

MEETING SUMMARY**Date:** June 13, 2011**Time:** 9:00 am to 10:30 am**Connecticut Department of Public Health:** Lisa Davis, Chris Andresen, Renee Coleman-Mitchell, Christine Parker, Carol Bower, Valerie Fisher, Barbara Walsh, Eileen Boulay, Stephen Poulin, Pamela Kilbey Fox.**Meeting Participants:** Tressa Spears Jackson, Amanda Beyus, Bonnie Smith, Steve Holeath, Tina Dugdale, Heather Peracchio, Brian Bonds, Sharon Okoye, Peggy Gallup, Grace Damieo, Valentine Nilke, Margaret Gerundo-Murkette, Ande Bloom, Jen Muggeo, Teresa Younger, Marie Spivey, Dawn Mays-Hardy, Lea Crown, Geralyn Laut, Chris Corcora, David Gregorio, John Bailey, Linda Bergonzi-King, Michele Albert, Beth Vumbacco, Heidi Zavatone-Veth, Betty Jung, Karen Spargo, Alison Harle, Dawn Grodzlli, Jane Ungemack, Olivia Henzo Goldberg, Daria Keyes, Bonnie Edmondson, Jill Zorn, Mario Garcia.**WELCOME AND INTRODUCTIONS**

Lisa Davis welcomed everyone and thanked participants for attending on short notice. Ms. Davis noted that 86 people participated in the June 1 conference call, an indication of the high level of interest in Connecticut regarding this grant opportunity. Meeting participants then introduced themselves.

Community Transformation Grant (CTG) Overview

Christine Parker summarized the grant opportunity (see 1-page grant overview at www.ct.gov/dph/communitytransformation for details).

- The CTG is part of the Affordable Care Act, allocating \$102 million for this fiscal year and \$900 million over five years. The CDC will make up to 75 awards to states, local governments, nonprofits and tribal organizations.
- The federal government will only approve one application for a specific region. Applicants have posted many questions on this and other topics (50,000 hits to CTG website), and the CDC is slowly answering these questions.
- Applicants can apply for either Implementation or Capacity Building funds.
- On June 4, the CT Department of Public Health (DPH) submitted its Letter of Inquiry applying for Capacity Building funds, and indicated that the state will address all five Strategic Directions.
- CTG requires five capacity building activities:
 1. Establish or strengthen a multi-sectorial community/regional coalition.
 2. Summarize existing community health data and/or collect health data, including the identification of population sub-groups experiencing health disparities and inequities.
 3. Conduct a health needs assessment of the community/region including identification of population sub-groups experiencing health disparities and inequities.
 4. Community engagement with minority communities.
 5. Conduct a policy scan and identify gaps in existing policies, environments, programs and infrastructures.

- As of last week, the CDC had received 666 letters of inquiry, and had not finished counting all of the letters. This will be a very competitive grant competition.

Funds for Statewide Chronic Disease Prevention

Renee Coleman-Mitchell described an additional funding opportunity for state health departments. On June 8, the CDC released funding for Coordinated Chronic Disease Prevention and Health Promotion. The purpose is to establish and/or strengthen chronic disease health promotion programs within state health departments. This is a formula-based grant where all 58 states and territories will receive an award based on the submission of an application. Connecticut's funding range is between \$300,000 and \$624,000. DPH plans to apply for this grant, which is due July 22 (one week after the CTG is due).

BREAKOUT SESSIONS – STATE AND REGIONAL DISCUSSIONS

Participants then divided in 6 small groups: a group for statewide organizations and 5 regional groups corresponding to the Department of Emergency Management and Homeland Security regions. Each group discussed the **barriers** and challenges in implementing the five capacity-building activities required for the CTG application. The notes from each breakout group are presented below.

