Updated September 8, 2022

SHA Design Team: August 2022 Discussion Summary

Attendees reviewed the following three design concepts for the State Health Assessment. These concepts arose from feedback collected during the engagement period (June and July 2022).

**Please note 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.

Benefits:	**Concerns:**
• Great idea – unrealistic to put all analyses into a giant report. This way you can cover the big topics and then regularly dive into specific topics – user-friendly and realistic • Identifies areas where other groups can plug in, like funding for research studies • Regional collaboration would be great – adds statistical power to rural data (outside of Montana) • Chunking it out, make it into sub-reports, make it accessible to the people who need particular info • Data is only as good as the information that goes in—rather than looking back, it might be nice to look forward to what else we need to collect • It might help people who support analyses to keep this work at the forefront of their workplans • Allows for emerging health concerns and flexibility • Not as much of a time crunch • This would help to identify and close data gaps. If we don't put them on paper, they may never get addressed • It is a big lift to incorporate all data at once and more beneficial to update overtime as data roll out/become available.	• Need to avoid being a book on a shelf that is never looked at and has no value at all • Should consider partnering with the data people in other DPHHS bureaus/divisions and other departments in state government to see what they have to say • This design could be interpreted and organized to support a specific message—how do we keep it from emphasizing a specific narrative while also including important details (regardless of the narratives) • How would you decide what goes on that calendar? Which issues or deep dives are prioritized to take place when? Could be challenging to decide. • If there has been a significant amount of change in public health staff that could be hard to transition for work responsibilities for the future analyses. o As epi capacity changes over time, could challenge the production of the report • Specific deep dives that don't happen again in the next cycle might be hard to make happen again and capture trend data (it might only be current state). • How are our community partners going to use this? This may not be super accessible to them. • Who is deciding what those evaluation questions are going to be? Is this another process that will need to occur simultaneously with the creation of the SHA? • Need to think through what this would look like. Would you make the SHA and then make 1 pagers about each subpopulation? What about each jurisdiction receiving information about their specific subpopulations? That would be more actionable.

Updated September 8, 2022

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.

Benefits:	**Concerns:**
• Organizational grant work probably could benefit from this concept, but the team has to be very intentional about how the report will be used and how longitudinal data will be maintained. • It would be useful to put the data into settings and use just-in-time information to help organizations adjust their protocols accordingly – e.g., heat waves and people exp homelessness; COVID in nursing homes; etc. • Mirrors needs assessments that are typically done. • Can identify data that can apply to multiple populations. • Can create risk scores. • Easily translated on how we identify groups for resource distribution. • Select data that represent all populations. • From a utility standpoint, helpful to tie some organization work with state work. If organizations, agencies, or health facilities are working on moving metrics in a direction, the data collected at the state level may have more power when reporting. • Thinking about community partners, they have a good understanding of the people in their area, but they don't always have the data. This can be a great supplement to support their work and focus. • This could highlight health priorities for different groups. Providing data to support more tailored work across the state • Humanizes work that would otherwise be only seen as data points, when the data is compiled in relation to subgroups/specific community member profiles • This would make the SHA more useful for direct application	• It's possible to come up with too many metrics and then not have the bandwidth to monitor it all. • Be cautious of framing – don't just choose metrics that are problems but also focus on assets. Create a narrative that's strengths based. • 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? • 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? • Self-reporting information or information collected on an individual basis might not be readily available or accurate • Emphasizing one group compared to others lessens the prominence. • Need to have SMEs to represent the groups properly. • 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. • 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. • 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 a concept that would be farther down the road because you would need baseline data prior to subgrouping. • 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?

Updated September 8, 2022

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.

Benefits:	**Concerns:**
• This is also a good idea. There's a lot happening in all the orgs that many people don't know about. It would be nice to have a place to highlight all those connections. • It also would help to eliminate duplication of efforts across the state. • It would allow alignment of strategic plans around housing, SDOH. • Many organizations probably have a lot of resources they'd like to share. • For individuals working with community members, having a resource supplement could make the data more usable. • When grant writing, having organizations and tools available that support a specific metric can provide strength and grounding for that health goal. • Ability to incorporate existing reports allows them to be viewed with a different lens and creates the ability for different interpretations and strategic planning. • Options 1 and 3 could be included in some kind of timeline to help show the big picture of this work.	• 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. • After-action reports – need to widen gaze and think about creating a data and info sharing public health infrastructure. • What is the age of that information and the threshold that's accessible for it being included in the document? • How the data were collected should be considered—the methodology should be sound for anything we are pointing people towards. • Could get outdated very quickly. Programs change and organizations leave. • 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. • 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.