SHA Design Team: September 2022 Discussion

Demographic Section

The State Health Assessment must include a description of the demographics of the population, including:

1. The percent of the population by race and ethnicity,
2. Languages spoken, and
3. Other characteristics as appropriate.

The group discussed what "other characteristics" would be of interest to see in the SHA. The recommendations included:

- Migration patterns
  - Note: this is of particular relevance for American Indian health. After 180 days without checking in at the reservation, you are ineligible for services, so a lot of migration patterns are seen as a result.
- Housing
- Resource use for disability services (like a parking tag—people may use a parking tag but not consider themselves to be living with a disability)
- Poverty
- Geography, access to services
  - IHS requires UICs to report ZIP codes for service area—it's important to know why someone is driving almost 90 miles for services, for example, if they have an IHS facility locally.
- Tribal affiliation
- Relationship status (not just marital status)
- Sexual orientation and gender identity
- 65+ age groups, older adults living alone
- Industry and occupation
- People with more than 1 job
- Rent vs own home
- Transportation use
- Types of health insurance
  - Dual eligible populations (65+ and people living with disabilities eligible for both Medicare and Medicaid)

Design Concepts Discussion

Attendees reviewed the three design concepts first presented in the August meeting and brainstormed how to address the concerns voiced for each design.

**Please note that they are not meant to be mutually exclusive—all three could be implemented at once.*

Design concept 1: Writing an initial State Health Assessment that is accompanied by a calendar of future analyses and evaluation questions for PHSD epidemiologists and partners to collaborate on to continue to enhance the work and answer key questions.

What concerns are the easiest to address and how would you solve them?

- Deciding on what goes into the calendar- identify data sources and questions that seem practical, epi staff that can work on that could be timely and prioritize that way. Not just staff time, but other things, like data and topics.
- Assign mentors to help support someone new- cross training to prevent loss if staff leave.
- Accessibility- focus on varied audience use, like Boards of Health for their use and education. Include additional resources, reference document, gives it added value (like design concept 3)
- Alternate formats- website, shorter formats
- Organize so that certain pieces are used as a reference, easy to use, understand

What concerns are hardest to address and what's in the way of solving them?

- Considering current focus, what to highlight now vs. not in a timeline, politics/hot button topics
- Events change and anticipating data needs to address that
- Make sure to allow flexibility
- committing staff time over extended period rather than in one push-could get too ambitious with calendar, requires more work after the fact, make sure there is capacity.
- Make a set schedule, but with some flexibility
- Skillsets of staff changes, staff time change, retain instructional knowledge- training
- set up transition process
- mentor program

Do you recommend we proceed with exploring this design concept - do the benefits outweigh the concerns?

- Process needs protocol
- Overall, the group supports the idea
- Seems easier for planning

Design concept 2: Attempt to identify a suite of metrics that can speak to multiple subpopulations that can be used to create "health profiles" for specific communities, like people experiencing homelessness, Veterans, families, etc.

What concerns are the easiest to address and how would you solve them?

- It's possible to come up with too many metrics and then not have the bandwidth to monitor it all
    - Not that big a deal - consistent metrics applied to subpopulations - have a set number of metrics
- The more data, the more convoluted the results can be. Some important points can be washed out. Important to be clear and simple if possible
    - This is another reason to have good metrics
- Rural and frontier communities don't always fit into categories very well. What do we lose after having created metrics? Who might miss out? Are we ok with that?
    - This is a concern anytime you have a metric - what are you measuring and how do you make people fit? Rural can be a category in its own right - there's overlap in issues and assets - this is OK, as long as it's clear what the limitations are
- Already have concerns about aggregating data—will this impact the way we can share information? Or will we end up with a lot of gaps?
    - In the process in next year of a revised way of sharing small numbers - this is a solution that's in the works
- Emphasizing one group compared to others lessens the prominence
    - That's what happens - by focusing on some sub-groups, other sub-groups might not be as visible especially in health disparities - about how you build good metrics to not exclude. Is this an issue at all? If you pull focus to people who actually are experiencing issues, that's not bad. Just don't create metrics that don't address any issues. Health equity and politicization - in the messaging - don't imply that other groups not in metric aren't important
- Need to have SMEs to represent the groups properly
    - Yes, you want to have them when you talk about addressing the disparities and deciding on final metrics. SMEs - don't have to be involved in the whole schmear. Need to build genuine relationships with populations we're trying to work with
- This seems like a concept that would be farther down the road because you would need baseline data prior to subgrouping
    - Could use this as a way to ID populations who should be prioritized for data - use as a reason to find a data source to use

What concerns are hardest to address and what's in the way of solving them?

