DE SHIP ASSESSMENT KICK-OFF MEETING
January, 19 2016

DISCUSSION POINTS

THE CURRENT SHIP

1) Benefits of current process and infrastructure:
    a. The SHIP has provided a platform for recruiting members and stakeholders, representing a wide range of disciplines, who had not worked together before.
    b. The infrastructure aided in the coordination of efforts, such as talking to a primary care provider (PCP) about a set of issues rather than numerous people contacting them individually.
    c. Consistent communication efforts support the coalition and workgroups. For example, semi-annual meetings kept everyone on pace and boosted morale.
    d. DPHI make themselves readily available for technical assistance and support, providing fast responses to questions and inquiries.
    e. The tracking form is a useful tool for updates.
    f. Priority setting meetings were helpful to buy-in.
2) Areas in need of improvement:
    a. The tracking form was not as useful for the mental health group- consider tailoring this for the complexities of these objectives/strategies.
    b. When the working groups were convened, it was a challenge to get the right people at the table: how can we make sure that we have all/enough of the "right people" there in a timely manner?
        i. Ensure continuity as well as "the right people"
    c. There were challenges with commitments to resources, consider a formal process of upfront assurance to time and assets to alleviate issues of disengagement once planning is complete
    d. Community benefit is realized, but the state didn't always have the resources to implement the plans
        i. Especially difficult for the healthy lifestyles goal
        ii. Need more non-governmental ownership of these goals (non-profits, other coalition members taking responsibility for the implementation)
    e. Center for Health Innovation should especially be involved in the SHIP moving forward
    f. There needs to be more collaboration with insurers to ensure that the behavioral health screenings in the SHIP are covered (tied to strategies within Goal 2)
    g. Approaches to integrate our work with Healthy Neighborhood work on population health should be explored.
    h. Concerns about change in state administration, and continuity: how to keep things going
        i. There is a need to continue to break down silos, but there are other forces keeping things separate
    i. Align efforts so they mutually reinforce instead of duplicate efforts
    j. Expectations of strategy teams need to be clear and concise. Consider developing a work plan with supports/resources in place for implementation- something that was not provided or communicated clearly this past iteration.
3) Needs that are not addressed in current goals and strategies
    a. Addictions, especially opioids: has been increasing since this process started, past 18-24 months have been more clear
        i. Trying to get people on opioids on long acting birth control
        ii. Not enough resources for treatment on demand: money has been allocated to increase services in DE so that detox will lead to a step-down program
            1. No intermediate residential treatment
            2. Workforce issues: not enough trained providers to deal with comorbidities
        iii. Access for some populations is particularly difficult
        iv. Many OD deaths were in people who were trying to get help:

b. Language barriers: requirements for small facilities mean that there are not many bilingual providers/certified medical interpreters
    i. These populations will just nod their head to the doctor without actually understanding diagnosis and treatment instructions
    ii. Brazilian Portuguese, Russian, Haitian, Creole, Spanish
    iii. Family interpreters are insufficient, and now unable to serve as a translator in many healthcare settings
    iv. Language line is both insufficient and under-resourced
c. Social determinants of health
    i. Poverty: the root of many other health issues
    ii. Work force issues
    iii. Education attainment
d. Trauma:
    i. Goes beyond mental health
    ii. Violence, especially in Wilmington
    iii. Abuse
    iv. Natural disasters
    v. Intergenerational trauma
    vi. Medical facilities have significant interest in related efforts- consider leveraging/engaging
e. Disjointed communication about resources that are there
f. Primary care physicians are concerned about screening mandates, because there are not enough services to refer individuals to, for services
    i. This is a challenge to address because we can't amass the resources unless there is a documented need
        1. Screenings can help with this

THE ASSESSMENT

4) Key topic areas and populations to be considered and/or included to effectively evaluate the state:
    a. Consider other strategic plans in place that could complement the state plans:
        i. What are the assets available now and what is coming in the future
    b. Capacity-building plans for non-profits/community-based infrastructure
        i. Resource development
        ii. Personnel
        iii. Especially difficult for physical activity and nutrition
        iv. Mental health can get reimbursement, has been hard to figure out how to get prevention reimbursed
    c. Businesses have not been a part of this conversation: engagement is needed
        i. Tie in to "work force of the future" issues
            1. Integrate this into a new "culture of the state": should emphasize the value of healthy employees
        ii. Incentives for participation?
            1. Community outreach and philanthropy are a core value of some major businesses in the area: Shoprite, Wawa, Acme (more?)
    d. Technology:
        i. How do individuals use technology?
        ii. How can tech help people access information
        iii. How can tech help people access providers?
        iv. Other uses of technology to reach goals?
    e. Minority communities need to be involved

i. African-American, especially in Wilmington
ii. Hispanic populations

f. Other groups traditionally left out that mandate inclusion:
    i. The disabled
    ii. Children
    iii. Folks in the middle who are ____ better economic times but
    iv. Care providers: people caring for elders, people caring for children with disabilities, specific populations (Alzheimer's, Parkinson's, etc)
g. Geographic areas of interest:
    i. Review the United way assessment from a few years ago:
        1. Eight geographic areas were identified as particularly high risk in various ways
            a. This can be an opportunity for drilling down in more detail in these locations to inform others
h. Transportation issues, especially in rural areas
i. In general, there is need to be able to tell a story about social determinants of health and their impact
    i. The organization of the assessment should reflect this
    ii. Think about assessing policies
    iii. Pull together data to empower people to move on common issues across agencies
    iv. Put coalitions in a good position to pull down funds from federal agencies
        1. Example: Ag program may want to do a needs assessment about nutrition
            a. Impacts of feeding programs
    v. Look at other government agencies and their needs assessments to get the best data/goals, etc.
j. How the results should be presented:
    i. Data need to determine decisions
        1. A lot of power in a few great charts: can inspire people
        2. Trends over time that are going the wrong way, disparities
        3. Incorporate into the HHS data release
    ii. Use to get foundation support?: make sure grant makers have state health priorities, also see what grant makers are directing money toward
k. Other components to consider
    i. What education programs that are already happening/how to link up to them
    ii. Herald good progress in education, housing, etc.: who is talking about health and health related things in these areas?
    iii. Have a resource guide at the end of the project to address social determinants of health areas
l. Modes of community engagement for focus groups :
    i. Faith communities
    ii. Committees looking at health needs

5) Other resources needed?
    a. Spreadsheet including resources for key informant interviews, focus groups, stakeholder surveys, and benchmark data
        i. Collective input
            1. Sending document around to meeting participants to populate columns based on knowledge/awareness
                a. This information will be combined into a master document and used for assessments