

**Primary Care Action Group
Community Needs Assessment
Meeting on April 24, 2012
Minutes**

Discussion

- Lyn recapped the recent CHA CHNA meeting and workplan. CHA's three committees are Process, Product and Data. The CHA meeting validated the work that this group is doing
 - Norwalk Hospital has a very sophisticated product, but it was very expensive (around \$100,000) and an outside group conducted it
 - Hartford Hospital found that existing data was not sufficient
 - Griffin is linked to Yale through its Prevention Research Center
 - This group has not yet made any decisions about spending funds on the CHNA
 - The product of established groups will surely differ from this group's newer product, but comparing benchmarks to each other is key
- The City of Bridgeport has done three needs assessments in Bridgeport over the last 6 years
- Subcommittees were reorganized to match the three CHA committees, as follows:
 - Health Needs Assessment is now Product
 - Asset Mapping is now Data
 - Process is a new committee for us
- We added Easton to our list of towns since it is in the area and will need to be covered by the hospitals as part of their CHNA
- Committee members are assigned as follows:
 - Product – Lyn (lead), Tom, interns
 - Process – Andrea (lead), Meredith, Lucille, Bill, Tina, Alison, interns
 - Data – Greta (lead), Sands, Amy, Patrice, interns
 - Behavioral Health – Tom, Jim, Meredith

Timing

- By summer 2013, the hospitals need to complete the needs assessment and have an action plan presented to their boards.
- This summer, interns will complete a baseline report card on each town (Bridgeport, Fairfield, Easton, Monroe, Stratford, Trumbull) using existing data and will identify what data is missing
 - The leads of each committee should meet with the interns early this summer
- The interns will also complete the asset mapping and have identified with the group the ideal survey tool/process to use

- By Labor Day of this year, this group should have a good handle on existing data and a recommended product

Next Steps/Follow-Ups for Reporting Back at May 22nd Meeting

- Lyn will find the name of the website that Jim Farnum is building with Bpt area data similar to DataHaven for New Haven)
- Lyn will send a grid that shows existing data that a past BH intern put together to the group
- Jim will report back on the DMHAS process as well as how to identify common data sets for behavioral health
- Lyn will ask CHA if they are looking at Medicaid utilization data or any oral health data
- Lyn will find out if someone from the UW can join this group
- Meredith will ask Orbit partners about oral health data
- Tom Krauss will ask UCONN for any oral health data they may have
- Sands will reach out to Polly in Easton to see if she has any interest in joining our group
- Interns will collect and analyze EMS data on the number of ambulance calls for transport and non-transport as part of our existing data review
- Interns will review 211 data for types of services being requested from our area
- Each subcommittee should meet before the May 18 CHA meeting. SET UP MEETINGS
 - Product lead: Lyn
 - Process lead: Andrea
 - Data lead: Greta

**Primary Care Action Group
Meeting on March 27, 2012
Minutes**

Discussion

- Hospital requirements for a Community Health Needs Assessment (CHNA) are still murky. Hospitals have flexibility in conducting their CHNAs.
- Towns do not have a prescribed methodology for their CHNAs but must involve the public, including consumers and providers; a visual presentation will be needed to engage the public. Andrea Boissevan commented that Stratford might re-engage the Healthy Stratford Council to serve as a focus group. The initial survey will serve as the foundation for future years' surveys, which can go more in depth as needed
- The CHNA process must be thoroughly documented, including meeting minutes. The process is just as important as the product. Other towns and regions have ideas that can serve as examples, and different towns have different perspectives. For example, Norwalk wants to be able to measure its successes, such as increases in mammography rates, while the Naugatuck Valley CARES survey, led by Griffin Hospital, has a broader scope than just health care
- The end result must be an action plan that the group builds together, but can be implemented differently in each community, depending on needs of the community; then all report back together and can modify the plan as needed going forward
- 3FOUR50 are three risk factors (nutrition, tobacco use and physical activity) that cause four chronic diseases that result in 50% of deaths. This has overlap with the CDC's Seven Winnable Battles. Other issues to consider include oral and behavioral health

Data Needs

- Andrea is interested in hospital discharge data on diseases like asthma. Health departments can target their community based on hospital data and work directly with key neighborhoods on key issues
- Town health equity index may be of interest
- FQHC data is a major element that is missing
- CHA is bringing together hospitals and town health departments to see how they can merge data and map it

Process/Structure

- An org chart was distributed that outlines the structure of committees in the CHNA
- This group's role is to:
 - Figure out needs

- Take learning and transfer them over to existing groups for implementation
- Greta Roberts from the Stratford Health Department and Lyn Salsgiver from Bridgeport Hospital will serve as co-chairs.

