CDAG March 24, 2016
Public Health Week Conference April 7, 2016

Compilation of CDAG and Other Partner Input

1. **Four Domains Overview Discussion Piece**

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   a. Who is the end user for this plan?
      i. Broad enough for general public, policy makers, patients, practices/ programs, public health community
      ii. Maybe how/where we communicate about the plan will drive its usability. Access will be critical to the plan.
   b. Root cause analysis is the key to drive analysis of interventions
      i. Models that address more patient centered care/community of care/ transitions in care
   c. Need for community partners to truly be linked to clinical community
   d. Add Health Communications as its own domain? It seems to be missing.
      i. This seems like a cross-cutting theme (across all the domains), along with policy/advocacy, health disparities, quality of life, etc. From a strategic standpoint, it may be best to stick with CDC's four domains for potential future funding opportunities.
      ii. Domains 3 and 4 both link into access. Can we condense clinical piece to be the communication between community partners and hospitals.
   e. Be sure we are incorporating all forms of public policy legislation
      i. Take a look at policies such a tobacco that impact environment
   f. Emphasize health disparities, as they are not explicitly stated in any one domain but rather across all domains.
   g. Very heavy on clinical side/need to be sure to emphasize prevention aspect
   h. Be sure to look at policy and systems when looking at data
   i. Embracing technology to find resources and partners. Is there one common glossary to go to for resources?

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   a. Cross Cutting Ideas
      i. Evaluation and over-arching data points would be helpful to the Plan.
      ii. Grassroots education could be either a strategy in domain 3 or a cross cutting strategy. This could modify risk factors.

2. **Epidemiology and Surveillance**

March 24

a. Look at policy and systems changes under epidemiology. Make sure we know about everything going on in Indiana by improving communications so we don't have to reinvent the wheel.

b. Gaps in Data

    i. Who's doing what?

    ii. Can you access data and understand how to analyze the data for a good clinical picture

    iii. It is expensive to get data analyzed (for example HEDIS data)

    iv. It is a challenge to get "real time" current data

    v. We need policy, systems and environment data

    vi. Local data is difficult to impossible to get down to city, zip code, block/ neighborhoods

    vii. Leverage data to make it more useful

    viii. State mandates on what's reported throughout state – very "light" on incidence

        1. Cancer data is only required by state
        2. Hospital discharge/admissions
        3. ED Data – vital stats – Kaiser
        4. There are issues with standardized/uniform reporting (example: all using the same methodology to calculate screening rates) and electronic health records

    ix. Gaps in health information exchange (EMRs)

    x. May lean on payers for claims data

c. What we are doing well in Indiana

    i. Practitioners have access to data (surveillance) that can be shared

    ii. Indiana Cancer Facts & Figures is a great example

    iii. Other examples

        1. Homeless Network/HMIS System
        2. Communities that own local data (churches, worksites, community based organizations)
        3. Tech point (Health IT data)
        4. Marion County Health Department around food access

d. Health by Design and Built Environment in Indianapolis

i. GIS (Statewide) data and community health planning (How)

ii. Leverage technology/IT for glossary page

iii. Take ownership and send a web form or request. People are looking for a place to share information.

iv. Be mindful of mental health

v. 211 has great data

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a. Gaps in Data

iii. Out-dated data is a problem. Some data comes out more quickly than others.
iv. Where is data coming from? Evidence-based programs? Need a database.
v. Acute care and primary care lack communication.
vi. Claims data is more available than true data.
vii. Data is needed on growing disease populations. (ex: dementia)

3. Environmental Approaches

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a. What innovative tech is being developed around chronic disease? We need and IT system to connect people, organizations etc. for health

b. Need to address financial disparities

c. Influence political will. Organizational will and collaboration can make a difference.

i. Some of the policies passed do not make impact.

