***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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| --- | --- |
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| NACDD Consultants | MaryCatherine Jones, [mcjones@chronicdisease.org](mailto:mcjones@chronicdisease.org)  Kayla Craddock, [kcraddock@chronicdisease.org](mailto:kcraddock@chronicdisease.org) |
| Date | June 12, 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  Belle | 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. |  |
| 5 minutes  Shelby | 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   No comments, though new members are always welcome! | 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  MaryCatherine | NACDD Updates | CSTE Update  Mary Catherine Jones – NACDD/EEC was a Bronze sponsor at the meeting. This gave our group the opportunity for an exhibitor table and couple of round tables – 1815 and 1817 epi/evaluation on the last day of conference. It did not feel quite as many chronic disease staff attended this year, but did have EEC members stop by and explain their work.  EEC Lead position available: We are looking for one person to round out the triad of EEC leads and assist with planning and facilitating our monthly meetings. They also attend monthly CVH Council calls. A job description is available in the Files box. If you have an inkling that you’d like to do this, please reach out to Shelby, Lara, MaryCatherine and Kayla. We are happy to answer your questions.  EEC exchange webpage – reminder that this page is available to EEC members.   * Login required to NACDD site * Link distributed only within EEC * Find meeting minutes from any past month here   Access the page here: <https://www.chronicdisease.org/page/CVH_EEC>  Zoom coming in July!  Kayla/Mary Catherine - We will take some time to test out and determine how best to use the platform for EEC calls. We will protect the information that is shared during the meetings (including any recordings, minutes, etc.) and limit to only EEC members via our private webpage. | Contact Kayla for assistance with accessing the page and/or submitting documents to share ([kcraddock@chronicdisease.org](mailto:kcraddock@chronicdisease.org)).  Review EEC leadership position descriptions to see if this is something of interest for you. Would love to have another EEC member take this role on by July. |
| 10 minutes  Lara | DPP Map | Growth of DPP among NYS targeted IMPACT Communities  Lara: In 2015 – funded with CDC 1422 State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke cooperative agreement. Through agreement NYS identified 4 partnerhips (clustes of communities/counties) throughout state who worked on a number of strategies.  Partnerships worked to establish new programs or enhance participation in existing programs. Work with communities with disproportionate risk of disease or SHD desparities.  Left map shows baseline of sites engaged in partnership counties. Right map – shows all of the sites engaged through the end of project. Sites were geocoded sites to show where participants could enroll vs. on path to enroll participants.  Good evidence to delay onset of DM through DPP yet the program is resource and time intensive.  Used data from BRFSS in both maps. In 2016 had expanded data collection to show county level estimates. Site level data is from web-based performance monitoring system (Catalyst). Used by partnerships (local impact partnerships) to document performance and DPP enrollment. ARC map desktop 10.6.  This is a final map, but used maps along the way to help with where to put resources and where to prioritize.  By the end of the project, partnerships were able to develop relationships to DPP sites in all 17 coutnies (6 at baseline which is an increase of 11). Total of 77 sites operating by end of grant period. And a total 1,112 participants were enrolled in DPP over the course of grant.  How to use map going forward – note that even at the end, there are some counties that they may only have 1 DPP site and some sites still not able to enroll participants.  Things to think about – larger metro areas – clusters of programs, and to think about how to reduce gaps in services in rural or more populated regions.  Question – DPP sites on path to enrolling – what state are they in? Criteria – whether a site was able to enroll participants or not. Not based on DPRP status. Went through sites that had partnerships for enrolling to see whether there was still an option for site to continue enrolling. If yes, they were “on path to enrolling.”  Do you have to do oversampling for the county level BRFSS measures and what is the cost? Rachael will send out info on county level BRSFF.  Updated data? not working with same partnerships now, and so not collecting these data but will reach back out to partners to share map with sites for feedback.  Will add to EEC resource page along with description. Update: awaiting DOH approval to share even on EEC website!  Caitlin (Maine) – like how easy to interpret and how you used BRFSS prediabetes vs. DM prevalence.  Lara - Improtant to split overall counts. Some earlier versions had prevalence, but when looking at # of sties and prediabetes it was the better match.  Adrian (MI) – interested in doing this – the size of sample that is needed for BRFSS.  Lara – can ask for more details and follow-up. Cost for questions?  Rachel (NY) – county level BRFSS.  Adrian – have you continued to keep track?  Lara – not working with same partnerships now, but will reach back out to partners to share with sites for feedback. | [Lara.kaye@health.ny.gov](mailto:Lara.kaye@health.ny.gov) |
