Partnership for a Healthy Durham Quarterly Meeting
January 24, 2018
Minutes

Facilitated by: Gina Upchurch

Present: Wilma Liverpool, Fred Johnson, Peggy Kernodle, Caressa Harding, Chelsea Hawkins, Khali Gallman, Jen Isherwood, Keyanna Terry, Angel Romero, Candice Chitton, Kendra Rosa, Pam Purifoy, RF Wilkins, Sara Abrams, Jacob Lerner, Tara Ilsley, Jen Meade, Megan Turits, Barbara Maier, Rebekah Dorris, Nancy Kneepkens, Heather Mountz, Kiah Gaskin, Annette Smith, Daniela Sostaita, Sophie Jordan, Amanda Snyderman, Mel Downey-Piper, L'Tanya Gilchrist, Maria Padilla, Nasim Youseffi, Amy O'Regan, Candice Givens, Gwen McKnight, Kate LeMasters, Courtney Bartlett, Don Bradley, Kimberly Alexander-Bratcher, Armenous Dobson III, Cheryl Scott, Cherie Conley, Jordan Smith, Elaine Hart-Brothers, Hannah Chesterton, Gizem Templeton, Kimberly Fisher, Kelly Warnock, Tricia Smar, Jen McDuffie, Betsy Crites, Natalie Rich, Jannah Bierens, Marissa Mortiboy, Gina Upchurch
Guests: Atalaysha Churchwell

Topic	Major discussion points	Action steps and responsible parties
Introductions		
Review October Minutes	There were no changes to the October minutes.	Let Marissa, Kelly or Gina know of any corrections to the minutes.
Duke PHMO ***Atalaysha Churchwell***, DukeWell	Duke Population Health Management Office has the following care management programs- Local Access to Coordinated Healthcare (LATCH), Northern Piedmont Community Care, Duke Connected Care (Medicare) and other such as private insurance. All services together are branded as DukeWell. These programs provide support services for high-risk patients through a number of services including complex care management, specialty rounds and palliative care. DukeWell examined its continuum of services to make sure none were being duplicated. Services include health and wellness, disease management, care management, complex care management, and advanced illness. All services still exist but are housed in one location.	Marissa will get a copy of the presentation slides to share with the Partnership.

	The DukeWell vision is to become "payer agnostic" and provide services to all Duke patients. DukeWell will work with inpatient care management, primary care, specialty care and home care to create a workflow between all of these areas. The goals is to improve patient satisfaction, improve patient outcomes through coordination, increase efficiency, focus on reduction of Emergency Department (ED) visits and inpatient admission/readmission. Complex care patients have multiple health concerns and are often not connected to services. DukeWell is determining how to connect complex care patients to services and manage their needs. Multidisciplinary teams wrap services around patients. DukeWell Specialty rounds has doctors specializing in endocrinology, cardiology, geriatrics, nephrology and palliative care. Specialty rounds see patients to improve the patient eyepieces, prevent a costly, unnecessary ED visit, admissions or specialty visits. Specialty rounds offer better coordinated care and share information with patients and through electronic medical records. Patient referrals can be made through the DukeWell website at phmo.dukehealth.org, email at duke.well@duke.edu, by phone (919) 660-9355 (WELL) or through the electronic medical record system, Epic. Caretakers in the home can also make referrals through the website or on the phone.	
Racial Equity Recommendations to the Partnership ***Jannah Bierens,*** Durham County Department of Public Health	Jannah did her internship with the Partnership in fall 2016, focusing on racial equity. This was part of her Master of Public Health program. Race is not biologically real but has a real-life outcome on people's health and lives. According to the Racial Equity Institute, "social and institutional power combined with race and prejudice. It is a system of advantage for those considered what and of oppression for those who are not considered white. Racism is a white supremacy system."	Marissa will add Jannah's presentation to the Partnership website and email to members. Jannah will work with Marissa to use a racial equity lens during the

