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Organizer 1:  Hopefully you all had a chance to go to the restroom so we could get right into it, and we want to remind you that the poster session begins at the end of this session.  So, we welcome you to stay.  We are doing a model that is adapted from the World Cafe model in terms of the style of facilitation.  So, we are going to ask some cooperation.  I am so glad people are coming, and please sit at a less-populated table.  Basically, this model requires that we have three rounds.  Each round is 12 minutes of discussion.  There will be a series of questions at each table, one question, basically, for you to address or discuss during that 12 minutes.  Now, you will also have to appoint someone as the recorder.  We have those big sheets or whatever.  There is a rotating that occurs every 12 minutes for each round.  So, everybody gets to talk about all of the questions, basically.  So, there will be three rounds.  There will be a recorded flip-chart sheet for round 1, followed by round 2, followed by round 3.  They stay at the table.  In the third round, the recorder will need to summarize all three rounds.  So, be cognizant of that as you are appointing your recorder.  You will not have had the benefit of the earlier discussion of the first two rounds, that third recorder won't, when you present.  I think we will probably need one person or so to move to this table, because Mary is recording for us.  So, we are digitally recording as well.  So, we are here today to talk about community health needs assessment, and hopefully everybody feels this is a very important and relevant topic to community-engaged research.  It can drive a lot of our work for a process to devise priorities from the community.  Also, it can be a way for community and academic partners to collaborate together, and also, we know there are challenges that exist in this process ... number one, with health systems and hospitals and relationships that they may have with the community, and likewise with our academic partners, but at this point, we all have to work together through this process for identifying priorities.  Also, community health needs assessment, just a brief background - I think we all know it is required as part of the Internal Revenue System and Affordable Care Act for hospitals.  They have to do this now.  It happens every three years.  As part of the process, community health needs assessment includes conducting the actual assessment, adopting an implementation strategy, the "meet the needs," identifying and reporting how they are addressing those community health needs, those not being addressed, and why they are not being addressed.  We know a lot of different models exist for the process.  Many come up with their own for the process, many whose others are in play.

Organizer 2: can I ask a question?

Participant:  Yes.

Organizer 2:  How many of you are involved with, or use the data, or the data is from your hospital?  How many of you don't have a clue, which is okay?  Okay.  Let me ask you a weird question.  Which hospitals don't have to do a community health needs assessment?

Participant:  For profit.

Organizer 2:  For profit.  And?

Participant:  V.A.

Organizer 2:  V.A.  And?  The third one is a hard one.

Participant:  University.

Organizer 2:  It is actually other governmental hospitals, so city-run hospitals.  It is a very technical definition.  The reason I ask is if you go, "Where is my community health needs assessment," and you are in a for-profit hospital, they are going to say, "You don't have a clue what you are talking about."  (Inaudible).

Organizer 1:  So, we also have five questions, and right now we only have three tables.  It is recommended that we have at least three people per table.  So, I am going to ask if a couple of you guys can ... it looks like we can at least form one more table.  We will only have four tablets.

Organizer 2:  Let me suggest that people who have done this or been involved with it, mix it up so that you have some people with experience and some people without.  If anybody is a real expert in this, you're not.  I probably know as much about this as almost anybody, and I am still learning.  We were talking to the CDC's attorney on this last week, and I was like, "Really?"

Organizer 1:  So, I need at least three people up here.  Are you recording, Mary?  Cool.  Okay, great.  So, I have all the questions.  I will keep time, 12 minutes.  Question #1 at this table, or do you want to pick your questions?  Oh, they are already picked.  Okay, let's get started.

TABLES CONVERSING

Organizer 1:  We will start with question #1.  Go ahead.  Who else had question #1?

Participant:  We did.

Participant:  Question #1 is the one about ... (inaudible).

