***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/)

|  |  |
| --- | --- |
| EEC Leads | Belle Federman (KS), belle.federman@ks.gov  Lara Kaye (NY), lara.kaye@heatlh.ny.gov  Shelby Vadjunec (WI), Shelby.vadjunec@dhs.wisconsin.gov |
| NACDD Consultant | MaryCatherine Jones, [mcjones@chronicdisease.org](mailto:mcjones@chronicdisease.org)  Kayla Craddock, [kcraddock@chronicdisease.org](mailto:kcraddock@chronicdisease.org) |
| Date | May 8, 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 minutes  Lara | Welcome and Housekeeping | Instructions for joining Adobe Connect  Just 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.  Poll—please answer the question in the Poll box and we’ll look over the answers and discuss. |  |
| 2 minutes  Belle | Poll Item | Review poll feedback  Belle – want to make sure EEC topics are valuable. Have some topics from you all, and answers to polling questions will give us topics to discuss. For now, anything else you all want to make sure we touch on now or during upcoming calls?  No responses.  Lara – see a lot of good responses to the poll question, which we can hopefully get to today and if not, in the future.  Poll responses collected during call:  *Prompt: The most challenging part of the 1815/1817 epi/eval work is….*   * Trying to figure out how to get quality data for PMs & think about how to evaluate health impact by year 5 while still in planning in phase, getting guidance, submitting required documents, etc. * How different the feedback was on Cat A and Cat B EPMP * Unclear, confusing, and late guidance from CDC * I'd agree with the timing of everything. It's also been hard this go-round to have different eval guidance between Category A and Category B. Makes it way more cumbersome than 1305 and 1422 were * It is being able to distinguish between the two grants, especially with one evaluator working between both grants. Also it is hard knowing who to deal with at CDC since there are different evaluation staff there. Finally, the guidance has been unclear. * Programmatic activities (approved by CDC) don't align with performance measures * Receiving so much information late from CDC. We are expected to have answers to all their data questions, but without a central data repository, it takes a great deal of work to get these data points. * Not getting any feedback from CDC about our evaluation plan * Figuring out the various data points and tracking we have to do and systems to do it. * Different requirement and guidance for category A and B * Creating a 5-year evaluation plan when the activities and interventions are still in planning phase * Trying to meet both CDC and state data collection needs * So much information, confusing * Different expectations for Categories A and B and the rush to establish data collection systems/sources for performance measures at the same time as you're designing evaluation questions and programmatic activities. * Differences between Cat A and Cat B PO expectations |  |
| 5 minutes  Lara | 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   Lindsey Kohler (AZ) – epi who just recently joined the team, but got feedback from CDC and am anxious to hear what others are doing with feedback  Olushola Ogunleye (VA) – interim chronic disease epi – working on 1815 and 1817. Want insights from those working on grant and ways to improve entire process.  April Hendrickson (CO) – also new, but having trouble with the audio. | 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 Kayla ([kcraddock@chronicdisease.org](mailto:kcraddock@chronicdisease.org)). |
| 5 minutes  Kayla | NACDD Updates | Kayla’s email in chatbox to make sure you on distribution list.  \*EEC Survey—what this is and why we’re doing it: looking to figure out how and why you have structured 1815 /17 the way you have, as well as  <https://www.surveymonkey.com/r/EECroles>  *Results from survey will be shared during June EEC meeting.*  EEC exchange webpage – reminder that this page is available to EEC members.   * 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   Access the page here: <https://www.chronicdisease.org/page/CVH_EEC>  \*We created webpage for EEC members only; log in via NACDD site – contact Kayla if you have questions. Will post meeting agenda and meeting notes for a reference point on these calls. Any documents you shared as resources for all on previous calls can shared with Kayla and she will post. May just take a few days to get on the website.  \*NACDD is proud to be a Bronze Sponsor of this year’s **Council for State and Territorial Epidemiologists (CSTE) Annual Conference**, June 2-6, 2019 in Raleigh, NC. Please stop by our exhibit table to learn about NACDD’s support to states on GIS in chronic disease prevention and meet your peers at any of the following NACDD events. MaryCatherine, Hannah, and Natasha will be attending. Table placement is listed at the bottom on the agenda. NACDD’s role in the conference is also listed. Look at 1815/1817 epi/eval roundtables that are happening – we encourage you to attend and get facetime with fellow EEC members and hear how GIS is making a difference in your work! | Contact Kayla for assistance with accessing the page and/or submitting documents to share ([kcraddock@chronicdisease.org](mailto:kcraddock@chronicdisease.org)). |