| 30 minutes Belle | 1815 Hot Topics | **BRFSS**  Has anyone added the BRFSS SMBP module or used state-added questions that address SMBP for 2019? See below for the CDC SMBP module and list of states that CDC has as using this module. The BRFSS will be re-designed for 2021 and CDC is interested in discussing potential questions with states. Thanks to Jing Fang (CDC) for sharing this info!  For those of you using the module, how are you planning to analyze the results? Are there specific analyses you plan to do? What will you do with the information?  Jing (CDC) – Hypertension management is a priority. We are thinking of developing a cholesterol module.  We’d like to consider what would be helpful for 1815 performance measures.  CDC has a list of potential questions that they might want to use or is looking for states to get input on how to phrase the question. The questions in the agenda are being used now in the 2019 BRFSS. It is the newest module. We could develop similar questions for cholesterol self-management.  Greg (ME) – We wanted to use the SMBP questions in our upcoming survey. We had it in our budget and our CDC person told us that they didn’t think it should be included. What funding sources are states using to run this module?  Steven (WA): We added 2 SMBP questions and are using 1815 or 1817 funds for this.  Brittany (UT): We’re using the full module this year, using 1815 or 1817 funds for this. We didn’t discuss the BRFSS with our CDC representatives, but it was in our budget.  Tiffany (ND): We were told 1% of each categorical budget on BRFSS. This was actually addressed in the FAQs during the application period for 1815. But BRFSS is told that programs that use that data – and this is no limit. The cost of the diabetes questions – is more than 1% per category. So we have had to do some negotiating. We don’t have 1817 only 1815.  Belle (KS): We had it in our 1815 budget, some funds for HDSP and some funds for DM questions.  Brittany (UT): There’s variation in how much BRFSS questions cost in states.  Belle (KS): The variation is quite large.  Question offered through the chat: Mojde Mirarefin (NV): I am wondering if our state has a good system in place to collect SMBP data why do we need to add SMBP question to the BRFSS? The data collection is at the patient level and we can explore difference in SBP and DBP.  **Health Systems Scorecard/State Assessments**  Has anyone developed questions related to pharmacy/ist engagement with health systems and/or as part of team-based care? Specifically, have you developed questions regarding any of the following: existence of practice policy recommending SMBP; # patients in practice with HTN advised to SMBP; does practice use team-based care and/or PCMH model; types of providers on team; practice policy/procedure to create a self-management plan for people diagnosed with HTN?  Some of the CDC Health Systems Scorecard questions align with these (thanks to Joanna Elmi for these notes in advance of our meeting):           existence of practice policy recommending SMBP – CDC is updating the HSSC this summer and we will add this question to Module G: Self-Management and Care Management           # patients in practice with HTN advised to SMBP – The HSSC will not include this question since the possible response options are limited to yes/no/NA           does practice use team-based care and/or PCMH model – This question is in the HSSC in Module A. Multidisciplinary Team for Care Management Approach (Q1)           types of providers on team – There are a couple of questions in the HSSC Module A. that speak to this: Q2 and Q7           practice policy/procedure to create a self-management plan for people diagnosed with HTN – In Module G, the HSSC has a question that asks “did your health system have a policy/protocol in place that required your practices to use any staff to work jointly with patients to develop their self-management goals?” This question can be assessed separately for patients with HBP, high cholesterol, pre-/diabetes, and obesity.    Rachel (NYS) - We created a health system assessment tool that was informed by the HSSC. Ours is very specific to how we’re implementing 1815. We have questions about practice and policies for SMBP and BP learner programs, trying to understand team-based care, including integration of pharmacists into the team and the roles they play.  Kristian (SC): We developed our own health systems assessment for FQHCs and rural health centers, which are our target population. We have questions about TBC policies and practices. We asked about capacity and established relationships with pharmacists, if they already have pharmacists on staff and in what capacity they work. We hope to do some TA site visits to get more depth on the extent to which they’re doing some of these activities and strategies. We have implemented most of the sample for our rural health clinics and are now rolling out the assessment with FQHCs.  Kayla: Can folks share their state-developed questionnaires?  Kristian (SC): Yes  **May Poll Follow Up: Overcoming Challenges with Differences in Category A and Category B**  Last month, our EEC poll showed that members are struggling with reconciling differences in guidance related to Cat A and B. Our May meeting addressed how some states are managing this. Has there been any inspiration since then? Ideas? New opportunities?  NACDD hears you. We realize this is causing a lot of issues and concerns from states. Your voices have been heard.  Lara – appreciate the awareness of issues for Cat A and B. | Please send your health systems assessments to MaryCatherine (mcjones@chronicdisease.org) and Kayla (kcraddock@chronicdisease.org) |
| 10 minutes  Lara | 1817 Hot Topics | Are there questions/issues specifically related to 1817 that folks have for the group?  Brittany (UT): How are people doing with updating the 1817 EPMP?  Kristian (SC): We had some information from Cat B that was useful, show us how we’re dovetailing our work with social determinants of health with 1817 evaluation. We’re having conversations with our chronic disease epi staff to see what data sources could help to support these efforts.  Brittany (UT): One issue for us that hasn’t gotten a clear answer from our CDC team has been priority populations vs. high burden populations. We thought they were 2 separate things. We thought you first identified the priority populations. Then, you would focus and identify the high-burden populations within that priority population. Are high burden subpopulations within the priority populations? Cat A said they are using these terms interchangeably. Cat B evaluator said that they are not. Confused about A vs. B and any evaluation guidance or whether this is programmatic guidance.  Rachael (NY): In 1422, priority pop was used interchangeably with high burden pop.  Marla (CDC): For Cat B, there’s a broader priority pop identified for strategies but a subpopulation that is more specific.  Tiffany (CDC): For Cat A. there are definitions in the NOFO. High burden population and subpopulation. DDT will address this further on subsequent calls. Tiffany will send this to MaryCatherine to send to the group. | Tiffany will send priority guidance to MaryCatherine to send to the group. |
| Adjourn  Belle | Next meeting Wednesday, July 10 at 2pm ET. Please email any agenda items to MaryCatherine or Kayla | | |