Participant:  We thought that some of the important things to do would be getting the stakeholders to the table first before we actually implemented the framework to make sure the buy-in exists for the framework to be implemented.  So, we would want to leverage the asset map at the health department so we would know who our partners are and potential resources as well, and also use the deficit map to see what areas of need may be addressed and bring those people to the table, too, to help choose our framework.  So, we thought potential people to include might be state partners, federal partners, community-based groups, faith-based groups, the private sector and universities, and that we would want to have pre-identified framework that may have been implemented in that context by other groups, so maybe a Parks and Rec Department implementing a behavior change strategy that was successful, and then have those on the table to choose from.  We thought bringing diverse partners together from the get-go would increase buy-in and strengthen the framework before it was implemented.

Organizer 1:  Alright, question #1 here.

Participant:  So, your answer touches on some of the answers that we gave for question #4.  We were talking about the first question, and we talked about focus group surveys, \_\_\_\_\_\_\_ forums and involved members of the community \_\_\_\_\_\_ the process, like you said.  We brought up the use of advisory boards.  We mean to have them engaged throughout the whole process, and have them provide advice to researchers and even to institutions themselves regarding the implementation of programs and also policies.  So, engaged community governments, advocacy groups or community brigades.  These community brigades could also be organized for the different social determinants of health that could be affecting the community groups.  Focus on social \_\_\_\_\_\_\_\_ more upstream and partnership with the Department of Health.

Participant:  I think everybody has already said what we said, but I think the important thing is to use existing stakeholders and get more people at the table.  I have some firsthand experience with these community assessments, and they happen literally in somebody's office at the back of the hospital, and then we see something come out that says, "Here are the results of the survey," but we haven't seen the followup, what are the metrics, who is evaluating, how you guys are readjusting your priorities, all of that kind of stuff.  So, the idea to bring people in to watch every phase of the process and using existing people, the existing networks that are already there.  They don't have to reinvent the wheel.  It is already all there, ready to go.

Organizer 1:  We will go to question #2.  If it was previously said, we can just support what the other group said and not have to go there.

Participant:  So, it said, "How can we encourage a shared \_\_\_\_\_\_\_ among the key organizations within communities to conduct those community health assessments together, especially in regions with weak or nonexistent Health Department.  What we thought is that we need to elevate the importance of these community health needs assessments.  I think right now people just look at them as a formality, like something I've got to get through to check off a box, and then like you said, somebody back at the hospital is doing it.  But we are like, "How do we elevate the importance of these?"  What we said was - couldn't we involve the State Health Officer and the CTSA to convene and to say that these things are really important and then they will also help set the priorities for the Health Department, so that more than one body could actually use the information.  That messaging is really important.  The hospital may not even realize how important a community needs this.

Organizer 2:  Does anybody know a place who did that?

Participant:  Kind of, but not to the level where you are talking about the Department of Health with some other collaboration or input to aid in the list of priorities, etc., and that is even better than we have.  But so far, what we have in Chicago is Code C3, which is the Chicago Consortium for Community Engagement.  It came out of the collaboration of the three CTSAs that we have, one with University of Chicago in collaboration with \_\_\_\_\_\_ University.  The other one is Northwestern and UIC.  So, all three are coming together with the Department of Public Health.  So, we are providing funding for the creation of a job within the Department of Health, who is going to be working with the data collected by the three CTSAs to address the strategic plan that the Department of Health had created for Chicago.  It is called the Healthy Chicago 2.0.  I am advertising the job.  Anyone?  It is going to be a little challenging having four bosses watching over you, but we are very excited, because it was a great idea.  It took us one full year just to describe what was expected of the job and how to pass it through the whole process within the Department of Health to get approval by everybody.  It was already representing basically the description of the needs of the community that was on all the assessments that had been made.  So, it was a long process that had already been done.  We didn't want to reinvent the wheel.  The three CTSAs were already coming together trying to find ... I remember this because it was one of the weirdest meetings.  I was new to the group, and we sat down and said, "Okay, what are we going to do?"  And we were looking at each other until somebody said, "Why don't we start thinking of doing something instead of waiting to define more things?  If we start working on one thing, we might come up with something else, and start aligning our interests into something."  Sure enough, by two or three more meetings, we realized the best way to go about this was to support the one thing that everybody was interested in, and that was helping Chicago.  So, let's go to work with Chicago's Department of Public Health, because they already have a plan.  They were launching at that time the Healthy Chicago 2.0 with a lot of beautiful ideas.  We already know that whatever we are going to be doing is already hitting the target, and so let's work together.  That is how we were finally able to create an internal agenda.  So, that is where we are right now in Chicago.