| 30 minutes Belle | 1815 Hot Topics | Modje (NV): Since the long-term outcome for this strategy is “proportion of people with diabetes with an A1c >9  ”, is it our priority to work with diabetic patients who demonstrate poor blood sugar control (HbA1c>9.0)? Or do you include diabetic patients whose HbA1c is more than 7.0?  CDC response: Strategy A3 long term measure is tracked and reported by CDC. I will recommend that you work with the diabetic population in your target area regardless of their A1c level.  Modje (NV): In the Category B Guidance document, the performance measures are defined as # of pharmacists who provide MTM services to promote medication self-management and lifestyle medication for patients with high blood pressure, high blood cholesterol. In the same document CDC defined high blood pressure and high blood cholesterol as:    **High Blood Pressure (HBP):**Systolic blood pressure (SBP) of 140 mmHg or higher or diastolic blood pressure (DBP) of 90 mm Hg or higher with a diagnosis of essential hypertension (ICD-10-CM: 110).  **High Blood Cholesterol**: Total cholesterol greater than 200 mg/dL, LDL greater than 100 mg/dL, HDL less than 60 mg/dL and Triglycerides greater than 150 mg/dL (National Cholesterol Education Program, 2001).    Do other states provide MTM to patients with blood pressure reading of 140/90 and patients with high blood cholesterol according to the definition? How do they collect data on blood pressure and cholesterol profile to make sure that MTM is working?  \*Shelby (WI) – for 1815, not looking at long-term outcomes for criteria to receive MTM as opposed to being on a statin or anti-hypertensive. For 1817, will have access to look at both who is being referred and the long-term outcomes b/c FQHC will query patient pop with uncontrolled BP and high blood cholesterol who would be referred to MTM via CHW. Both (FQHC and CHW) would record BP measurement to be able to see if MTM was helping to improve adherence and BP outcomes. Linking data for 1817.  Dora (RI) – re-reading this and wondering if one thing underlying this is that in some cases the work that the team chose as priority areas for moving the needle, are not always easy to match with the assigned performance measures. Some occasions we’re resigning ourselves to having a poor match with internal performance measures and know official data will not be great. For example, unlikely we will move the needle on EHR adoption b/c as a state we are maxxed out, so looking at QI measures internally.  Mojde (NV) – the FQHC we are working with said they can select pts appropriately, but what are others doing?  Lara (ND) – taking a community pharmacy approach b/c there are very few chains and few FQHCs have pharmacies within them. Helping them track their metrics for the patients they choose. Start with one chronic disease and go from there. Hoping overall metrics will improve as well as patient metrics. Challenge for us b/c pharmacists have info all over the place and across platforms, a real struggle.  Mojde (NV) – how do you track BP and cholesterol?  Lara (ND) – most is patient self-reported from medical records. But goal is to have pharmacists take it. Not starting with cholesterol, looking to BP first b/c more comfortable with it.  Renato (CA) –Regarding the 1815 evaluation plans, how are the teams evaluating the program for each strategy? Within one year per performance measure or overall? One strategy per year across core areas or each year a different core area across strategies? How using the areas defined by CDC (approach, efficacy, impact)? For A1 – improve participation in ADA recognized DSME program – when you evaluate, what approaches are you using within the 5 identified by CDC? All of them or 1?  Shahid (VA) – This may be described in the guidance sent out by CDC. Not right in front of me, but guidance is that we don’t have to address each core questions every year b/c they are developed to be based off the stage of program implementation. Not necessarily have sustainability and impact in year 1. That is what I recall, but may be wrong.  Dr. Clark (FL) – 1815 and 1817 – to address this question, the approaches are different. Evaluation officer for 1815 is to address 5 different eval components ongoing for each year. Builds on previous year’s approach.  Renato (CA) – That is my understanding. Need to build on it within Category A each year of the grant.  Dr. Clark (FL) – We have a team of evaluators that work collectively and a person dedicated to each category.  Tiffany Burgess (CDC) – typed in chat box that Cat A is an overall approach for the total 5 years and not stepwise. Speaking – we requested a plan for the totality of the NOFO.  Marla (CDC) – Cat B, it is the stepwise approach. If you want to incorporate all aspects into your evaluation, that is fine. But for reporting, you are only required to report on that measure for a given year.  Tiffany (CDC) – if you recall, we provided guidance and gave sample questions for each core areas with the understanding that there will be revisions and changes as you flesh out the plan and the years go on. For this plan, you have 60 days to revise and send back the sustainability piece and impact. Based on what you are proposed to do for now, very high level, and understand that you can have some revisions next year. Want to make sure you have guidance and questions from the Category A webinar. Have 60 days to revise EPMP.  Renato (CA) – if you received feedback on May 1, deadline for revisions is July 1st?  CDC staff - If no feedback, reach out to CDC evaluator for 1815. 