	African-Americans are two to five times more likely to have bad outcomes across systems in North Carolina. Said differently, whites have 25%-60% as much of a chance of bad outcomes as black population. Discrimination, residential segregation and health disparities are byproducts of racism yet not acknowledged as such. Evidence-based interventions are not enough alone. And blaming an entire population of people for negative health outcomes is unethical. Ultimately, racism is the root cause, to the root causes. Jannah conducted interviews with Partnership members. They were in agreement that racial equity needs to be addressed by the Partnership to effect change. Racial equity tools recommended are from the Government Alliance on Race and Equity (GARE) Tools and Resources guides. The website includes astrategic planning and action planning guide. The Racial Equity Tools website has a variety of tools including planning, action and evaluation. Other tools include Health Equity and Social Justice 101 Online Training series through National Association of County and City Health Officials (NACCHO) and The Roots of Health Inequity from NACCHO and the National Institutes of Health (NIH). Jannah recommended five things the Partnership can do to address racial equity in the next year: 1. Survey Partnership members 2. Create a racial equity committee/workgroup for the Partnership 3. Consider racial equity when action planning including: • Create a racial equity guiding statement • Engage people of color as subject matter experts, • Move away from behavior focused interventions only,	Partnership's action planning process. Share your ideas on how the Partnership can incorporate racial equity with Jannah, Gina, Kelly or Marissa.

	• Focus more on those who need more 4. Organize a place and space for trainings and discussions • Conduct at least one quarterly Partnership meeting dedicated to racial equity • Host a racial equity event in the evening or on Saturdays, at least quarterly • Provide racial equity articles, events, clips in the Partnership Post 5. Engage community and build improved community leadership • Collaborate with community groups to hose evening and weekend events • Invite community social justice movements/organizations to Partnership and work together to promote each other • Do not underestimate the power of breaking bread together The Partnership plans to incorporate racial equity into its work after encouraging members to attend the Groundwater presentations and two-day workshops for the last three years. The next steps are to use a racial lens during the action planning process which will start at the April 18 Quarterly meeting. The April meeting will be from noon to 2:15 pm. Partnership members will select committees for 2018-2021, examine Community Health Assessment data, ask why to get to the root cause of health disparities and use data and feedback from the community to develop ideas for the action plans. Marissa would like to see the Partnership move more towards systems and policy change instead of just programs and education.	
Community Health Assessment Update ***Marissa Mortiboy,***	The Community Health Assessment (CHA) report due to the State on March 5. Most sections have been written and editors have started reviewing. There are now 14 chapters including a new chapter addressing LGBTQ+ issues.	Partnership members were asked to share the survey with their networks and encourage

Durham County Department of Public Health	Once the draft is submitted to state in March, Marissa will post on Partnership website for a one-month comment period. The report will be finalized in April. The Partnership will have an online CHA health priorities survey available in English and Spanish beginning the week of January 29. The purpose of the survey is to narrow down the list of health priorities to the top five. The survey is short and asks for opinions on the top priorities, how to address the priorities Marissa created a flyer for the survey and will send the survey link and flyer once all the materials are ready. Durham County Department of Public Health interns will be working with Marissa to get the word out to the community.	community members to take the survey when at meetings or working with clients.
Announcements	End Poverty Durham and Food Policy Councils across state are asking organizations to sign on to a campaign to protect SNAP. If interested, sign within the next weekys. Marissa will send out the presentations and link to the campaign to the full Partnership. May 17 is the annual Community Health Coalition meeting at Ivy Center, meeting starts at 5:30 pm on mental health and health disparities. Principles of Community Engagement document is available to help empower non-profits. TRY meets monthly second Wednesday of each month. They have a Plan for Zero to eliminate suicides, overdoses, etc. Visit durhamtry.org to see what TRY works on. The next meeting is February 14, 10:30 am-noon on the second floor of Golden Belt. • Project Homeless Connect will be held at Durham Bulls Stadium on January 25, 9 am to noon • The annual homeless count is the night of January 24. Volunteers are welcome. • The Durham Crop Hunger Walk will be held March 25 at Duke Chapel. • Four day chronic disease self-management class training are free and available to those who want to co-lead trainings in the community. The dates are March 20-21, 27-28 at the health department.	
Next meeting	April 18, 2018, **Durham County Human Services Building, 414 E. Main St.**, noon	