Resources

- Both Bridgeport Hospital and St. Vincent's Medical Center will have summer interns who will work on the CHNA. One goal is for them to create a comparative profile of every town using existing data indicators
- Look at RYSAP data (Bob Francis)
- Look at Datahaven data (Betsy O'Connor)
- Will need to determine future financial resource needs

Timeframe

- The intent is to complete as much of the asset mapping and collection of existing data as possible by the end of August 2012

Next Steps/Follow-Ups for Reporting Back at April 24th Meeting

- Greta Roberts will take the lead on the review of existing data
- Tina Baptiste to take the lead on asset mapping
- Patrice Sulik to take the lead on health needs assessments
- Next PCAG meeting on April 24th: agenda includes discussion of key next steps in Health Needs Assessment, Asset Mapping and Existing Data.

Major Category	Health or Population Measure	Cofactors/Variables	Database or file name	Location of database	Smallest Unit	Data as of: Frequency	Update	
Vital Statistics	Births	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	Deaths	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	Fetal Deaths	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	All deaths	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	Brins to teenagers	Race, Age	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	State	2009 Annually	2009 Annually	
	Low Birthweights	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	Prenatal Care and adequacy	Race	CT Vital Stat Data 1	http://www.ct.gov/dph/dph/mis/mis/mis/mis/2008.xls	Town/District	2009 Annually	2009 Annually	
	Mortality	Cause	Age Adjusted Mortality Rates by Town	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2007.xls	Town/District	2005 - 2007	Every 3 years	
	Years of Potential Life Lost	Cause	Years of Potential Life Lost	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2007.xls	Town/District	2005 - 2007	Every 3 years	
	Lead	Percent of children with Lead Screening	Age at test	Lead Screening by Town and age	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.xls	Towns	2009	2009
Demographics	Blood lead levels	Screening age, level	Elevated Blood Lead Levels	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.pdf	Town	2009	Every year	
	HIV Prevalence	Not rate - list number	CT HIV	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.pdf	Town	2009	2009	
	2010 US Census	Race, Education, Housing, Language	US Census Bureau	http://quickfacts.census.gov/qd/states/09/0914260.html	Towns	2010	Every 10 years	
	Cancer Incidence	Breast, Colorectal, Lung, Prostate Year Diagnosed	CT Tumor registry	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.pdf	Town	2003 - 2007	Sampling every 5 years	
	Cancer Incidence	Cancer Incidence	SEER	http://statecancerprofiles.cancer.gov/quickprofiles/profile_p1703&004death	County	2008	2008	
	Compare Risk factors and assets	Grade 7 - 12	RYASAP Survey	http://www.nyasap.org/datasearch	Town	2011	Every 3 years	
	Socioeconomic Comparison	Income, Home Ownership, Education	NA	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.xls	Town	2008 - 2008	2008 - 2008	
	Child Health	School demographics	Free/Reduced Lunch, Not fluent in English, Disability, Preschool, Test Scores	Strategic School Profile	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.xls	Neighborhood school	2009 - 2010	Every year
	Asthma	Asthma Prevalence	Asthma Prevalence by School District	Asthma Prevalence by School District	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2009.xls	Town	2006-2009	2006-2009
	Sexual Health	Annual Number of Hospitalizations from Asthma	Ethnicity, year, gender, race, age, admit type	Connecticut EPHT Network	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Reports%20Hospitalization	Town	2010	Every Year
EMS Response	Annual Number of Deaths from Asthma	Ethnicity, year, gender, race	Connecticut EPHT Network	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Reports%20Mortality/Annual%20	Town	2010	Every Year	
Mortality	STD Incidence	Chlamydia, Gonorrhea, Syphilis, Age, Race at CT STD Control Program	Connecticut EPHT Network	http://www.ct.gov/dph/dph/mis/mis/mis/mis/mis/mis/2011/q1/q2/q3/q4/qrd_ab_110711.pdf	Town	2009	Every Year	
Risk Behavior	Age adjusted mortality rates	Cause of death, Gender	Ambulance	http://www.nccd.cdc.gov/bfss-smart/viewnat.cfm?r=384851&astabken=APP-V.CCDCRSITLP.CDC.GOV@51	Town	2007	2007	
Injuries	Behavioral Risk Factor Surveillance System	Age, race, gender	BRFSS Survey data	http://apps.nccd.cdc.gov/bfss-smart/viewnat.cfm?r=384851&astabken=APP-V.CCDCRSITLP.CDC.GOV@51	Metropolitan Statistical	2010	Every year	
Air Quality	Intentional and unintentional injuries	Type of injury, Race, Sex, Intent	WISQARS	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Reports%20Quality%20	County	2006	2006	
Heart Health	Ozone, PM25	Days above Ozone standard, Year	Connecticut EPHT Network	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Reports%20Hospitalization/Annual	Town	2010	2010	
Infectious Disease	Number of Hospitalizations from MI	Ethnicity, Age group, Admission Type, gender	Connecticut EPHT Network	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Diseases%20Counts.rdl	Town	2010	2010	
Birth Defects	Reportable Disease Counts	Ethnicity, Age group, gender, race	Connecticut EPHT Network	http://dph.ehph.ct.gov/DPHReports/DPHReportViewer.aspx?Report=Documents%20Reports%20Birth%20Defects	County	2010	Yearly	



