Session 2: Thursday, September 15th 4:15-5:15pm

Location: Stouffer

Session Title: Neighborhoods and Public Health

Organizer: Pritchard

Primary Notetaker: Pitingolo

Attendance: Doom, Coulton, Martin, Morgan, Austensen, Abraham, Kingsley, Sanders, Parks, Smith (Geoff), Linn, Kessier, Carroll-Scott, Stahl

[Start 4:15]

Pritchard: I’m with a new organization, Data you can Use, welcome! Let’s introduce.

Linn: Program Analyst in Chicago and use technology.

Smith: Depaul.

Parks: Price center at USC.

Sanders: Chapin Hall.

Kingsley: No consulting on IDS.

Abraham: Data Haven.

[Other intros too fast to record]

Pritchard: I have some questions to put out there and then we have it go as it does. I just came from a very organized version of a session. I want to give context about what I’m interested, then see how people are doing things with data. Once we have a sense of what people are doing I’ll ask what you wish you could do. Then after that, some advice I would be grateful. Then let’s think about what we can do together. Sound right? OK. OK. Good. I have been in a building across from a new school of public health. Slightly controversial because there’s a medical college and the university of Wisconsin school of Medicine. We’ve already got this thing in Madison. They argued that we need it because the problems are in Milwaukee and there’s a distance in perception between urban and non urban health problems. They put it downtown in a new development and co-located the public health department there. They brought in an amazing dean and worked together and a lot of work together. Then she left. So we have building relationship with public health and good progress and student and data sharing. There’s an interim dean and a significant funder suggested partnering with us in NNIP and see the synergies. The school has little community engagement and we are good at that. How can NNIP be a good partner? The other part of the story is that I’m working on a story on neighborhood organizing and crime. All CDBG funding now goes to neighborhood organizations that the police department is doing organizing neighborhoods. We have educated white females now getting money from the police going door to door asking questions about ‘how’s your collective efficacy’? [laughs in the room] We have another project and knocking on doors of African Americans asking about collective efficacy. Turns out that community organizing based on crime control is offensive to them. They don’t want to give info or talk but they love the work of health navigators in the community. Health navigators come from the children’s hospital. They go to community events and talk about things beneficial to people. It seems like a reason to look at health data. I wanted to get out that context before we start. I don’t know if everyone is doing something in health.

Carroll-Scott: What school?

Pritchard: School of public health. I want to hear some views and ideas.

Carroll-Scott: I’ve been evaluating programs that come from South American community organizing. Patient navigators have been around for a while in California where there’s a diversity of cultures it’s the only way to connect people. I’m irritated by the recent interest among patient navigators taking a look at patient population to understand trends. There are still health and hospital systems. They’re not talking to their neighbor. It has limitations, especially community organizing. I’ve been butting heads where civic associations are trying to organize people around health and chop comes in and says they have navigator and things. It creates a fractured system of what I’d consider a subset of community organizing. I think it’s an important place to go.

Pritchard: There are many ways to approach this. I’m thinking about how health data and neighborhoods could be beneficial.

Carroll-Scott: They collect data but it’s the least sharable. We’re working hard with nonprofit hospitals to see if there’s a way to extract data from their records to create neighborhood estimates which in and of itself is a valuable community organizing. I argue is even more valuable than random data for community health mandates. I think there’s a lot of potential and money going to patient navigators that there wasn’t before. I think there are opportunities I hope we’re having the right conversations.

Martin: Our former partner at Coalition for Regional Future was here. We worked with Q-core which was a data collaborate for hospitals to map some data for the regional atlas - asthma, obesity, diabetes. We pulled obesity from dmv licence data. There’s a theory that people don’t really lie about height and weight on dmv.

Smith: Is it not that up-to-date?

Coulton: For a big picture it’s OK.

Martin: Anyway. They get charged a lot of money to do it. Hospitals and county health departments all collaborate. We worked with the health management program at our university that does consensus building. As data and demographics people we wrote a great proposal but we were short on the equity piece. We haven’t really addressed how to bring in community organizations. They chose Q-core which has none of that stuff. I thought they were sincere about being an engagement. It wasn’t really a community facing thing in the end.

Pritchard: So we have hospitals doing self-serving data collection.

