Minutes

**Data Committee**

**Hosted by Delaware Community Foundation**

**Community Services Building**

**Conference Room 109**

**100 W. 10th St.**

**Wilmington, DE 19801**

Date | Time 2/3/2017 9:00 AM | Facilitator: Peggy Geisler

 ***Attendance:***

*Emily Vera, Dave Crimmins, Matthew Christensen, Vik Vishnubhakta, Matthew Willaims, Donna Mahoney, Sheila Bravo, Nicole Moxley, Peggy Geisler, Brian Rahmer, Noel Duckworth, Deb Burton, Steve Martin, Donna Snyder-White*

Committee Purpose: To help support local Healthy Neighborhood Councils with a focused, consistent and viable plan for data collection and management, and to help gauge and measure the success of planned strategies for improving population health.

Minutes

January meeting minutes were approved.

Recap

* Chart provided to review DCHI Committee, Council and Task Force structure
* Each Healthy Neighborhood will be working on plans. Each plan will need data for catchment areas and to establish baselines. Communities will also need to determine what is realistic based on this data, develop a dashboard and a plan to work toward those metrics.
* Communities need access to data, and help with application. Communities may need help moving beyond outputs or short-term outcome measures.

SCORE Card Review Clinical & Healthy Neighborhood

* Re-cap Maternal Child Health
	+ Babies Born Healthy- to term and determined by birth weight
	+ Developmental Milestones- assured that we can get that data
* Review of selected MIH-Related Data Sources (Vik)
	+ American Community Survey (ACS)- Having one data source that is consistent and updated on regular basis allows for comparisons to be made to other states, w/in state and w/in specific communities.Good news: Easy access to get granular data; Bad news: Hard to drill down to zip code or census tract level
	+ UDS Mapper- allows us to go on a website, click on zipcode, one metrics listed is low birth wt itself . Took 60 or so zips in state and aggregated into zones. More of a community-oriented set of zip codes. DPH administers the MIC-V every 5 yrs to do a needs assessment and identify at-risk zones (i.e. SES, poor birth outcomes, etc.) This is a statewide document, but it can be drilled down to a dashboard and sent out to this committee.
	+ MIC-V Needs Assessment – most recent is from last year. Using data and national sources. ACS, PRAMS (state-specific), Healthy Women/Health Babies data (can look at zips)
	+ Child Dev Watch- depending on how referral came in, if direct referral from birth-3, was put in a separate system. Might be a source of additional data.
	+ Challenge w/zips/census tract- It is popular to look at county health rankings, yet not very useful in DE. Benefit of County Health rankings- can compare across counties of similar counties. But NCC gets lumped in LA county (?) Aggragating zip codes into zones provides more meaningful analyses. Premise of HN was built on county health rankings. Have to be able to communicate these issues to the HN Committee
		- Trend Data: One drawback w/M/CH data is that there is always a lag. How far back to do comparison to do trends? W/in last 5 yrs. 2010-2014 data. Only looking at ACS because its the most recent data.
		- Zones- can still aggregate up to county level or cross-over? Don’t cross-over. Tricky w/Milford and Smyrna. Could look at overall measures w/in county and look at the zones. For those that dominate- could use as a tough proxy. Ex. Adverse poor outcomes- tends to occur in specific zones. That is what DCF does on their site.

