing this?Belle: This aspect is overwhelming because it looks like you’re choosing indicators for the full 5-year period. Other questions from states?  |  |
| 10 minutesMaryCatherine | EEC Roundtables | Last year, EEC held two virtual roundtable discussions, which were in-depth discussions on specific topics in between our regular EEC meetings.* Topics specific to 1815/1817 that we should consider?
* More general topics? Engaging partners in eval? Building data collaborations across categorical programs?

Does anyone have clarity on the operationalization of the numerators or denominators from Category B? Is there another group interested in discussing this? Lara: We spend a lot of time talking about this? It would be interesting? Mojde: Yes. Also, what kinds of indicators are you choosing for your evaluation? For me, its very general and very dense sometimes. I am not confident that I’m on the right track.Rachael: Yes. This would be interesting. Lena: I’m participating in an epi/eval NACDD Peg Adams peer learning group and we’re having these discussions but it would be helpful to open this up. |  |
| Adjourn | Meet everyone face to face at the Grantee Meeting EEC Get-Together Wed. 3/27, 5:15-6:15pm. It will be fun!Next meeting Wednesday, April 10 at 2pm ET. Please email any agenda items to MaryCatherine |

# Other News and Updates

3/20/19 Modje (NV) updated her comments made at this meeting: Our program side included activities regarding data submission in the scope of work and annual work plan. Please find below the language for data sharing activity.

* Maintain aggregate information sharing of EHRs between Nevada Health Center (NVHC) and Division of Public and Behavioral Health (DPBH) for high cholesterol, high blood pressure, diabetes, and prediabetes.

NVHCs’ administrator and leaders will work with CDPHP to identify the key quality improvement measures to eliminate health care disparities:

NQF0018 for high blood pressure

NQF59 for diabetes

Prediabetes based on the Preventing Type 2 Diabetes Toolkit

CMS347v1 for high cholesterol

* Submit the Chronic Disease Data (data poll for the patients with diabetes, prediabetes, high blood pressure, and/or high cholesterol served at NVHCs) on quarterly basis.

The excel file NVHC submitted to us quarterly doesn’t have any identifiable information. It includes chronic disease (prediabetes, diabetes, hypertension) related data and demographics.