Organizer 1:  It will be interesting to see how that agenda influences the CTSA's health priorities.

Participant:  We have had tremendous support, as you can imagine, from the Department of Health, and the Commissioner is very happy.  The Medical Director is working with us.  The Director of Epidemiology for the \_\_\_\_\_\_ is working with us.  They attend the meetings ... (inaudible).  We have another \_\_\_\_\_\_\_ that we represent, as their mission has been representing the QHCs and the \_\_\_\_\_\_ and basic organizations that are working toward helping communities.  So, we feel pretty sure we are representing as close as we can.

Organizer 2:  (Inaudible).

Organizer 1:  Okay.  Question #2?

Participant:  We said similar things.  Form a community coalition and then try and pitch it in terms of the benefit, both to the community, but also to the partners participating, so especially in a such a resource-constrained environment, if we can identify redundancies, we will save time and money, and also it looks really good politically.

Participant:  I think the only thing that we can add is that we don't need to reinvent the wheel.  We need to use active relationships that already exist, and we have some examples of successful regional models that could be replicated in similar kinds of environments.  A great example is when you put somebody really interested on the committee, it makes a big difference.  This was a Mayor on the example.  A Mayor on the committee who really wanted this to be a good report will make sure it is a good report.

Organizer 1:  Why don't we start here with question #3, and can you read the question to start?

Participant:  I don't have question #3.

Organizer 1:  Do you have #3?

Participant:  Yes.  How can CHNA processes better serve a special population and strengthen community benefits for them?

Participant:  We went back to that issue with active relationships.  There are partners and organizations in the community that serve those special communities.  Make sure they are involved in the process as opposed to reinventing the wheel.  Bring the right people to the table.  I think that was the major thing.

Organizer 1:  Alright.  Question #3 here?

Participant:  Highlighting the strengths and assets of community, prioritizing \_\_\_\_\_\_\_ ... (inaudible), offer education, screenings services, etc., participating community \_\_\_\_\_\_ and transparency with community members.

Participant:  There are already listening groups out there meet with special populations and leverage those meetings, and not just wait until your CHNA process to engage those groups, but regularly go in there and be transparent about what you are doing for the CHNA and here is what our improvement plan (?) process is, and make it an ongoing and regular process.

Organizer 1:  Okay.  Question #3?

Participant:  Ask the Health Department and then reach out to other key partners to ... (inaudible) ... to validate what we learned there and get more feedback.  (Inaudible).

Organizer 1:  Okay.  Question #4, and the question is - how can every CTSA hub ensure CHNA processes are effective and meaningful within their hub, and how should they address duplicative processes as CHNA efforts within their hubs?

Participant:  The CTSA should serve as a convener to bring together the stakeholders so that they work on that duplication and so forth, but also the sharing of definitions and sharing of surveys, because we all reinventing the wheel every single time creating new surveys.

Organizer 1:  Right.  Question #4?

Participant:  That was when we made reference to the collaboration, because the CTSAs can address the needs as defined by the local Department of Health since they have already done the assessments and they already have a plan.

Participant:  We said the same thing.

Organizer 1:  Let me tell you guys this worked.  It was kind of off the cuff and on the fly, but it worked.  So, thank you so much.

Participant:  So, there is one point that we raised that I think is worth raising here.  This is the first round of a 15-round boxing match.  This law is weak.  It doesn't have teeth.  It doesn't require strong engagement.  It requires checking boxes.  So, another thing CTSAs could do is make sure they are involved as policy as the next iteration of this law comes out.  The reality is - if you want to check the boxes, you can get away with it.

Participant:  The state health officers are meeting next week and one of the things they are talking about is not waiting for federal action.  Chicago is an example as a city, but some states are saying they are going to expect coordinated action.  The states sometimes have more influence over their hospitals than some of these federal departments.  So, sometimes the states are doing that.  So, this may happen in the institutions near you sooner than you think, so it is worth getting movement on it.

Organizer 1:  Thank you all so much for staying over.