Connecticut Association
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CONNECTICUT
HOSPITAL
ASSOCIATION

CADH-CHA Collaboration Meeting

March 30, 2012

12:30-2:30 p.m.

Meeting Notes

Participants: Please see attached list.

Welcome and Introductions

Nneka Mobisson-Etuk (CHA) welcomed everyone and introduced partners from the community health centers. For those new to the collaboration, Nneka reviewed the impetus for convening the collaborative, the mutual interests of advancing community health needs assessments (CHNA) and the value of working together to maximize resources and knowledge.

Participants introduced themselves.

Local Health/Hospital Partnerships-Lessons Learned

Jennifer Kertanis (CADH) referenced the meeting notes from the February 28th meeting and asked the group to review them to make sure they were accurate and complete. As recommended in our previous meeting, Jennifer thanked representatives from Norwalk, Hartford and the Naugatuck Valley for their willingness to share the lessons learned in advancing their community health assessments.

Norwalk: Tim Callahan, Director of Health in Norwalk shared Norwalk's experience in advancing their community health assessment. There are long standing partnerships between the health department and the hospital. The Norwalk Health Department was instrumental in establishing the community health center. They collaborated on the first community health assessment in 2000. More recently the interest in advancing a community health assessment was supported by mutual need, a demonstration grant from the National Association of County and City Health Officials, and interest and support from the Norwalk Hospital Foundation.

Norwalk has chosen the *Association of Community Health Improvement* model after researching several. This model will allow them to advance more quickly. The hospital and the health department are the leads and want to bring an established structure and framework forward to the community. They have very active community-based groups and organizations. They issued an RFP for a consultant, whose primary role will be data collection. A kick-off meeting was held on March 26th and included a broad range of participants. Consultants presented a framework, timeline. Work will include a least 9 focus groups. Norwalk is purposefully calling this a community health assessment as opposed to a community health *needs* assessment. Its focus is broader than health care and will include social determinants of health. They will not be surveying people as part of this assessment. Surrounding towns of Darien, New Canaan, Wilton and Westport will be included. Hope to have the assessment completed by September and a Community Health Improvement Plan by October. Tim emphasized the importance of keeping to a tight time frame and avoiding too much talk and not enough action. Norwalk Hospital is not approaching this from a marketing perspective, they prefer to emphasize their interest in supporting good health in the communities they serve.

Larry Cross shared the experience of his community health center in Bridgeport in advancing a community health assessment and conducting community interviews using a CDC tool. It resulted in neighborhood improvement projects.

Evelyn Barnum from the Connecticut Association of Community Health Centers commented that the centers must restate their data, needs, and objectives every five years. A tool called UDS mapper uploads the data submitted by community health centers on services, population and costs. Unfortunately the data system does not speak to hospital data but provides excellent information on the penetration of health center services.

Hartford: Tung Ngyen, Epidemiologist of the Department of Health and Human Services for the City of Hartford reported that their community health assessment process began two years ago and has been supported by the Hartford Public Health Advisory Council, which is an advisory group that includes the Hartford-based hospitals and community organizations. Historically, Hartford has completed a health survey every three years. Tung and the hospital partners acknowledged the issues of competition and turf. In advancing the community health assessment they wanted a product beneficial to all involved.

They started by exploring other assessments and hired Holleran Consulting LLC to look at secondary data sources. While this provided a start, the group did not feel that it was sufficient. It took a while for the group to process what should be in the report. They looked at the Health Equity Index, although hospitals did not readily embrace the social determinant perspective. After some internal discussions and education, it was recognized that the social determinants must be the focus if the goal was to focus on prevention.