Data Needs

* CHNA Committee wants to drill down and understand access issues, especially for hospitals having extremely poor birth outcomes. Just because patients signed up for insurance doesn’t mean they’ve accessed healthcare. If access is a problem, increase CHW doing outreach- if you sign up, you get assigned a PCP, and ensure that they’re connected.
	+ Prenatal care utilization is captured in PRAMS- self-report. Weighted avg so get an idea how overall state would’ve responded. Data available retrospectively up to 2013
	+ Sussex- plenty of providers but access barriers like transportation. Can’t address until we know where those pockets are.
	+ DCF- going to be interested – can drive philanthropy in those high risk zones
* Key considerations regarding access:
	+ Childbirth is a unique healthcare experience- doesn’t tie to ongoing or prior access issues. Relative to prenatal care, system has done a good job to make sure that that aspect of care delivery experience is robust and well distributed. Gains made in measures of prenatal care pretty good, but still haven’t made a dent in racial disparities. If we’re equating that measure and building resources around that, there’s a disconnect. What is it that we’re not doing that we should be doing? There will be some marginal benefit gain for hospitals to be working together, but question is setting a goal that will address disparities in infant mortality. Actions need to match up.
	+ Meredith Evans study broke US into 63 counties. Redtistributed health outcomes and mapped out. Lots of counties at far end (poorest). Some states include both high and low end. Construct shows grouping of health outcomes are very much similar regardless of state. Extrapolation at state level, so it means we should begin to look across census tracts and group ones that are alike relative to their social determinants of health. What is it that certain places are demonstrating that others have or don’t have? Lot of data out there of states who’ve set a goal of improving pop health vs health equity. Some have set both. Those states have only been able to do one or the other, not both at same time. Important considerations for understanding what we set out to measure against a dashboard of indicators.
* Should HN focus on health equity data?
	+ HN is starting in these areas. We know there’s a housing, workforce dev, school problem. Need to be able to make an argument around that.
	+ Communities understand what it is that is keeping them back from thriving -data would help validate that. Policy makers need to understand and pay attention to health equity data. Fundamentally political choices- the distribution of material resources across communities and societies is the very definition of health inequity.
	+ DCHI needs to be focused on policy. If dashboards aren’t representative of those things, can’t create a policy agenda representative of that. Plenty of dashboards exist, but need ones that address health inequities.
	+ DCHI efforts have to include policy, system levels change and organizational capacity.
	+ Proposal: Look at a set of outcomes and outline back. Ex. Infant Mortality 🡺SIDS 🡺what’s causing it? Safe sleep environment vs. co-sleeping 🡺 Social Ecological Model (what’s occurring in zones where SIDS is or isn’t an issue). What are the important elements of intersections along pathway that gets you to ultimate outcome defined by funder?
		- Implication: For certain communities, approach may look different. Some strategies are going to be universal, like baby boxes. In African-American population, the data is clear that there is a 40 yr multi-generational embodiment. We can correlate those elements of inequities to disparities and pin point safe, affordable housing, violence & trauma prevention, ability to hold and maintain job w/livable wage.

Behavioral Health and Substance Abuse

* UD administers the Youth Risk Behavior Survey (YRBS) and Delaware School Survey (DSS) which includes data on substance abuse and behavioral health. UD doesn’t publish data below county level, but if you partner w/a district or school, they can give permission to use their data. Can use YRBS data for regions. Can also aggregate data over other years. Difficulties when talking about zip code, census data and communities. A Prescription Drug Monitoring group is coding at census track level and has access to DELJIS to overlay criminal justice data.
* Does DE have data on substance abuse by adults? No, just BRFSS, but does not include cigarettes and alcohol. Admissions thru ERs provide data for opioid overdoses. One hospital also looked at ER data and found that of patients presenting with physical ailment, 50% of those hospital admissions were MH related. Can hospitals tell us zip codes of patients? Yes, since the numbers they’re getting are large enough.
* DE has started participating in the National Violent Death Reporting System (NVDRS), but doesn’t participate in the Drug Abuse Warning Network (DAWN). DAWN was a public health surveillance system that monitored drug-related hospital emergency department visits in order to report on the impact of drug use, misuse, and abuse in metropolitan areas and across the nation. *NOTE: DAWN was discontinued in 2011, but SAMHSA is developing other sources of data on drug-related emergency visits*
* MH is pretty widespread w/different effects. Confluence of MH issues w/economic issues is what drives high risk in communities. Collecting MH data won’t solve issue.
* Scorecard has item on depression, but question is about not being able to go to work, so excludes those unemployed.
* For adult MH data, we can start w/providers and pull data from the DSAMH treatment database.
* Other data sources: ACEs via DE Household Survey, Law Enforcement data, YRBS alsohas data on feeling safe at school, and other data on bullying, which is a M/CH priority
* Proposal: Put all points together for zones
* State and NCC gov’t transition plans - need to look at efforts included in plans related to substance abuse & MH
* DCF is creating a list of cross-sector initiatives. DANA is comparing service delivery thru non-profits.
* Compared to the energy, time, $ and political effort to create all payer database, focus on pop health thus far has really only been improvement of patient experience and costs. Database as a culmination is supposed to represent all aspects of Triple Aim. But other piece is missing from data repository. What is equivalent for pop health?
* DHIN- Important to look at access to data and sources, especially since it is now being framed as a Community health record. What are the rules that a group like this can put around sources used and/or data that should be included in a community health record?

Update on SIM Funding Application

* Stakeholder funding provided to DCHI was being used to support PMGConsulting contract for Project Director of HN. However, CMMI has now approved that contract as an allowable cost in SIM grant, and so unrestricted funds will be freed up for HN infrastructure and programming. More details on this at next meeting.

Next Steps:

* Vik- Will provide zones and concrete data on measurements
* Steve- Will pull and present data on MCH zones
* Peggy- Will present on what SCHC has done
* Brian- Will prepare to discuss what Triple Aim means for the community mean and looking at pairing up w/DHIN db
* Explore big data grant from ACCEL
* Develop a system for local communities to access this committee- ex. Applying for a grant- huge capacity win for community

**NEXT Meeting: Friday, March 3rd, 9 -10:30 AM at the Community Services Building- Room TBD (the Data Committee meets monthly the first Friday of each month at 10 AM)**