1817 feedback will go out next week. Revisions based on feedback needs to be submitted via Grant Solutions. 1817 feedback will be sent out next week, with info on how to submit, etc. soon.  Mojde (NV) – For the health impact statement, we need to identify an indicator. So can long-term outcome for Cat B go under health impact of effectiveness?  Marla (CDC) – Follow up with evaluator, but sounds like the request is for you to provide statement for overall impact and what you expect that to be. Not sure, so follow up with Cat B CDC evaluator for more clarification.  Kira (ME) – Understood there would be notes circulated from performance measure round table but haven’t seen it. Can we expect it?  Marla (CDC) – We compiled all of those, and the document is lengthy. Gone back to summarizing in clearer ways that people can follow. All the things people are in the process of getting out, will post in the AMP system as resources rather than distributing. Will have summary available, but I can also send to people in the next few days. Goal is to not send so many emails.  Kayla – request to post to people on this call.  Marla – will check with Letitia. Will double check and give it to you in the next day or so.  *See action item update.*  Emily (TX): How are states collecting performance measure data from partners? For example, are states creating reporting templates or letting partners do that? What frequency is data being collected? How is accuracy of data being verified? We are creating reporting templates, but what are other state doing?  Renato (CA) – we are considering our evaluation sample as a prospective cohort. Some tools are quantitative and some qualitative, mostly from local health departments who will partner with champions who will collect the data. we are using survey monkey to administer these tools. We collect them quarterly and annually. We have another tool to assess team-based care, which is done every year.  Jackie (Chicago) – similarly, have templates we created and will be sent out quarterly in survey gizmo asking partners to complete it. For eval and sites who are reporting, we need larger data sets which you cannot type in manually, so likely have them upload xls or csv files. May do it through gizmo – looking into it b/c it is going to be a limitation for that method.  Lara (NYS): For anyone building a web-based system for data collection, what is being collected and how? Challenges in the process? Strategies for overcoming the challenges? We have multiple data sources, but one is Catalyst web-based online data collection system which we also used in 1422 and are using again in 1815 to collect some performance measures quarterly and maybe more frequently with program side to monitor what is going on with partners. Testing it out soon. Exciting to use web-based system. There is a cost but unsure of total funds required. The company’s name is Spectrum Health Policy Research. Drawback is that tool does not provide partners a copy of what they submitted so not ideal for them.  Emily (IN) – we are going back to using a reporting template and what IL is talking about with uploading files, we use Simplicity, which functions like dropbox. Grant access to partners. Did excel online test run, but going back to this b/c we want everyone to know what they turned in/ The receipt issue got to people and not effective.  Other web-based tools mentioned in chat box: REDCap. Connect with Lindsay (AZ) [lschulz@email.arizona.edu](mailto:lschulz@email.arizona.edu) to learn morel  Other questions posed (through chat or email):  April (CO) - 1817 evaluation question: For bi-directional e-referral (A1 and/or B6), patients are being referred to evidence-based programs, which have already been proven to have positive patient level outcomes. Does it therefore make sense to report on patient level outcomes as part of Impact (i.e., seems like that may be more of an assessment of the program vs. the e-referral system)? | Requested notes from March grantee roundtable discussions included in EEC report out. Document will not be available on NACDD-EEC page, but you can expect to see this on AMP once it is launched. |
| 10 minutes  Lara | Feedback on EEC modernization efforts | * In January, we moved from conference call-only to Adobe Connect. How is this working for people?   + No response. * We have eliminated roll call and are capturing attendance information through the Adobe Connect interface. To what extent do people still feel like they’re able to “get to know” each other in the absence of hearing the names of everyone on the phone?   + Shahid (VA) – not allow us to get a sense of who is on call, Adobe is fine. Does diminish understanding of who is on the line, and that is a bit of a drawback.   + Renato (CA) – we really like Adobe with chat, files you can download, easier for us to follow   + Many chats that support the latter notion * What are other recommendations for how we can optimize these meetings and keep people engaged?   + Renato (CA) - calls archived?   + Kayla – archiving is done using the notes and minutes from each call, available on EEC webpage. We will make a note to organize this moving forward. | Refer to NACDD-EEC page for archived meeting minutes/notes and other resources that have been shared. |
| Adjourn  Belle | Next meeting Wednesday, June 12 at 2pm ET. Please email any agenda items to MaryCatherine or Kayla | | |