Statewide Group

I. Coalition Barriers

- Past coalitions were not sustained or lost momentum.
- Coalitions often lack benchmarks and tangible outcomes.
- “Key players” must be brought to the table and their roles must be defined.
 - i. A compendium listing how the work of state agencies and partners intersect would be useful in identifying “key players”.
- Coalitions often happen at the state level; they are not typically regional.
- Leadership/governance of the coalition is important.
 - ii. Having the health department as the leader is associated with politics.
 - iii. Responsibilities of coalition members should be defined.
- Coalitions that link similar/common towns and cities could be useful. Linking by geography dilutes need.
 - iv. This could involve peer groupings (the Department of Education has done this).
 - v. UConn's Five CT
- Connecticut needs coordinated regional structures.

II. Data Similarities

- The Health Equity Index is an example of socioeconomic data linked to health outcomes.
- Town-level data and pockets of data exist throughout the state.

- There are notable gaps in the data that is available.
- There is a need for timely data.
- A systematic approach to data collection is necessary at the local level.
- The American Heart Association's "Get with the Guidelines" has established methodology that could be used for data collection.
- Indexing might be useful to compare communities.
- Linking health data to education and other socioeconomic data would be useful (Health Equity Index).

III. Needs Assessment

- Community involvement in the needs assessment and planning process is important.
- Instead of focusing on needs focus on assets.
- Data collection standards and methods are important when conducting needs assessments. Established methodologies should be used.
- Quantitative and qualitative data should be collected.
- Quantitative data exists at the local level; therefore, local governments, agencies, and other local groups should be involved in conducting the needs assessment.
 - i. There needs to be a greater awareness of existing data.
 - ii. The existing data needs to be taken to the next step.
- Coordination of data will be important.
- Our current fragmented system needs to be brought together for needs assessment and evaluation purposes.
- It was noted that data necessary for the needs assessment may be different than the data used for evaluation.
- Identifying the commonalities among at-risk groups will be helpful.
- The needs assessments should be ongoing.
- There is a need to build capacity to use data and translate it into practice.
- An assessment of ongoing, evidence-based interventions is needed.
- Sharing "best practices" in a structured way will be important.
- Evidence-based interventions need to be identified and systematized.
- ACHIEVE Communities could serve as an example of what has already been done.

IV. Community Engagement

- Building trust is very important.
- Community members unite around issues in their communities not in their "regions".

- Community groups that are not “health-related” should be involved in planning and in the intervention.
- Education and recreation are topics that motivate people.
- Community engagement needs the “youth voice”. Youth should be involved in a systematic way.
- Getting feedback from community members should occur on an ongoing basis.
- People in communities should be taught how to obtain the information/data that they need to support their efforts to create a healthier community.
- “Successful” communities can be used to mentor other communities.
- The Health Equity Index should be used in community engagement.

V. Policy Scans and Gaps

- The American Heart Association has the capacity to locate Connecticut and U.S. policies.
- The Division of Adolescent and School Health (DASH) collects and reports data on youth health risk behaviors and school-based health policies and programs.
- The SustiNet Health Care Cabinet is an advisory board consisting of government and non-government members and is involved in making health policy recommendations. This group should be involved in policy scans because they will be familiar with health policies.
- Established methodologies should be used when conducting the policy scan.

VI. General Comments

- Must identify what makes Connecticut unique from other grant applicants.
- Communication between agencies, partners, communities, programs, etc. will be very important to this grant.
 - i. Ongoing communication will be necessary to influence policies and build trust.
- The process should address the following disparities:
 - i. Racial, Ethnic, Gender, and Disabilities

Region 1 (Southwest CT)

1. Establish or strengthen a multi-sectorial community/regional coalition.

Existing coalitions:

- Fairfield Community Environmental Justice Coalition.
- Bridgeport ABCDE Coalition (Community Development) – Focus on disparities.
- Stratford, Trumbull, Stamford, Westport, Norwalk and New Canaan all have coalitions.

Barriers/Comments

- Bringing smaller coalitions together can be a challenge.

