**Welcome to EEC!**

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| EEC Members | 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 | Shelby Vadjunec (WI), Shelby.vadjunec@dhs.wisconsin.govEmily Peterson Johnson (TX), Emily.johnson@dshs.texas.govJulie Cleaton (AK), julie.cleaton@alaska.gov April Hendrickson (CO) AMP Liaison, April.hendrickson@state.co.us  |
| NACDD Consultants | MaryCatherine Jones, mcjones@chronicdisease.orgHannah Herold, hherold@chronicdisease.org |
| Date | March 11, 2020 |
| 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. |

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| Agenda Item | Discussion | Actions |
| **Welcome, Housekeeping and Polls**5 minutesEmily | Please enter your First Name, Last Name and State abbreviation into the Chat so we know who’s here. Welcome to our newest EEC Lead, Julie Cleaton, who will be joining us in April. Julie works on 1815 activities as well as a Cancer grant.Hannah - We are starting with a couple polling questions. You should see 2 questions about the COVID-19 response.Emily - most of us are working in chronic disease, but it seems that this may impact our epi or eval activities. However it appears that those who are assigned to the response will still continue their regular work duties.April (CO) - COVID support varies for Epi and Eval. Epis may be asked to help out more given their expertise.Deirdre (San Diego) - Two of my team have been tapped as surge support for GIS for our EOCDoes anyone want to speak up about how the COVID response is affecting your work with 1815/17?Lara (NY) - We’re early on in the process, so right now there is a volunteer list for a call center. We’ve been asked to sign up if we can be flexible about doing shifts at the call center. Most of us haven’t been assigned to shifts. It’s unclear until the schedulers reach out. It’s not clear whether individuals will be working primarily at the call center or just 1 day per week. It’ll depend on the individual. Once we hear more we’ll know how it impacts 1815/17.Shelby (WI) - There is so much unknown - like Emily said.Deirdre (San Diego) - We were already short staffed so this will slow things down. I anticipate that we are at the early stages and that things will be much more intense as soon as we have a confirmed community acquired case.Angela (WA) - In my small team of 5 people working on all chronic disease grants (1815/17) - my data support person got called out right before the PMs were due. My supervisor is now called out for a week working on the incident management team. Another on our team is being activated later this month. It’s really impacting our work.April (CO) - Epis are being asked to do more/take on a larger role given their expertise, eval being asked to help out with the call center. The 1817 strategy 3 media campaign program contact is being asked to do quite a bit of media work related to managing response to COVID-19. It hasn’t only affected epi/eval, but also the programmatic side. |   |
| **New Member Introductions**5 minutesShelby | EEC is a community of peers and we love to get to know each other. We also know that there’s a lot of talent in this room. Any recent professional accomplishments or kudos you’d like to share? If there is anyone who has been part of EEC for a while, you’re also welcome to re-introduce yourself at this time.If you were part of the EEC breakout group for the recipient meeting in Atlanta, Marla (from CDC) (aside from MaryCatherine) is the longest standing EEC member. There are lots of you out there who have been members for a long time. I’ve been with EEC for 5 years.Emily Styles (MN) - Epi/PM reporting for 1815 and 1817 In position for 5 yearsAngela (WA) - I’ve been with EEC since the beginning. Carrie Oser (Montana) - Epi/Evaluator for Cardiovascular Health Program for more than 10 years. I've been a member for many years. | If you did not receive a calendar appointment for this meeting, please add your email address to the Chat and/or email Hannah (hherold@chronicdisease.org). |
| **NACDD Updates**3 minutesMaryCatherine | EEC will be offering a roundtable this spring to follow up on the January discussion about changes in hospitalization rates for CHD, HF and HTN. We are working with CDC DHDSP Epi and Surveillance Branch to see how national data compare with the data observed in NYS and ME. Caitlin and Rachael have agreed to co-facilitate this roundtable. We will let EEC know once a date has been identified.Based on EEC email discussions, we are developing an EEC roundtable for April to go into more depth on the topic of which option works better: embedded epi/evals in programs or separate epi/eval units. Angela and Anna have agreed to co-facilitate this. We will focus on the epi/eval perspective in these discussions but programmatic staff are welcome to attend. Hannah sent out an invitation from HealthSystems@Chronicdisease.org for Tues. 4/14 from 1-2pm ET.NACDD will be awarding travel scholarships for a few GIS Network members to attend CSTE this year in Seattle. If you would like to be added to the GIS Network list to learn about this and other opportunities, please email Hannah. Hannah - the March GIS Network Newsletter is scheduled to go out tomorrow, 3/12. If you do not get that newsletter please contact Hannah and she will add you to the mailing list. The newsletter will include the details on the travel scholarship.CDC is looking for input from states about changes to 2020 Census methodology. See webinar info below. | Check the internal EEC webpage for meeting notes and updates: <https://www.chronicdisease.org/page/CVH_EEC>Not getting Off the Cuff, NACDD’s weekly Monday newsletter? Email Hannah for assistance hherold@chronicdisease.org |
| **AMP Update**3 minutes April  | * Slides and recording from 1815/1817 Cat A Feb. EPLC-Evaluation approaches for DP18-1815 Category A strategies A.6 and A.7, and DP18-1817 strategy A.5 (unable to attach the recording due to file size restrictions)
* Link/URL for 1815/1817 Cat B Feb. EPLC-Evaluating Telehealth and Cardiac Rehab Strategies:   <https://adobeconnect.cdc.gov/pt6a11mntc2c/>
* 1815 Category A & B Evaluation and Performance Measure Reporting Webinar 2/11/20 slides, Q & A, and recording (unable to attach the recording due to file size restrictions)