1. We need more impactful policies
2. How can we help people enforce good policies?
3. Increase public health funding (we are 44th)
4. Education of decision makers

ii. Shift from individual interventions to environmental interventions

1. Reward positive systems
2. Smoke-free air in multi-family housing and workplaces

iii. Tobacco

1. Increase tobacco tax
2. Taxing ALL tobacco products
3. Well-funded tobacco program

d. There are too many barriers for Hoosiers when it comes to transportation, education, finances and other resources
    i. 96% of state money goes to cars and trucks
e. Change our air quality/improve testing
    i. Struggle to make case against businesses
f. Schools/Children's' Environment need reform
    i. Need 30 min of physical activity required in schools. Mandatory recess. (kids and orgs serving kids 0-5, pre-school, daycare etc..)
    ii. Early childhood education minimum physical activity and nutrition requirements (farmers markets)
    iii. Find a way to have SNAP accepted at food markets
    iv. Shared use facilities
g. Social/environmental injustice effects health
    i. Quality of housing available and location needs attention
    ii. Parkland expenditures (built environment)
    iii. Opportunities with zoning (built environment)
    iv. Access to recreational facilities for public/those in poverty (back to shared use)
h. Increase breastfeeding. Breastfeeding initiation with AA moms
i. SRTS/complete streets
j. Baby-friendly hospitals
k. Living in a rural area is the top indicator for obesity
l. Attractive places to encourage health
m. What are the costs of inaction?
n. Increase education level

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a. Access
    viii. There is variation in availability in primary care in Indiana. We are in the bottom 4 in the nation for funding. FQHC and primary care clinic visits could require a lot of travel for many.
    ix. Drug crimes scare rural areas away from walking trail construction.
b. A holistic approach is needed
    x. Too many silos. Work toward collaboration.

xi. Look at addressing basic needs like housing, If basic needs aren't met, everything else will fall apart.
xii. Quality improvement. Where are time and resources being wasted?
xiii. Which collabs. Are working?

4. Health Care System Interventions

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a. Gaps
    i. Healthcare and social service system (working with community settings)
    ii. Telehealth
    iii. Social determinants are not prioritized in healthcare system
        1. Barriers
            a. Reimbursement for all members of the team and community based resources (example: environment buildings)
            b. Documentation may not cover the whole picture
            c. Connecting between agencies
            d. MCE, hospital, social systems
            e. Time
    iv. Effectiveness of intervention
    v. Resources
    vi. What do you do with the info?
    vii. How do we encourage a patient care team approach?
    viii. Healthcare providers (especially rural)
        1. Continuity of care
b. Patient Care Approach (example: integrated mental health – grant funds. EMT Trained on Asthma Care)
    i. How can we keep the "whole" health team?
        1. ISDH as support? – Technical support
            a. Medicare – diabetes prevention reimbursement
            b. Accreditation
            c. Home visits and follow-up case management (not easily reimbursed)

ii. Bigger issue 0-64 more patients=more services needed (example: ACO success strong). Lobbying for improved health in community tie in (example: police – walk to school)

iii. Prevention of Chronic Disease

iv. Messaging: how can we reach more?

1. What is our message?

a. Information sharing: pharmacy data as an example. Surescripts – Systems do not talk. "right people have right access"

v. Lack of cardiac intensive rehab programs in Indiana

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a. Broad social marketing campaign in Indiana around health would be great. Broad enough to cover all populations. This will require funding.
xiv. Should we choose a few areas of concentration?
xv. Address a broad population to hear all voices.

b. Policy
xvi. No current legislation that addresses chronic disease specifically.
xvii. Turn data into economic gain. Show how certain programs will actually help the economy.

5. Community programs linked to clinical services

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a. Dentistry

i. Indiana has far fewer sliding fee scale clinics than other states (example: health professional shortages). This issue has occurred in dentistry due to lack of data gathering

ii. Unable to find partners who have evidence based (St Franciscan) data to report – as it is too difficult to connect to EMR. Try to provide data to provide return on investment

iii. MHS working in community – go to people vs planning events waiting on them to attend event

b. The best results of engaging population in programming (preventive)

i. YMCA is with health care provider – but the problem is they will not allow access to EMR

ii. YMCA diabetes preventive program now paid by Medicare

iii. Healthcare professional – now includes case managers (nurse practitioners, RNs PT, RRT asthma educator, CICOA, EMS, paramedicine program)

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a. IUPUI was just awarded a grant to work on this domain.
b. It is important that we all use the same language. (social marketing campaign)
c. Keep evidence based practices in mind.
d. Centralized database. Make 211 more health oriented.