Carroll-Scott: Is quality care a community development? The strategy is not about community development or engagement.

Martin: They are starting to realize they need demographic data to understand the populations.

Carroll-Scott: Bobby do you know about something in California?

Stahl: I was involved a few years ago when electronic medical records were coming online, Childrens’ was one of the first that created an office of social determinants. Even though there is a lot of money going to this, I think they are well aware of the limitations. Food security is an issue that Children’s Hospital is addressing with parking lot farmers markets. They are completely infiltrated by capitalism and growth and huge developers. Unless they’re in on conversations on police presence and safety. Unless they’re developing affordable housing people don’t care about their role.

Coulton:I’m in line with cynicism but I don’t think they overcome big neglect. Both projects involve using electronic record data. One is a big population based accountable care that serves hundreds of thousands of individuals kind of on the east side of cleveland. There’s a saturation that gets closer than sending a navigator. In order to look at environmental conditions affect patients we link human service records by using address and parcel lookup. Does this house have code violations? Is it old and was it bought by a speculator? Is there children? Involved with homeless services? It’s all coming into a secure resource environment. There’s a lot of technology involved in making this happen. The idea is that we can take a condition, like asthma because of it’s relation to the environment. By looking at patterns and say asthma that results in hospitalization, then look at housing conditions, you can look at what’s happening around. The plan is to work with CDCs in cleveland and other advocacy groups who are concerns to do something like say do something about code violations. It’s very much at the stage of matching the data. It was a big fight to get permissions to have those record data and medicaid claims in the same environment.

Pritchard. In Milwaukee because funding is neighborhood based, the hospitals are a place based version of this. It’s not just client based but in terms of the intervention. We just got a grant to treat a first arrest as a public health emergency. Instead of how to respond to an outbreak, if there’s a first arrest, how would you intervene? I don’t want to be too cynical because some things are good approaches but they’re small scale.

Sanders: Not a perfect match but worth something. Oak Park shares a border with Chicago. It started out as schools, parks, nonprofits. It’s still there. It was supposed to get kids would need intervention into special kindergarten slots. They’re also out beating the bush to screen kids of developmental problems. Thousands of screens, going to hair salons to get parents screened. All the major preschools are participating. The ones who need services the idea is aggressively go after services. Those are set aside for kids with risk factors from economic factors to something else. Since they decided to fund it themself, oak park is income diverse and serve people from chicago. If you look at their website the collaboration for early childhood in oak park. We’re handling the data side with linkages in a secure environment. We’re not working with hospitals but with pediatricians. When my kid was 3 he wouldn’t talk and someone came now he won’t shut up.

Abraham: We were able to get all hospitals and community foundations in Connecticut to fund it. We raised half a million from hospitals and half a million from community foundations. We’re publishing that now. The key is that the foundations are passion driven. It’s up to us and foundations to hold community organizing events, like church organizers as much as we can, to give data back to those groups. We’re trying to make it an annual basis not just a one thing thing. One of the main costs for us was a large survey, Amy helped. The idea of tying those things together is more important than healthcare. Bringing in more passion driven focus on public health and see what it is they do. Sustainability is the main question.

Kingsley: I have a question, maybe a dumb one. It seems like orgs focus on a narrow subset of patients. Is anyone aware of hospitals sharing accountability for a geographic area? Seems like that work.

Carroll-Scott: CMS has funded things going beyond their patient populations and getting reimbursed.

Linn: We’ve started to display data on the Chicago Health Atlas and work with hospitals to visualize data based on service areas. That’s not the complete version of what you’re saying.

Abraham: there are nonprofit models where hospitals provide free services then people show hospitals show how much they’re saving.

Carroll-Scott: I think that’s more secondary prevention.

Stahl: I can give you the info for someone who can answer your question.

Morgan: Allegheny Health Dept received a dash grant. As part of this they’re collecting data related to cardiovascular disease. They’re going to run a big model on it and they come to use because they’re obligated to share with the public. I’m not sure the best ways to do this. Maybe people had some resources.

Carroll-Scott: Philadelphia has a good portal to look at.

Morgan: They’ve chosen indicators. They want to use this as a place to make it accessible. A lot of it is cool stuff that’s never been shared before.