# Other News and Updates

BRFSS Home/Self-Measured Blood Pressure Module 2019

Known States:

Alaska

Connecticut

District of Columbia

Delaware

Florida

Georgia

Idaho

Illinois

Kansas (1)

Kentucky

Maryland

Maine

Mississippi

Montana

Nebraska (1)

New Mexico

Ohio (1)

South Dakota

Texas

Utah

Washington

Wyoming

**BRFSS Home/Self Measured Blood Pressure module**

**(ask only those with hypertension)**

1. Has your doctor nurse or other healthcare professional recommended you check your blood pressure outside of the office or at home?

1 Yes

2 No

7 Don’t know/not sure

9              Refused

2.Do you regularly check your blood pressure outside of your healthcare professional’ office or at home?

1.            Yes

2.            No [GO TO NEXT SECTION]

7. Don’t know / Not sure [GO TO NEXT SECTION]

9              .Refused [GO TO NEXT SECTION]

3.Do you take it mostly at home or on a machine at a pharmacy, grocery or similar location?

1 At home

2 On a machine at a pharmacy, grocery or similar location

3 Do not check it

7 Don’t know / Not sure

9 Refused

4.How do you share your blood pressure numbers that you collected with your healthcare professional? Is it mostly by telephone, other methods such as emails, internet portal or fax, or in person?

1.Telephone

2. Other methods (email, internet portal, fax)

3. In person

4. Do not share information

7. Don’t know / Not sure

9. Refused