- Who would convene meetings?
- Towns like Greenwich have low-income housing that most people are not aware of.
- Economics of cities and towns vary greatly

2. Summarize existing community health data and/or collect local health data, including the identification of population subgroups experiencing health disparities and inequities.

Existing Data sources:

- Bridgeport Health Department has conducted their own health survey, creating a data portal.
- Data Haven @ Yale – Unsure if the data are just New Haven or regional.
- Connecticut Hospital Association research data – CHIME data.
- DPH mortality Data.
- Behavioral Risk Factor Surveillance System (BRFSS) Data – Question if it can be broken down by region.
- BRFSS SMART data - Selected Metropolitan/Micropolitan Area* Risk Trends from the Behavioral Risk Factor Surveillance System.
- Census data.

Barriers/Comments

- It may be difficult to compare data sources as they are not all the same or standardized.

3. Conduct a health needs assessment of the community/region including identification of population subgroups experiencing health disparities and inequities.

- As part of Joint Commission requirements all hospitals must conduct health needs assessments. Many hospitals are working in collaboration with local health departments to do this.

Barriers/Comments:

- Region 4 has health needs assessment posted on the website (Local HD and hospitals).
- Check Regions 2 & 3 for Public Health Ready program (assessment for emergency preparedness). Check National Association of County & City Health Officials – Project Public Health Ready (All hazard approach)
- Department of Emergency Management and Homeland Security is overseeing a needs assessment for emergency preparedness – it may be a useful model for DPH to follow.
- Need to improve access to needs assessment data – it is in multiple locations.
- May be difficult to combine local health needs assessments into one regional picture.
- There are inconsistencies in data.
- Check Health Equity Index (used by local health departments) – looks at socioeconomic determinants of health.

4. Community engagement with minority communities.

Community engagement is a part of:

- Fairfield County Environmental Justice Coalition
- Fairfield County Safety Coalition
- Local Health Depts. Healthy Eating Coalition
- Neighborhood Revitalization Zone program
- Activities in the REACH & ACHIEVE grants
- Preventive Resource Center (Yale/Griffin Hospital)
- YMCAs
- Community Health Centers

Barriers/Comments

- Cultural differences within groups
- Undocumented immigrants
- Transient populations
- Multiple languages within one subgroup
- Health department workforce does not represent the communities we serve. There needs to be more community representation.
- Too many small coalitions – How do we get them to work together?

5. Conduct policy scan and identify gaps in existing policies, environments, programs and infrastructures.

Barriers/Comments

- There are local ordinances and municipal statutes in cities, and regulations in local health districts. All can be more stringent than statewide policies. Often are easier to get approval and to implement.
- Look at what is happening in local schools, such as regulations to remove vending machines, healthy food options, etc. The CT School Nurse Association may be a good resource for individual school health policies.
- No natural regional authority in place – DPH may want to look at Department of Emergency Management and Homeland Security model for regional authorities – (Emergency Operation Centers).
- Changes in physical environments and community development are necessary to bring about policy changes.
- Need to look at zoning regulations
- Need to identify existing bike paths/walking trails.

Region 2 (South Central CT)

The facilitator briefly outlined the strategic directions and how the CTG supports policy, environmental, programmatic, and infrastructure changes.

General Topics

DPH approach. Participants expressed concerns about the DPH approach from the perspective of eligibility and the impact of the DPH application on other potentially eligible counties. For example:

- Larger counties can apply independently. Some concern exists about submitting multiple applications (statewide and individual counties).
- Concern exists that a county infrastructure does not exist, albeit county boundaries exist. The absence of a county infrastructure may work against counties considering a submission.
- Areas of the state might be very different, and this creates a less targeted approach. Changing health outcomes requires targeted efforts.

Defining the region. The regional designations appear somewhat arbitrary.

- The regions used for the purpose of this discussion may or may not make sense. The regions do not match the county boundaries.
- Too many regional designations exist, and this issue begins with State agencies. Geographic areas tend to host multiple "regional" collaborative approaches, yet this does not necessarily lead to better coordination of services or data collection/planning.
- Concern existed that by engaging in the discussion, DPH leaders would view this as an "endorsement" of this particular regional approach.