# Other News and Updates

**Torch Insight tool**

We would like to bring attention to Torch InsightTM, a health analytics dashboard, for state and territorial chronic disease directors and their staff. The easy-to-use interface allows NACDD’s health department Members to access up-to-date healthcare market data to support program planning. There also is an option to export the data and integrate it directly into internal reports to get deep intelligence about specific, target populations and potential partners.

If you are unfamiliar with Torch, you can review the webinars below. We will highlight some uses of Torch during our June EEC call.

* March 2018 webinar <https://vimeo.com/261485452>
* July 2018 webinar <https://vimeo.com/281965855>
* TorchInsight video for NACDD <https://www.youtube.com/watch?v=TtFue5G1g94>

**CSTE Annual Conference**

Meet Your NACDD Consultants (MaryCatherine, Hannah and Natasha) at the **CSTE Annual Conference and NACDD Exhibit Table. Conference schedule below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Event | Date | Time | Location |
| GIS Network Exhibit Table | Sunday, June 2 -Wednesday, June 6 | 10:00 a.m. - 5:00 p.m. ET | RCC Ballroom A Booth 8 |
| Breakout Session: Novel Data Sources and Methods for Chronic Disease Epidemiologists  State Health Departments Are Using GIS to Support Community-Clinical Linkages for Improving Blood Pressure Medication Adherence | Tuesday, June 4 | 10:30 a.m. - 12:00 p.m. ET    11:24 a.m. ET | RCC, 306A |
| GIS Network Roundtable | Tuesday, June 4 | 5:45 p.m. - 6:30 p.m. ET | RCC, 203 |
| Cardiovascular and Diabetes Program Surveillance and Evaluation for 1815/1817 | Wednesday, June 5 | 1:00 p.m. - 1:45 p.m. ET | RCC, 204 |