- Will the state be able to create profiles for communities that really need it but have limited data on them (e.g., Queer communities, Black/AA people, Latina/o people)?
    - This seems like the biggest challenge - how to collect it - this seems like the biggest threat to this type of approach. Not hard to parse these groups out, but some of the data might be hard to get on a consistent basis - don't create sub-groups without mechanisms to collect data about them.
- Be cautious of framing – don't just choose metrics that are problems but also focus on assets. Create a narrative that's strengths based
    - Valid concern but solution is simple - concern no matter which design concept - solution is clear if not easy
- Self-reporting information or information collected on an individual basis might not be readily available or accurate
    - This is a high concern if trying to break into sub-populations. For people requesting different types of data in different ways - there's always going to be a chance to not ask the right question or get the right data

Do you recommend we proceed with exploring this design concept - do the benefits outweigh the concerns?

- Sometimes letting the data guide what we look like creates problems. Geography, communities=counties, not reservations because not in data. Leads to groups being invisible/masked due to limitations of data.
- Adding more metrics is never the right first answer. Figure out what data you already have available, people generally only report what they have to. What data do people have to report and how can it be utilized?
- Overall, yes, proceed with this concept.

Design concept 3: Include existing reports (like needs assessments, strategic plans, etc.) and resources (like programs, organizations, and tools) that speak to the health concern in the SHA.

What concerns are the easiest to address and how would you solve them?

It's possible to come up with too many metrics and then not have the bandwidth to monitor it all

- Not that big a deal - consistent metrics applied to subpopulations - have a set number of metrics

Could get outdated very quickly. Programs change and organizations leave.

Solutions:

a. This is true anytime you cite a source. You can date and cite it and people will know when it was created. The benefit of having these resources available is well worth it.

b. Share the umbrella weblinks. The organizing body should keep the reports and resources updated on those websites.

It will be hard to organize in a way to maintain connections that are meaningful and continue to connect programs that should be connected, but this group can figure it out.

Solutions:

a. Similar to above solutions. This document isn't meant to sustain relationships but can initiate the connection.

b. How the data were collected should be considered—the methodology should be sound for anything we are pointing people towards.

What is the age of that information and the threshold that's accessible for it being included in the document?

Solutions:

a. We interpreted these two concerns to mean, we need to consider how we will select the resources and how we will know what resources to include.

b. Something to consider but not something to stop us from doing this.

c. We know we can't add it all. But we can set some parameters and explain that we know we are not adding everything. This would be a starting point.

A crosswalk would be more helpful—have a summary layout of different topics and note across documents/programs which ones have that topic as a focus area to help everyone save time when orienting to a new health priority area in their work.

Solutions:

a. A crosswalk would help community members and organizations know which contacts are related to the priority areas.

b. developing a crosswalk, already seemed like a solution. I think the people who did the report or work, could help summarize and list topics covered. We could leave room for others to comment on how they used the work.

What concerns are hardest to address and what's in the way of solving them?

After-action reports – need to widen gaze and think about creating a data and info sharing public health infrastructure.

Solutions:

a. Not very clear what this means. However, there was an idea it meant we need to create more than a document with resources. That it needs to be multi-media and accessible to add resources and connect with people across the state.

b. (Mackenzie's summary) This may be a different type of project, possibly a mix of CONNECT, Insights, ArcGIS community maps, etc.

This would be a whole project in and of itself. Maybe consider doing this as a standalone resource in a future appendix of the SHA.

Solutions:

a. The Design team could assign a workgroup to focus on this.

b. If the document includes a cross-walking of health priority in the SHA associated with each resource, this file should come out with the SHA.

c. Maybe it is an appendix. But it is not a reason to not do this.

Do you recommend we proceed with exploring this design concept - do the benefits outweigh the concerns?

- Yes