Building a Coalition

- DPH might think about developing statewide coalitions (with representatives from all regions) around specific issues and then allowing regional collaboratives to pick up the models and implement. Organizing collaboratives by regions tends to place the same players in the rooms, and this does not always lead to productive discussion and may limit perspective to only what exists (or does not exist) within that region.
- The politics across regions tend to be very different. Knowing the players and politics across all regions takes time and energy for those organizations / people who work across geographic areas.
- Some vibrant coalitions exist now within towns and across towns. These coalitions contain history (i.e., issues, leadership) and may or may not be able to be replicated or expanded. Also, changing an existing coalition requires organizational support and a commitment to work through the change process: What benefits exist? What limitations? What unintended consequences? What is at stake to not change?
- Continuity of leadership and membership tends to change over time, particularly when leadership positions are linked to elected officials.
- Must figure out how to engage with and coordinate between other planning initiatives and bodies such as the Council of Governments that do planning / governing with a broader geographic perspective.
- Challenge to engage the consumers of services in meaningful ways in leadership positions in coalitions.

- The more significant coalitions such as the Directors of Health and DPH must first get on the same page, establish common ground, and improve their relationship/capacity to move a coordinated agenda.
- Be clear on resources and communicating statements related to how resources will get divided – must balance needs, politics, and adjust for cost variations in rural/urban areas, among others.

Community Health Data

- Supply more current data.
- Supply data that relates to answering the question, “is this working...has the situation gotten better?” And connect the question back to the resources. For example, tobacco-related behavior and health outcomes could look much different if tobacco funds are invested in tobacco prevention activities.
- Provide / increase capacity to deliver special analyses relevant to local/regional planning; at local level, resources / expertise are not always available.
- Modernize computer systems.
- Standardize data collection and data interoperability (e.g., hospital data collected on different information platforms).
- Promote data sharing across different health information systems at aggregate level and across geographies.
- Incorporate national, state, and local benchmarks into data reports so the data holds more meaning in the context of “how are we doing?”
- At State (agency) level, promote standardized data collection and reporting that translates into more meaningful and useful reports.
- See also suggestions under Needs Assessment.

Needs Assessment & Health Disparities / Health Equities

- At State level, get on the same page and timeframe about conducting needs assessments related to health / well being.
- Establish a clear direction for a five-year period and ask funders/stakeholders to invest their funds in one primary process.
- Provide adequate resources to conduct comprehensive needs assessment (v. compiling and quilting disparate reports).
- Engage human resources (low cost or free) from university and high school students – this will require a clear plan of action and training.
- Hospitals are currently planning for or starting needs assessment processes; catchment areas differ by hospitals; methods differ; and sometimes purposes differ (e.g., hospital attempting to demonstrate need for a type of facility that generates significant revenue). These needs assessments may or may not be helpful to the community/region. Find a way to engage the hospitals in the planning process.
- Community needs assessment requires strong community input / engagement. Use a process that allows the community to state their perceived situation and needs v. the experts v. the data. Stop relying on a few focus groups or public sessions to meet a public input requirement.

- Conduct needs assessments at levels that allow for accurate and meaningful reporting (at a smaller geographic unit of analysis) of health disparities and inequities.
- Use methods to effectively communicate findings – including those findings that may be politically or economically unappealing in the short term. For example, poor health in a specific town may relate to lower academic achievement which relates to lower demand for home sales. Sometimes, the information gets lost in translation – which then limits change.
- Use the Connecticut Cancer Plan as a model process.