Carroll-Scott: The Philly one has multiple data sources. Philadelphia Dept of Public Health.

Morgan: What is the role in the other communities of the health depts?

Stahl: I used to work at the public health department. I saw a body of work known as Place Matters, still doing great work. We had the benefit of progressive folks who funded the evaluation unit. There’s a huge focus on using good clean, robust data to manage place based change. I did a lot on lead and mold mitigation. I saw how they did wonders for our ability to make changes. My cynicism about hospitals engaging on hospital data. I think they can do a better job. I can go on and on about the good work they’re doing. They’re one good model for how public health depts work with nontraditional partners. Not just community based organizations. People who represent a base. The Health dept looked at health impacts on foreclosure crisis. Then there was development without displacement.

Morgan: Our health dept has pie charts.

Pritchard: We talked about the importance of integrating people and place. This is one of our best ways of integrating it. I know in our one instance there’s a strong feeling that the health dept doesn’t take a public health approach. They have strong efforts to integrate, which I think is an important factor. Anyone else wants to give a good example?

Martin: I’m not involved yet, but there’s talk about developmental origins of health. My former dean has done this. Two generations from now what you’re exposed to today will affect it. Drawing from that, there’s a focus on pregnant moms and babies. One group is doing the baby booster initiative. We want to support them. I met with them but they’re not doing indicators yet.

Coulton: I’ve heard a lot of money gets spent on these assessments that don’t yield much. Is there something we should know about that world?

Carroll-Scott: Part of the strategy to create regional consortiums of hospitals. In Philly there are many hospitals with overlapping areas and they all spend money on the same data from the same consultant. Our DHHS is founded through a local foundation to help them with implementation plans. They’re using primary and secondary data in a neighborhood way. But what happens is it falls to public or community relations who don’t have power in this hospital organizations. We need to be pushing and it can be shared in a meaningful way.

Abraham: Just view health as part of your NNIP indicators project.

Kingsley: Trust for America’s Health is going a project with Deloitte to get creative and push banks under CRA to take a valid community needs assessment.

Pritchard: You can register opinions about the extent of community engagement. It’s a way to get in. What does it look like on the front and the back ends. That’s a potential way.

Carroll-Scott: Utilization and outcomes data isn’t the full experience of health in a community. To really understand a community's health you need all of that.

Stahl: Public Health Depts have to be accredited. One of the steps is a robust community led health assessment. Our public health dept is coming to the end of that. Lots of residents were present and talking about their needs. Topics were access to high wage employment and crime prevention.

Carroll-Scott: Regional coalitions need the public health depts. To have the same working groups is just a waste of energy.

Pritchard: Five hospital systems in mke got together and got done and realized they hadn’t looked at community health. The experts think there are community clinics in mke and we pushed and documented way more than they ID’d. That’s a whole 5 systems doing planning around missing that many visits to community clinics. There’s that end of it. OK. Anything people would love to have? Is there some data health and neighborhood related you could get at?

Abraham: Race. It’s hard when you don’t have segregation.

Pritchard: It’s being made on observation not self report.

Sanders: We need birth certificate data. You need to know how many 3 year olds there are.

Coulton: You can’t get it?

Sanders: You know Bob is persistent and he’s closer but not there.

Coulton: Ohio is easy.

Kingsley: Integrated population health database in Camden NJ. It links health to labor, food stamp, incarceration.

Coulton: You can’t exchange back to the physician private records but you can develop a risk score based on things like job opportunities.

Kessler: Allegheny does predictive analytics for how often a call will lead to an investigation. We have a H2 committee now to integrate health records with data warehouse. Pittsburgh has 2 silo’d health care systems.

Carroll-Scott: Unitedhealth lets you apply for de identified claims data. It was a complicated process to apply but it’s great data. Looking for people to tie it to contextual data. It’s national and down to the zip code level.

Pritchard: Anything you think is worth pursuing as a group? An idea? Source? Panelist?

Kingsley: I mentioned the trust and being interested in financing. They didn’t have a good grip on data requirements. A group like NNIP might really inform them.

Pritchard: Anything else? It’s hard to have ideas this late in the day. I appreciate the conversation, it’s given me good ideas. If you do think of something, we can still pursue it.

[End 5:15]