Are there plans for both cat A and B to keep the calendar updated on the EPLC meeting? Where should folks get updates?Tiffany (CDC) - I will talk to leadership - everyone should get a calendar tag via email regarding the dates. Going forward, 1815 and 1817 will be separated for Cat A. I will see if we can also keep the AMP calendar updated as well.Upcoming conference calls:* 1815 Category A Evaluation Peer Learning Community (EPLC) call scheduled for April 16, 2020 from 3:00-4:00pm EST. The topic for discussion will be Evaluating Strategies to Engage Pharmacists in Providing Services to People with Diabetes.  Is there a set date on which Cat A EPLC calls will be offered moving forward? –for CDC DDT
* Cat B posted information about the EPLC to the Rigorous Evaluation Group feed. It looks like they plan to hold EPLCs the 4th Thursday of the month at 3pm (see attached overview doc)—Can CDC DHDSP confirm this?

April (CO) - Has the 1817 Year 3 APR webinar been posted to AMP?Marla (CDC) - I will follow up on that.April (CO) - Can you confirm that the EPLC calls will be monthly moving forward? Marla (CDC) - fourth Thursday of each month. We’ve been doing these for 4-5 months now. There may be some months we don’t do it, but that’s our general plan. We’re open to any feedback about the best way to organize those.April (CO) - Cat B will be 4th Thursday, and Cat A will be 3rd Thursday?Tiffany (CDC) - Cat A will be quarterly. The first call had 1815 and 1817 together, but the calls will be separate now and on a quarterly basis. |  |
| **Questions from States**25 minutesShelby | As MaryCatherine said - we will be having a roundtable to address the epi/eval question.Update from Anna Hamilton (LA) regarding emailed question to members about separate vs. embedded epi/eval staff.Anna (LA) - To provide some context for this question, originally, our bureau had our epis and evals in separate divisions. The majority of our staff are located in New Orleans, whereas programmatic staff were in Baton Rouge. There was organizational and physical distance. We piloted a move of the evaluators to the programmatic division with the hope that having one eval for each program division would let us work more holistically rather than being reactive. We wanted to be proactive and look at eval as a whole. Once of the concerns was would we lose the autonomy of eval or collaboration between evaluators. How are other states organized? Do they have this structure with data in a different division, or are evals also with program staff? What are the pros and cons of both setups?MaryCatherine - I know you heard from some people, can you give a general takeaway of what you heard?Anna - I got a lot of responses, they were all helpful. The consensus was that the closer evals can be to program staff, the better. The more you understand what is happening in a program, the richer the eval can be. The other big answer was that there should be a separate space, either a workgroup or expert evaluator where the evals can get together and discuss best practices or throw ideas off each other. The expert eval would be someone they could come to answer questions about methodology or answer questions about best practices. Some answers were that if someone needed to receive negative feedback and that person was a supervisor, it would be a difficult situation, but overall people agreed the pros outweigh the negative.MaryCatherine - I’m looking forward to having this discussion in April and hearing more answers.We also have a question from Rachael in New York State.Rachael (NYS): I have another surveillance question. We just started analyzing our 2018 BRFSS data, we are trying to do some validation, and in that process we saw that after being quite stable for a few years, we saw a pretty significant decline in the prevalence of testing for high blood glucose in the past three years (part of the prediabetes optional module). After holding steady at around 58% for 5+ years, it dropped down to 51% and we cannot figure out why. We don’t appear to be seeing any changes in other indicators, so are wondering if something is going on in terms of the coding or introducing some systematic bias. Have other states experienced similar declines? If you haven’t gotten around to analyzing yet but do at a later date and see something like this, I’d be interested in hearing that as well.Shelby (WI) - This is another great question. I don’t know if people are not aware, haven’t gotten a chance to look at the data, or if they’re trying to speak but on mute. You can also type in the chat box. From WI perspective, ours hasn’t changed that drastically and has stayed in the same range, but we’ve also had some variation over the years.Dora (RI) - Hi Rachael, Unfortunately RI did not include that module in 2018.April (CO) - I don't think CO consistently administers that module to be able to monitor trends.Angela (WA) - I haven't analyzed the data yet, but will share results with Rachel once I get it done.We’re going to move on and open it up to other general questions. Feel free to continue to answer Rachael’s question as well. Other questions from states?Lena (WI) - Rachael, echoing what Shelby said, WI hasn't had the same trend as you, but can share results with you. We've run the module 2011-2014 and 2016-2018Elizabeth (IN) - How wide are the confidence intervals for both years?Rachael - I’d have to check, but I know they’re pretty tight. It’s a significant difference.Shelby - Any other questions? Understanding that we have state recipients and CDC on the phone. I’m not hearing any, let’s transition to 1815/17 evaluation, but feel free to jump in during that discussion if you have questions. We can also address questions on future EEC calls if we don’t have time now. |  |
