CHNA Steering Committee
Friday, September 24, 2021 @ 2 pm
Meeting Minutes

Attendees:
Denise Barton, Strategy & Business Development Coordinator, Frederick Health
Barbara Brookmyer, MD, MPH, Frederick County Health Officer
Lisa Brown, Project Manager, Health Literacy, Asian American Center of Frederick
Anamaria Matamoros Faustin, Hood Student Intern, Frederick Health
Diana Fulchiron, Behavioral Health Work Group Lead, Frederick County Health Care Coalition (FCHCC); Director of Community Impact, The Community Foundation of Frederick County
Malcolm Furgol, Executive Director, FCHCC; Community Benefit Specialist, Frederick Health; Consultant, United Way of Frederick County
Stephanie Gonthier, President, Market Street Research (data consultant)
Rya Griffis, MPH, Project Coordinator, University of Maryland School of Public Health, Horowitz Center for Health Literacy
Maria Herrera, Spanish Speaking Community of Maryland (Frederick location)
Janet Harding, Director of Cultural Awareness & Inclusion and Co-Lead, Bridges Health Educator Program, Frederick Health
Inga James, MSW, PhD, Vice President, FCHCC; President & Executive Director, Heartly House
Elizabeth "Liz" Kinley, Project Manager, Community Health, Frederick Health
Heather Kirby, LSWA, MBA, AC-SW, Chronic Health Work Group Lead, FCHCC & Vice President, Integrated Care Delivery and Public Health Officer, Frederick Health
Pilar Olivo, President and ACEs/Infant Health Work Group Lead, FCHCC; ACEs Liaison, The Office for Children and Families
Leah Stansberry Richey, MPH, IRB Program Assistant, OMH Minority Health Literacy Grant team, University of Maryland, School of Public Health, Horowitz Center for Health Literacy
Colleen Swank, LHIC Grant Coordinator, Frederick County Health Department (Recorder)
Rissah Watkins, MPH, CPH, Director of Planning, Assessment, and Communication, Frederick County Health Department

Focus Group Planning Updates

Malcolm Furgol convened the meeting and provided an update on focus group planning activities. He said that the lead partner agencies began recruiting participants this week for the four focus groups. Potential participants are directed by the lead partner agencies for eligibility screening to either an online survey (URL, QR code) or a live chat by phone with a Market Street Research (MSR) staff person. Ms. Barton added that MSR reports that three participants have passed the eligibility screening so far, and daily reports will be provided to the CHNA team starting on Mon., September 27, 2021. The goal is to complete the recruitment/screening process by October 5, 2021, with a total of 6-8 fully screened participants for each focus group.

Mr. Furgol stated that based on survey data analyses, more disparities were identified in the Latinx female population than the Latinx male population. Therefore, the decision was made to replace the Latinx male focus group with a Latinx female focus group. Maria Herrera, who has already started recruiting for the Latinx female group, said that this is an easier population to reach than the Latinx male population. So, the final focus group target populations are:

- *Latinx women*
- *African American Women (pregnant or childbearing age)*
- *Vulnerable Neighborhood (Census tract 7505.03)*
- *Low-income/ALICE seniors*

Action Item: After the meeting, Mr. Furgol will email the focus group recruitment materials to the committee members. This includes recruitment flyers and the FAQ document given to the partner agencies.

Denise Barton provided an update on her recent briefing meetings with partner agencies that serve the focus group target populations.

- In regard to low income/ALICE Seniors, partners at Advocates for the Aging said that many in this population do not have smartphones or other appropriate devices and may not have internet access. Ms. Barton said that Community Health Workers (CHWs) assisting participants without internet access would need a tablet with MiFi.
- The Advocates for the Aging partners also suggested that it would be best to give the $100 incentives directly to the senior participants, so Ms. Barton said the distribution plan for incentives may need to be modified.
- Ms. Barton also said that the elderly population is not homogenous and can be broken into 3 groups based on health risk: healthy and active, at risk, and frail. She suggested that the partner agencies try to recruit participants from all of these categories, if possible.
- Potential participants who live in a multi-family setting will have the challenge of finding a quiet place where they could participate in the virtual focus groups.

Action Item: Ms. Barton will provide Mr. Furgol with the email address for the Advocates for the Aging partners so that he can follow-up with them on the issues stated above.

Priority Planning Process Discussion

Mr. Furgol said that the CHNA team would like to continue the tradition of making improvements to the priority-setting process every cycle.

- Mr. Furgol reminded the team that, unlike last cycle, the Coalition Board would like to have final approval of the top priorities selected at the Summit/event.
- Ms. Watkins said that due to COVID19, the priority-setting event to be held in early 2022, will be in a virtual setting. Since the previous Summits were held in person on a

weekday and lasted a few hours, many community members were unable to participate due to work conflicts, childcare issues, etc. She is hopeful that the new virtual setting will allow for broader community representation at both the Summit and in the LHIP Workgroups.