Marie Spivey (CHA), member of the Hartford Public Health Advisory Council, commented that the hospitals came to the Advisory Council and the health department to see if this work could be done collaboratively, they built trust over time. Marcus McKinney (St. Francis Hospital, Hartford) commented that hospitals have been doing community benefit work by serving the under-served in communities for a long time. He sees this new community health assessment work as an expansion of that and suggested that it must include the community voice, with community defined in the broadest sense.

Naugatuck Valley: Dawn Barrett, Jesse Reynolds and Karen Spargo presented on behalf of the Valley Cares initiative. In 1998, Patrick Charmel was named president of Griffin Hospital, Karen Spargo became director of the Naugatuck Valley Health District, and CDC began investing in the Yale-Griffin Prevention Center. These events spurred some of the early discussions about a community health assessment in the Valley. They described the importance of building trust, establishing working relationships and ultimately buy-in for establishing a structure and framework. Earliest assessments were not glossy, but rather dry tables and graphs of primarily health statistics that were used for planning purposes but did not easily translate to the community. They used a model created by Jacksonville, Florida. Over time the assessment expanded to include additional towns and became more user friendly. In 2009, a searchable data base was created. It took a considerable amount of time to identify and prioritize indicators, breadth versus depth. Emphasis was placed on measures that were meaningful and actionable. Over time the report became shorter and more user friendly and supported evidence-based practice.

While the primary audience and end-users include the community, the United Way, Griffin Hospital, Yale-Griffin PRC and Naugatuck Valley Health Department are the key players. A committee of five people serve as the steering committee.

Jesse shared a very specific example of how the assessment resulted in modifications to breast cancer related activities at the hospital and local health level which resulted in measurable changes over time. They also highlighted community use including planning, community-based initiatives, improvement planning and funding.

Karen Spargo emphasized the importance of documenting the process including meeting minutes. She also said that the data “crunchers” are not necessarily the best folks to be developing the health improvement plan and at a certain point the health assessment needs to be handed over.

Sharon (CADH) thanked the teams for presenting and sharing their lessons learned. She summarized some of the key themes including: importance of the process and issues associated with building trust and establishing a method for decision making and governance; establishing criteria for selecting indicators and benchmarks; use of existing data; inclusion of the broader community; dissemination of findings; and ability to replicate and refine the process over time.

Work Plan/Timeline and Products: Jennifer Kertanis reported that a key objective of the collaboration is to develop tools and products to support community health assessments and improvement plans. In the past two meetings we have laid a solid foundation for articulating a common vision and establishing some mutually agreed upon outcomes. Having done that, the collaboration now needs to move into a work phase. She suggested that we establish two working groups, a Data Subcommittee and a Process Subcommittee. The Data Subcommittee will frame the core data elements, benchmarks, data sources to be included in a community health assessment and also identify tools and standardized questions that might be used to collect primary data. The Process subcommittee will frame the guiding principles of a successful community health assessment process including overcoming barriers, establishing trust, governance, structure, decision making and partners. She asked for the group's reaction. Russ Melmed suggested that a third subcommittee be considered-the Product Subcommittee. This group would explore the structural elements of a community health assessment, investigate different models and those that best support translation to community health improvement plans. Participants agreed that this additional subcommittee would be of value. Thad (Chatham H.D.) suggested that these three subcommittees consider both the community health assessment and the community health improvement plans in their discussions of data, process and product. This was a model that the group embraced.

A question was raised regarding the time commitment for the subcommittees. Jennifer responded that we intended for the work of the collaboration to be time limited and had proposed 8-12 months with meetings approximately once a month. Jennifer indicated that it will depend on the subcommittees but proposed that the subcommittee meetings take the place of the larger group meetings as their work advances.

The next meeting of the collaboration will be held on **May 18th at 12:30 p.m. at CHA**. In the meantime, CADH/CHA staff will coordinate and support subcommittee meetings. If necessary, a portion of the May 18th meeting can also be dedicated to subcommittee work.

Data Subcommittee:

Russell Melmed, Ledge Light Health District
Sands Cleary, Fairfield Health Department
Greta Roberts, Stratford Health Department

“Process” Subcommittee:

Thad King, Chatham Health District
Andrea Boissevain, Stratford Health Department
Janette Polaski, Backus Hospital
Daun Barrett, Griffin Hospital
Karen Spargo, Naugatuck Valley Health District
Catherine Rees, Middlesex Hospital

“Product” Subcommittee:

Lyn Salsgiver, Bridgeport Hospital