Community Engagement with Minority Communities

- Define more clearly what community engagement means across all components of the process (e.g., leadership, coalition membership, participation in needs assessments, implementation).
- Narrowing target groups tends to result in better community engagement, and also requires more resources. Define the issue that helps determine who to engage.
- Determine the specific role / responsibility of public health (local / State) in conducting community engagement. Often public health works with other groups who are skilled in community engagement.
- Determine how and when to engage groups. For example, engage them in health needs assessments, engage them in interpreting findings and identifying solutions, and engage them in implementation.
- Find a way to emphasize how active participation / engagement impacts health outcomes of friends and family members.
- Find a way to de-politicize the engagement and to share the information, particularly with leaders who may be threatened by the outcomes of the discussions.
- Focus on high risk behaviors (not high risk populations).

Policy Scan

The group ran out of time prior to finishing discussion on the barriers related to policy development. Initial thoughts included:

- State leaders must coordinate their planning agendas, time frames, resources, tools/methods, and commit to a longer term process (that does not change with elections).
- Leaders must be on the same page in how they communicate the message to the public.
- Legislature and lead committees should be on the same page about conducting needs assessments (e.g., hospitals, regions, agencies).
- Find a way to fund / support the organizational development necessary to build / grow functional coalitions.
- Find a way to get elected officials across towns to support a health policy agenda for their towns and their school districts.

Region 3 (North Central CT)

Note: Region Three includes parts of three counties – Middlesex, Tolland, and Hartford

CAPACITY BUILDING ACTIVITY 1) Identify community based agencies/organizations or coalitions that align with the five Strategic Directions:

- CT Breastfeeding Coalition;
- Local Mental Health Authorities;
- Hospital Groups (eg: Eastern Connecticut Health Network, Community Health Centers, etc.);
- CT Hospital Association;
- *Public – Community representation is clearly needed!* Residents to help us move in the right (transforming) direction; and
- Safe Physical Environment: include police on planning committee...if 'safe' is all forms of safety.

Barriers: Doing the same old thing with the same old partners. Need to transform!

CAPACITY BUILDING ACTIVITY 2) Existing community health data-what exists, what is needed:

- Health Equity Index is in process in some communities: data comes from a variety of sources;
- Electronic Health Records needed to track all activity per patient-only have each little piece currently, cannot see the whole or treat the whole without other pieces;
- Hospital Data;
- Regional Action Councils (RAC) data –they are required to perform community surveys, have some local data; and
- Discovery Collaborative- has early childhood data.

Barriers:

Utilize different numerators and denominators throughout different surveys equal hard to compare results. Access to specific populations varies: e.g.: school based data; senior data collection only includes those seniors who get out of the house and go to community programs, college population may be reachable, but 18-25 year olds continue to be mostly missed.

Capacity Building Activity 3: Health Needs Assessment: Population subgroups that experience health disparities and inequities.

- Health Equity Index helps to determine subgroup status;
- Non-diverse staff is a barrier “public health has become a world of white women”; and
- Lack of cultural competency may be overcome by use of community outreach workers (also see below).

CAPACITY BUILDING ACTIVITY 4: Community Engagement with Minority Communities:

Workforce development is critical: Tap into current workforce, expanding roles of current job titles.

E.g.: Increase work time from 35 to 40 hours/week - and add community development to job description, so those workers go into community to facilitate community engagement for the extra five hours/week.

Success: Opportunity Knocks has done focus groups, including subgroups e.g.: parents of young children to discuss barriers to adopting healthy nutrition habits – this process has been effective in promoting change, they have buy-in/take ownership of the 'problem' by being included in the solution.

CAPACITY BUILDING ACTIVITY 5: Conduct Policy Scan, identify policies addressing all areas:

- Promote environmental strategies in human services.
- Data is the key!
- Need to identify the gaps, and work with coalition members including the public to resolve different/incorporate better policies and strategies.

Region 4 (Eastern CT)

Before addressing the barriers for each capacity building activity, the group discussed several broader topics.

