**Welcome to EEC!**

|  |  |
| --- | --- |
| Register for EEC meetings here | <https://chronicdisease.zoom.us/meeting/register/d036cbbd925610a07510d14dfea9e911>  Please be sure to *download the appointment series* to your calendar.  If you are sharing a workstation, please be sure to enter the First Name\_Last Name (State) to the Chat for all members of your party so we can track attendance. For example ***MaryCatherine Jones (NACDD)*** |
| EEC Leads | Lara Kaye (NY), [lara.kaye@heatlh.ny.gov](mailto:lara.kaye@heatlh.ny.gov)  Shelby Vadjunec (WI), [Shelby.vadjunec@dhs.wisconsin.gov](mailto:Shelby.vadjunec@dhs.wisconsin.gov)  Emily Peterson Johnson (TX), Emily.johnson@dshs.texas.gov |
| NACDD Consultants | MaryCatherine Jones, [mcjones@chronicdisease.org](mailto:mcjones@chronicdisease.org)  Hannah Herold, [hherold@chronicdisease.org](mailto:hherold@chronicdisease.org) |
| Date | September 11, 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  Shelby | Welcome and Housekeeping | Instructions for joining Zoom  If there are multiple folks sharing a login, please enter everyone’s names and states into the Chat using this format: firstname\_lastname(state) |  |
| 5 minutes  Emily | 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   Abby Hoffman (KY): 1817 evaluator  Bao-Ping Zhu (NACDD): Director of Performance and Scientific Research | To add new members to the EEC list, please contact Hannah Herold, [hherold@chronicdisease.org](mailto:hherold@chronicdisease.org) |
| 2 minutes  MaryCatherine | NACDD Updates | Welcome to Hannah, our new NACDD co-consultant for EEC. Hannah and MaryCatherine have worked together on GIS projects. Hannah is replacing Kayla with CVH Council/Network and EEC.  Send us resources to share on the internal EEC webpage: <https://www.chronicdisease.org/page/CVH_EEC> | Hannah’s email is on page 1 of the agenda.  Please copy both MaryCatherine and Hannah on your communications. |
| 25 minutes  Melissa Moorehead/All In | All In Data for Health | DASH & All In  Robert Wood Johnson Foundation (RWJF), the largest health philanthropy, is working to address social determinants of health (SDOH). DASH is a RWJF project to increase compilation and use of data across sectors to address SDOH and health equity.  DASH is a partnership between the Illinois Public health Institute and the Michigan Public health Institute. Our mission is to empower communities through shared information, but increase local capacity and share data across sectors for health.  Social: refers to a construct and it is through law and policy and programs that are according to existing economic forces. That is particularly interested in the way they reflect distributions of power and resources an opportunity that themselves reflect generations of classism and racism. Measurement and impact of social determinants become more complicated the further upstream we go, which is why I imagine CDC and many others try to seek innovative ways to blur the lines between these means and interventions alone cannot address external conditions, they can we mitigate them.  Health: the existing measures of health are derived from healthcare and increasingly we want to talk about health in terms of well-being and equity. And it requires new ways of looking at it. There's a population level when a population represents an aggregation of individuals; the public-health level, which straddles those layers and seeks answers to social problems at a different level; and the community level--that intersection of an aggregate burden of disease at a local level or the resiliency assets, and cooperation between sectors and other things that can build a culture of health at another level.  A pyramid effect can be helpful to see how addressing those socioeconomic factors at the bottom and the lower part of that pyramid can have an impact on how costly and effective interventions are at the top of the pyramid.  DASH is still collecting data on data sharing work and every community we think as a unique set of conditions at different levels, but we also see commonalities to figure out where we can connect with others and help others connect to each other to advance working toward a culture of health. Common use cases is another way we codified this work since we are data and we are looking for multi sector partnerships that are using data in cross sectors for a number of different use cases or reasons.  There are two broad aims for data sharing: 1) whole persons systems of care and 2) place based systems. These have some overlaps in terms of sectors participating in the types of data collected. There is plenty of room for each of those aims to grow or improve at the data literacy level and the data systems level and most projects end up focusing more on one then the other.  DASH’s first funding opportunity funded 10 communities in 2016 and 2017. One was the Allegheny County Health Department Alliance for Health, which used Medicaid claims data about conditions prevalent at a ZIP Code and maybe at a neighborhood level to try to look for things that would have an impact on cardiovascular disease. They have it tool called the Framework for Epidemic Dynamics and used this to analyze whether making changes to certain conditions in a neighborhood with themselves extrapolate out into better health outcomes in that neighborhood. They found out that there were not specific elements to say that this one thing we need to solve and we will get a good health improvement. It did help to eliminate some of the connections and ways that the focus needed to shift a little less on housing but thinking more about housing as the public health importance itself.  Another DASH project was with the City of Chicago, which looked for different types of data that were present as part of information about neighborhoods like housing age, which they married with information on electronic health records when women came in for pregnancy related issues and childbirth, they could correlate the address within area that had high risk of lead paint exposure and then call up a targeted outreach from the housing department to check out the conditions at that person's home for remediation.  