Minutes

**Community Health Needs Assessment Collaborative (North)**

**Hosted by Westside Healthcare**

**300 Water St. Suite 200**

**Wilmington, DE 19801**

Date | Time 2/1/2017 2:00 PM | Facilitator: *Peggy Geisler*

*Attendance: Brian Rahmer, CCHS, Maggie Norris-Bent (on behalf of Lolita Lopez), Westside, Kathy Matt, UD, Ebony Brown, St. Francis, Bettina Riveros, CCHS, Peggy Geisler, DCHI, Arek Tatevossian, St. Francis, Matt Swanson, DCHI, Edhraim Kaba, HJMC*

Committee Purpose: The CHNA Work groups will oversee the integration of clinical data and the coalescing of common metrics across the clinical delivery system and with community-based organizations for the purposes of aligning strategic initiatives to addresss converging clinical needs and social determinants of health.

**Minutes**

Update on Healthy Neighborhoods – Wilmington/Claymont

* DCHI as an anchor/backbone agency is working to build an infrastructure focused on the Triple Aim.  DCHI’s population health effort is overseen by the Healthy Neighborhoods Committee, which is working alongside committees focused on workforce development, payment transformation, clinical outcomes, and patient/consumer advisory.
* Within the Healthy Neighborhoods Committee, three subgroups have been formed to better operationalize this work. One group is focused on Data (includes epidemiologists from multiple sectors across the state), another on Sustainability, and then this Community Health Needs Assessments Committee convenes healthcare systems in the northern, central, and southern parts of the state.  All three of these HN Subcommittees are responding to and providing information and resources to equip Healthy Neighborhood Lead Councils with the information and resources they need to address their communities’ pressing health issues and to strategically align with priorities identified by the healthcare systems.
* A Wilmington/Claymont Council has formed and had a soft launch on 1/31. Task forces of the Wilmington/Claymont HN Lead Council have also formed and been meeting to address some priority health areas. A Behavioral Health Task Force has formed a robust group. HN staff have also met w/members of the Wilmington Consortium, a group focused on maternal/child health and in operation for 25 yrs w/infrastructure that goes across neighborhoods. They have already done programmatic implementation (HCA, community programs, baby showers) but one area of need is how you change systems and policies.
* Chronic Disease Task Force has formed. Small group of attendees but enthusiastic about collective impact. Still assembling so no specific health issue focus yet. A Healthy Living Task Force is also being established.
* Downstate, the Sussex County Health Coalition has partnered closely with Healthy Neighborhoods and has transformed into a Healthy Neighborhood structure as of 2/1.   The Sussex Coalition’s efforts to review, assess and effectively communicate offerings of diabetes management classes in the county so providers could make better referrals and help fill the classes is one example of how local councils can engage in systems coordination with healthcare partners.
* Efforts are currently underway to launch a Dover/Smyrna HN Lead Council as part of the 1st wave.

Data

* Clinical data should not be the driver, rather how does it marry up w/community assessment data? Ex. ER study- patients presenting w/physical ailment but secondary diagnosis was MH. 50% of people coming in w/these issues had secondary diagnosis.
* Emerging Trends from CHNA: Much overlap. Opportunities exist for access to care, MH and MCH. Drill down if you want to get to the root of matter.
* Moving forward- what is your data showing around your patients? Ex. Oral health main driver in ER. CCHS- coming to ER for short-term care and $ would be better spent in prevention
* CCHS screened everyone admitted through mid-year for substance abuse- picked up hundreds (500 in 6 mo’s that otherwise would not have been captured)
* Overarching trend is that evidence shows us that formal pop health agenda has to be inclusive of connected sources of data beyond clinical setting. Census and zip code level data of SDH and now more formal arrangement of hospitals, partnerships, and others on patient level clinical info. Frame of reference for Data Committee is “understanding your local community”. We’ve agreed to a scorecard, but it doesn’t look at critical indicators of priority health issues. Data committee has been tasked to pull together every bit of resources they can around that program, but also spear heading all of the community data.

CHNA- Strategic Charge

* What are the priorities and the value of HN in playing facilitator role? DCHI has convened the northern delivery system to discuss individual priorities and strategic alignment. On other side, DCHI is convening Healthy Neighborhoods across city and bringing in folks who aren’t typically engaged in a health conversation. Think in terms of what things you are really focused on across these neighborhoods in order to build strategy around that.
* Concern: This is a very high level discussion. We need to come to residents’ level of understanding. Great need and disparities. This body could help address that.
* Proposal: Begin by focusing on access to care. What does it mean from each HCP perspective and how is that defined by the community? Although access to care was not indicated as a priority for all, everyone defined it a little bit differently
* In NCC what does access to priority care look like in all of our communities? Also, how to bridge gap as to why people are going to EDs and not able to access PCP
* CCHS has data on appropriate use of ED and PCPs; CHWs study- saw shift in delivery of services- utilizing primary care in more services. Coordinated approach that holds up sustainable CHW. Strategic element of what CHNA is supposed to assess- build strategic plan w/strong community engagement component to be responsive.
* Next Steps: Take a deeper dive on access points- what does that mean and look like? Look at mechanism of standing up a CHW network: mobility and transportation, cultural barriers, etc. CCHS found that most ED visits are mid to acute. Medicaid analysis found similar severity. However, CCHS is plowing forward on CHW front.
* How many people are actually using a PCP, walk-in clinic, ER? If patients don’t pick a PCP, they are assigned one based on location. Spent resources convincing people they’re consumers of healthcare. Not strong evidence that people who tend to be sickest/costliest tend to overuse a certain aspect of system like ED, but underuse for long period of time followed by very costly intervention and then put them back in environment that caused same condition in first place. Middle income women w/children using ED the most.
* Mediating role of CHWs- -can be a value add and have relatively constant contact w/broader system. Ex. FQHCS working to help residents know about local services available. HJMC is sending out info. door to door, bringing in psychiatrist, and expanding hours to be sure to provide care. Westside faces similar challenges to HJMC, especially in the Northeast.
* Health data doesn’t always address problems w/resources in DE- ex. Transportation- Paratransit, buses and other transportation may run late, or not run all day. These are issues that CHW won’t be able to resolve. Unified voice needed for policy advocacy.

Next Steps:

* Set up regular meeting schedule. Need 1 ½ hours. Need to build a working relationship around a common goal. Need to understand landscape of access and operationalize it via policy, resources, and collaborative programming.
* Helpful for each organization to define access and bring data. Start w/Wilmington/Claymont. Ex. Use 2016 data to look at where patients are coming from by zipcode.
* Primary care data- Primary care looks very different. Could develop rubric or survey as a framework and begin to prioritize what each group stands to gain if issues w/access are alleviated (ex. shifting from ER to PCP).
* Need data around those not accessing PCPs (uninsured and/or not utilizing). DPHI Household survey may be a source. Brian will compile and present at March meeting.
* Identify alignment between CHNA Implementation Plans and Healthy Neighborhoods- Are there pieces that all of us are trying to put together that are suited for the objectives or missions that DCHI/HN has set out to do? Ex. Commit to prioiritzing strategic implementation of CHWs (Maybe DCHI hires and works collaboratively w/institutions.)

**NEXT Meeting: Thursday, March 9th from 8 am – 9:30 at Westside Health on Water Street (pending availability).** Committee will meet the 2nd Thursday of each month from 8 am – 9:30. A recurring meeting invite will be sent, along with reminders for action steps.