General Topics

- **Building on ACHIEVE successes.** Three health districts (Ledge Light, Eastern Highlands and Northeast) representing 22 towns received CDC funding for the ACHIEVE initiative to substantially implement the five capacity building activities. The CDC provides extensive training to ACHIEVE communities. Willimantic is a key community not included in ACHIEVE. Given the success with ACHIEVE, this approach could be expanded to Willimantic and the other Eastern CT towns. Participants suggested that this region (or smaller sub-regions) could move from capacity building to implementation fairly quickly.
- **Defining the region.** Participants highlighted the difficulty in defining a region. Depending on the sector / project health districts in are different regions (including different counties). Region 4 only applies for emergency preparedness. Willimantic, part of the Enfield Health District, is often left out of discussions and regional efforts. Because there are no county governments in CT, defining regions is much more complicated than in other states.
- **Applicability of a regional approach.** Participants argued that most policy change efforts focus on either state policies (e.g., smoking bans) or town policies (e.g., school district, town budgets, zoning). Even seemingly regional systems (e.g., bus routes) are based on budget decisions at the town level.

The group then discussed barriers and challenges in their capacity building efforts, and strategies for addressing these challenges.

Building a Coalition

- Identify who from a 10-town region to bring to the table. You do not want to have 10 of each stakeholder (e.g., superintendents), or the coalition will become too large. A solution is to identify policies in a regional coalition, and focus on addressing these policies at the town level.
- Condense the work to manageable bites. The coalitions focused on which policies they can change, and which policies can have the greatest impact.
- Engage stakeholders from different sectors. Staff sowed the seeds for participation over many years through relationship-building. It's also important to have a clear plan and vision for the coalition, and to clearly articulate the connection between the sector (e.g., transportation) and health. It can be easier to engage non-health stakeholders in a rural community that does not have major health providers.
- Address barriers to participation. In Willimantic, it is critical to address cultural and language as barriers to participation.

Community Health Data

- Go beyond the numbers. Health data needs to look beyond the number of participants in programs. It is also important to collect rich, qualitative data that comes from being in communities for a long period of time.

- Measurement of policy and systems change. Measurement is a real challenge for policy and systems work and require different outcome measures than for programs. Several foundations including Annie Casey have been researching how to measure success in this area.

Need Assessment & Health Disparities / Health Equities

- New London has piloted the Health Equity Index. This allows you to get to the neighborhood level, and can serve as a launching pad for conversations with policymakers and neighborhood residents.
- Different populations experience health disparities in the region. Many isolated rural communities have poorer health outcomes, due to lack of transportation and lack of trust (e.g., traveling to a city hospital). In Willimantic, a key group is undocumented residents, where language and lack of trust is are major barriers to care.

Community Engagement with Minority Communities

- Address neighborhood mistrust. Through the Health Equity Index (HEI), New London engaged the community in a neighborhood rollout plan. Staff held neighborhood focus groups and listened to resident concerns, and tried to identify an action item that could lead to an immediate result (i.e., not just seen as more talk by outsiders). Often, staff would come back to the group to discuss what they did, and perhaps request additional neighborhood actions (e.g., residents attend a Town Council meeting).
- Staff time for community engagement. The HEI provided significant funding over two years for the pilot-test, but that funding is now ending. It takes substantial staff time to do this work at the neighborhood level.

Policy Scan

- Through ACHIEVE, the CDC has identified the key policies to examine. These helped the health districts in deciding on policy priorities.
- Make the case for policy and systems change. Health department staff need to understand the social determinants of health. Then they can make the case for these policies at public hearings where policymakers are deciding whether to make budget cuts to bus routes, etc. This is a real challenge, given the recession and the opposition of many residents to property tax increases.
- The public health results of policies and societal changes are not seen for many years. For example, as women entered the workforce, there was no safety net for families with respect to healthy eating. More families began eating fast food and processed food. Over time, people stopped learning how to cook from their families. We can see these effects today.
- Addressing social/emotional health and healthy/safe physical environments. ACHIEVE does address these issues to a certain extent, depending on the community.
- Look at state policies. DPH can start with its own policies, ensuring that there adopted for all community meetings (e.g., healthy food at all meetings).