| **1815/1817 Evaluation**20 minutesEmily | 1815/1817 Evaluation DeliverablesEmily - the next section is a question posed by Lara regarding the process model (the evaluation deliverable) for 1815. This was announced in the EPLC webinar on Feb. 11, there is a whole slide deck about it on AMP. Lara’s question is about whether other states have ideas on how to create this and if they have resources they could share that they’re using to develop this process model or previously developed process model.Lara (NYS): CDC has requested a process model for Category B evaluation. We are trying to become familiar with the Cat B Process Model deliverable and understand the value it offers. What ideas have other states had on how to create this? It looks like the design can be state-driven. How will CDC aggregate it across states/use the info in a comprehensive way?Lara - we’ve been reviewing the guidance for the report coming up for 1815 for year 2, and part of the ask is including a process model, which was not part of our original plan for this. In reviewing the webinar and some guidance documents I’m starting to get an understanding of how we’re supposed to use this, but also challenged because our original plan addresses the questions we laid out and identifies indicators for that. This seems a little duplicative, I’m trying to get a sense of the added value of this deliverable. How is the CDC going to use this process model? Is it an internal process for evals to review in writing the report? Are other states having similar questions or concerns?MaryCatherine (NACDD) - is there anyone from CDC Cat B who can address the question of how CDC will use this info?Marla (CDC) - As Lara said, a lot of this is for states own use for program improvement. The Core Areas are outlined. We got a lot of questions about efficiency. In some of the guidance we gave a while back we tried to come up with ways to help recipients think through efficiency, as well as allow the opportunity to think through inefficiency. A lot of states have had issues getting contracts and programs going, so they may not be able to say at this time what was efficient, but they could identify places where things didn’t go as planned. We came up with a few examples to help people think through ways they could address efficiency and inefficiency. For all eval deliverables we do have a process for analyzing these, doing a summative analysis. We’re calling them memos that outline what we’re seeing that recipients are describing in the categories. We’ll be doing something similar each year. We’re doing this so state recipients can build towards showing impacts in final years. There is a lot of flexibility in terms of what people want to use. We always have a lot of mixed feelings about providing examples because we don’t want it to seem like that example is the prescribed way of doing something. But people had a lot of questions so we wanted to give an example. It’s by no means the only way to do it. We tried to give links to resources for people to look at. Please don’t feel like you need to use the model we provided or do it the same way we did it. We struggle with examples but in this case erred on the side of providing more examples.Lara - should there be an additional diagram modeling out, something of your own choosing?Marla - yes.Can other states on the call speak to resources they are using to develop this process model? Models? Examples? Does anyone have ideas of how they’re going to acquire the information needed for the model?Tiffany (ND) - Our biggest concern/issue is that we work with multiple health systems. They are all in different places w/ different successes and challenges. Do we pick one health system and do a process model on them? Or do we need to do one on each? There is no way to do one for all of them because the same model will not apply to all.Marla (CDC) - It’s whatever is most beneficial in terms of the work with your state. If you’re really trying to identify where things could be improved, you may want to focus on one partner or system where there seems to have been challenges. Look at where something was planned and didn’t work out, or where things could be more efficient. Or you could look at where things did work with one of your partnerships. You don’t need to do everything about everything.Anna (LA) - We have that same issue. I'm planning to pick one health system or a selection of health systemsEmily (TX) - Does anyone have other questions about process modeling? I know that my CDC evaluator told us that we should feel free to send in a draft example as we’re working on it in the coming months to get their feedback. I’m sure this would apply to other project officers or evaluators. That’s an idea.Emily - perhaps there will be more questions in the coming months as we put these together. If you think of a question feel free to reach out to MaryCatherine or others on the top of this agenda.MaryCatherine - We have some opportunities that we’ve talked about and we plan to convene to discuss topic-specific items. We may have another call offered.Emily (MN) - I have one more question. We are looking for an example of a provider satisfaction survey related to implementation of clinic based strategies. Something that assesses improved job satisfaction or efficiency, etc. as a result of the new protocol. Has anyone used something like this and would be willing to share?Susan (?) - I have a survey we created for a Diabetes ECHO for providers. It isn't exactly what you are looking for but may be helpful. I collected various different info from other provider surveys.Emily (MN) - I will take anything similar! Please email to emily.styles@state.mn.usMaryCatherine - I think at a minimum, we can include this in the notes and also include this in the email when we send notes out.Marla (CDC) - One small announcement. So people know, in the next few days we’ll be posting on AMP recipient profiles and PM snapshots. This will be a snapshot of recipient activities and PMs. We have drafts for Year one, these will be posted to AMP. These won’t be shared publicly, but starting Year 2 they will be posted on our website. This is for people to look at them and keep in mind the info is from Year 1. This is Y1 activities from the APR and PM data. Soon, we’ll have 1817 snapshots posted as well. Some of it may look older but keep in mind that it’s everything from year one. There will be an email with this info.Hannah (NACDD) - will this list the strategies?Marla (CDC) - First page will be summary info on the state (which strategies they selected) and second page will list strategies, the key activities, and the performance measure for Year 1.Kelly (CO) - In response to Lara’s question, I have created an early draft of a process map for our health navigation (CHW) strategy using a handy tool I discovered called Plectica <https://www.plectica.com/>. It's free if you keep it under 100 boxes and I've found it to be easier to use than PowerPoint for mapping systems. It remains to be seen whether it will ultimately have all of the features necessary to meet the specifications illustrated in the CDC example.MaryCatherine (NACDD) - Remember that if you’re working on drafts or anything you’d like to discuss, we can always make time on the agenda to include that. Please send things to myself or Hannah prior to the meetings and we’ll add it to the agenda.We look forward to speaking to everyone next month. |  |
| **Adjourn-Next Meeting Wednesday, April 8 at 2pm ET.** |