- Ms. Watkins pointed out that the priority-setting event needs to be scheduled in January 2022, in order to factor in the time needed for the recommendations from the Summit to be reviewed by the Coalition Board for final approval.
- Ms. Olivo agreed that increasing community involvement in the Summit and in the LHIC Workgroups that begin to be formed at the Summit is important. Based on her recent experience organizing a large, virtual workshop, she said that the team may want to consider the use of breakout rooms and training facilitators for those small group discussions.
- Ms. Barton asked if the purpose of the Summit would be to prioritize the top 3 health improvement areas, as has been done in the past, or to provide a forum for public input. She said perhaps the focus of the Summit could be public input with the Coalition Board then responsible for the prioritization.
- Ms. Watkins said that at the last Summit, after the top 10 health improvement areas were presented to the participants, through the use of fact sheets and short presentations by experts on each topic, the group had difficulty narrowing down their top choices. As a result, the top 3 priority areas were very broad and some topics were actually the combination of more than one area. This has resulted in problems with implementing the LHIC Workgroup action plans this cycle, since action plans need to be very targeted and specific in order to be implemented successfully. She recommended that topics not be combined like this again.
- Mr. Furgol said that public input, rather than prioritization, could be the focus of the Summit. If this was the case, what data should be provided to participants to review beforehand?
- Ms. Olivo said she is concerned by the current lack of confidence in the work of the LHIP Workgroups, which is viewed by some as irrelevant or duplicative of other community efforts. How does the team increase confidence in the LHIP Workgroups with the main stakeholders, maintain community participation in the process, and have the process add real value to the community? There is a need to tackle relevant issues and to move forward effectively.
- Dr. Brookmyer agreed that the LHIP Workgroups are viewed the way Ms. Olivo described them. She said Workgroups need to perform landscape analysis and problem solve. Some Workgroups have engaged members who work in the public health area but others have members will less experience and knowledge of the issues. So, it' not surprising that the LHIP Workgroup process is very challenging and, as a result, the efforts of some Workgroups have stalled. This situation may be related to problems with the prioritization process. The team should make sure that the agencies involved in the top priority areas are included in the Workgroups.

- Ms. Fulchiron agreed that the priority topic areas are too broad, including Behavioral Health. She said that this Workgroup had very passionate and dedicated members in the beginning of the cycle, but the topic was too broad to tackle. She said the topics need to be narrowed, either before or after the Summit.
- Ms. Kirby said it is too hard to narrow down the priority areas in the large, Summit setting, so maybe there could be a broad information sharing forum first and then the prioritization could be done.
- Ms. Olivo agreed with Ms. Kirby and suggested there could be a multi-step process to prioritize the top health areas. Instead of having the Summit participants review the top 10 issues and narrow that list down to the top 3, perhaps the Summit participants could be presented with the top 3 priorities and then help determine how to better focus these areas.
- Ms. Watkins suggested that the Coalition could use the prioritization criteria to determine the top 3 priority areas and then ask for public input on interventions in these areas.
- Ms. Kirby said she liked Ms Watkin's suggestion. She would like to get input on how to better focus the top 3 areas and determine what are some potential interventions for the community in this area. The more we can help facilitate that narrowing, the more successful we will be.
- Ms. Watkins agreed and said we could have the community that is impacted help solve the problems. This would also be a way to make the Workgroups more accessible to the community.
- Dr. Brookmyer pointed out that this would be shifting the public input more into the intervention side.
- Ms. Barton agreed this would be a good idea. Find out what is meaningful to the community and if the community is ready to implement that intervention, including considerations of resources and sustainability. Achieving collective impact requires the ability to track actions and measure outcomes. She said not all possible interventions are at the stage where they are ready for implementation. Some are still in the advocacy or awareness stage, and selecting these would hamper engagement and outcomes.
- Mr. Furgol said there should also be opportunities for people to suggest new interventions. Ms. Barton said they would need to be evidence-based interventions.
- Ms. Herrera said the CHNA team needs to do a better job at informing the community of the successes of these efforts. The team is asking people to participate in focus groups or other types of engagement, but they are not seeing the outcomes.
- Ms. Harding agreed with Ms. Herrera and noted that the Dental Clinic and the Prenatal Clinic are two examples of tangible outcomes for the community in prior cycles.
- Mr. Furgol said these issues are related to the Coalition's ongoing efforts to improve its communications and community engagement. There may be a new platform for communications by the time of the Summit that would help with this.

Mr. Furgol said that the Committee members seemed to have reached a consensus today that the Summit event should focus on public input on possible interventions and focusing the top 3 health topics. However, more details need to be worked out on the pre-Summit prioritization process. He asked for volunteers to participate in the new CHNA Prioritization and Public Input Planning Workgroup. In addition to Mr. Furgol, members who volunteered for the new Workgroup are Maria Herrera, Pilar Olivo, and Rissah Watkins.

> Action Item: Mr. Furgol will arrange for the first meeting of the new CHNA Prioritization and Public Input Planning Workgroup. (This was later scheduled for Monday, October 4, 2021, at 3 pm.)

- Dr. Brookmyer pointed out that there is a lot of agreement in public health, including the World Health Organization (WHO), on how to prioritize local health improvement needs. This process includes 5-7 questions, which were used last cycle, and include questions such as:
    - What percent of the community is impacted?
    - What is the significance of the need? (i.e., if not addressed, would it result in death?)
    - Does this need have a disproportionate impact on another group?
    - Are there interventions available to address the problem?

Mr. Furgol said he would like to take advantage of the expertise of the Summit participants and have a conversation at the Summit on how to improve the implementation of the LHIP and the Workgroups, in general.

Public Data Sharing Discussion

- Mr. Furgol asked about the process for sharing the CHNA data with the public as we move forward in the process.
- Ms. Watkins stated that the health department's CHNA Report will contain all the data and will be made available to the public for both the public-comment period and later as the final report.
- Ms. Olivo asked for confirmation that the dataset currently available from MSR should only be discussed within the CHNA Steering Committee and should not be shared publicly at this time.
    - Ms. Watkins responded that the dataset is still in the analysis stage and is not available to the public yet. The Data Workgroup is working to identify the important parts of the dataset which will be incorporated into the final CHNA report. The issue of sharing the full dataset with the Coalition and other partners for use for their internal work on future initiatives and grants would be another conversation.

The Next Steering Committee Meeting:

- Friday, October 8, 2021, 2-3 pm

(CHNA Steering Comm Mtg Minutes-09.24.21-final)