DASH Kickstart Grants: $25,000 for six-months for community impact contracts that are actionable and targeted. We are looking to find a certain thing is more geared toward creating and supporting those cross sector partnerships and sharing data across sectors. We will be offering more of those grants in the future and we are looking at different ways to fund this activity.  Mentorship program: we have a mentorship program that contains quite a few public health authorities and housing authorities, healthcare entities and a lot of different players.  We have tried to develop technical assistance opportunities for our awardees as well. We realized that no one organization or person or sector can solve four SDoH, and unfortunately no one is. We reach out to the other programs as we learn about them, like the Build Health Challenge and the New Jersey, the public health national Center for innovations, and others to work together to build an even bigger learning collaborative and that is at its heart what all in is.  All In: is not an organization, it is a confederation. Partners are aligned around these big missions and goals about supporting the sustainability of a movement that acknowledges that health is a product of different forces including environmental forces and we are all trying to build the evidence base to help people get a better start and move forward faster and harness the power of peer learning.  We have publications and we have a newsletter that people find useful. There is an online platform for the peer-to-peer collaboration and we offer webinars monthly on topics that come up from the all in constituency and we do peer-to-peer site visits both among communities that have been funded by an All In partner. With DASH people can apply for support assistance to visit another site.  Membership: Membership is open to everyone who is aligned with those mission and values and is working on building a culture of health. To join the online community, go to the All In website and sign up. You can also request the newsletter, a monthly newsletter that is created outside of the online platform.  <https://allin.healthdoers.org/> | See presentation slides  Reach Melissa Moorehead here: [mmoorehe@mphi.org](mailto:mmoorehe@mphi.org) |
| 20 minutes  Shelby | EEC Crosswalk for 1815/1817 | A subgroup of EEC members has been working on a crosswalk for 1815/1817 evaluation and reporting requirements.  We know that there are differences between a Category A or Category B and share the same understanding that there are frustrations. A few of us got together and started working on taking the evaluation plan as one Crosswalk and then kind of trying to lay out in different areas of where are the similarities and where the differences. We are still waiting for CDC feedback, but this will be posted on the EEC internal website.  We are working to include hyperlinks that would also be stored on the EEC website and everything would be at one stop. On the second page we list the due dates.  This document is still a draft. | Will be posted on the internal EEC page  <https://www.chronicdisease.org/page/CVH_EEC> |
| 5 minutes  Emily | Questions for Peers | April (CO): Questions re: 1815 PM  For the 1815 PMs, two fields that were added, narrative and setting. The webinar mentioned that the narrative field is the same as the progress notes, but progress notes change annually and you will have a different progress annually. We were thinking about including progress notes in the measurement notes section. Are other statesleaning in that direction? For setting, even though it is in each measure, any suggestions on how to answer this?  Emily (TX): The narrative part of my document is very condensed, but it is kind of a summary of what I put in the implementation brief, kind of a high-level snapshot of Y1. For setting, I have put three clinics and one internal medicine and they are located in East Texas, for example and the specific place where the strategy will be implemented. We’re mostly working in clinics and hospital settings where we can write about what kind of system it is and where it is physically located in Texas.  Tiffany (ND): In North Dakota we use the narrative to describe the data and how the data was pulled or the ranges that we used to have that and utilizing what tools. In the measurement notes we described that data a little more diving into how many systems participated in each data set, but we are not doing progress notes in these performance measures and we did not plan to do that.  Lara (NY): Is there a spreadsheet where CDC identified the measures that they will be reporting that we do not need to report? What was that document?  ?? (state?) We are using a performance definition document and in that document it says that some will be recorded by CDC but the Excel sheet did not have that specification so it created some confusion.  Lara (NY): So written into the definitions document for each category and Category B would specify there.  Emily (MN): I used the narrative section to provide context for the work we were doing for the strategy and description of our data collection methods. I included specifics related to the actual results in the measure notes to provide context for the work we were doing for the strategy and description of our data collection methods. I included specifics related to the actual results in the measure notes.  (??) Did anyone have problems with the cells being locked in the performance measures? I had to unlock it tab by tab.  Shelby (WI): I reached out to my CDC evaluators to get a truly unlocked one but they could not provide one. There is a way to unprotect the sheet or unlock the worksheet individually by each tab, however, if you're trying to do modifications, it will break some of the formulas that are being used.  Tiffany (ND): There was a new version uploaded mid-August that will allow you to enter percentages. CDC hasn’t announced this. |  |
| Adjourn  Shelby | Next meeting Wednesday, October 9 at 2pm ET. Please email any agenda items to MaryCatherine or Hannah | | |