# Other News and Updates

**Subject:** Census Bureau’s new Differential Privacy Methodology & Potential Health Data Implications
**When:** Tuesday, March 31, 2020 11:00 AM-12:30 PM (UTC-08:00) Pacific Time (US & Canada).
**Where:** See Zoom info

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**Changes to Census 2020 Methodology: What Are They and How Will They Impact Your Work?**

Starting in 2020, the Census Bureau will be implementing a new stringent disclosure avoidance measure called differential privacy. This procedure, which introduces noise into enumerated population counts, will have important implications for two of the most widely used scientific data sources in the world (decennial census and American Community Survey). Though state population counts will remain unaltered, all other geographic levels could be subjected to noise injection, which will impact many sectors, including public health. It is important for public health practitioners to understand the implications of this change and to develop a set of best practices. In this webinar, speakers will discuss the details of differential privacy, the underlying policy rationale, and provide examples of its potential public health implications.

* Dave Van Riper (IPUMS): Differential Privacy and the 2020 Decennial Census: Implications for Health Scientists
* Lance Waller (Emory): Differential Privacy, Synthetic Data, and Spatial Statistics:  Can They Fit Together?
* Karyn Backus (CT Department of Health): Impact of Differential Privacy on Public Health Indicators

For questions related to this webinar, contact Linda Schieb at ekf7@cdc.gov

***Data Compendium***

The U.S. Department of Health and Human Services (HHS) and other federal partners have released an updated *Compendium of Federal Datasets Addressing Health Disparities*. The Compendium was produced by the Interdepartmental Health Equity Collaborative (IHEC) and hosted by the HHS Office of Minority Health. First released in 2016, the Data Compendium serves as a resource that identifies the relationship between socioeconomic factors, social determinants of health, and health equity. This updated Compendium includes descriptions of more than 250 databases, information relevant to public health crises, and information on datasets with more controlled access.



Click on the link or paste the link in your web browser to read the compendium.

<https://www.minorityhealth.hhs.gov/assets/pdf/2019%20IHEC%20Data%20Compendium_FullDocument_RegularFormat%20-%202-6-20-508-2.pdf>