Region 5 (Northwest CT)

1. Current Coalition. Organizations

- UCONN, Waterbury Extension-Danbury & Torrington, Danbury Western Connecticut State University, Community Colleges – Naugatuck Valley Community College.
- Greater Torrington/Litchfield Charlotte Hungerford Healthy Planning Team
- Hospitals in Region 5 – Needs Assessment (Danbury, Charlotte, Sharon, St. Mary's, Waterbury Griffin, New Milford Hospital).
- CADH – Health Equity Index-Torrington and other community
- Office of Rural Health Torrington
- Litchfield Food Policy/Food Coalition–Torrington WIC.
- Waterbury Food Resource Committee and CT Food Bank, other food pantries, shelters and churches.
- Danbury Farmers Market Community Collaborative – Peggy Zorne.
- Safe Environment Brown Fields coalition.
- New Milford Hospital–Plow to Plate Program.
- Wholesome Wave Organization – Michele Nischan.

2. Existing Data

- Area Hospitals
- YG PRC – Yale Griffin Prevention Research Center
- Local health departments – community health assessment for accreditation, CHIP improvement plan
- Heart Safe Communities (state-wide)
- Stay Well Health Center and other community Health Centers (Danbury)
- New Opportunities (meals on wheels, other services – (Greater Waterbury Area)
- VNA –expanding – maybe new/recent data?

3. Needs Assessment–See above

4. Community engagement w/ minority populations

Now Inc., (Valley) team see below

- Senior Centers
- Shift in Spanish – speaking/minority population from urban → suburban population emergency preparedness
- Linguistic Inequities and healthcare inequities – obtained from Early Census Data
- Neighborhood Revitalization- Parish Nursing
- Community Recreation Department
- YMCA – Waterbury, Danbury, Torrington, Naugatuck
- Hispanic Center of Danbury

5. Policy Scans – very little done in this area

- State Food policy
- RUDD Center obesity and policy research
- End Hunger CT

*Region has 3 sections–DEMHS–Waterbury, Danbury, and Torrington

*ACHIEVE Communities/Preventive Block Grant – Communities including Injuries

*NOW, Inc. – New Opportunities, Team – Naugatuck Valley, Education Connection – Torrington

Community Anti-poverty agencies

COMMENTS AND NEXT STEPS

Chris Andresen reconvened the group and asked participants to share any general questions or comments about the CTG and small-group discussions.

Question: Realizing that this is a new process for DPH, how would you envision this group's role going forward? How will the group be involved if the grant is funded, or if the grant is not funded?

- Chris: We've wrestled with that question as well. In one respect, we are building a network to promote public health in Connecticut. This is the ultimate networking opportunity. It can build connections across organizations and individuals, connect names and faces, and reinforce relationships. A question that came up in our breakout group is how do you catalogue all the skills, knowledge, abilities and willingness to contribute across organizations and sectors? How do we replicate successes in some communities in other towns and communities?

Question: We initially divided into the five Department of Emergency Management and Homeland Security regions, but you can divide the regions very differently (counties, other regional groups). The CDC is looking at county-level regions. How will this dialogue – how we define regions – play out?

- Chris: We are still looking at this issue and working it out now. One idea was to use peer communities, cities and communities that are comparable. The CDC has been fairly flexible in the past, so we should be able to define regions in a way that makes sense for Connecticut.

Question: What does DPH need from the participants to complete the grant? What are the next steps in completing the grant?

- Chris: We need to write up and distill the notes from this meeting first, and then identify what we still need for the application. We may reach out to the full group or approach individuals with specific requests. But over the next month, we will be mainly focused on writing the application.

Lisa Davis thanked everyone for their participation – this group has been very helpful in developing the CTG application. DPH sees the community-based approach for CTG as a model for other grants as well.

Chris Andresen noted that DPH will keep partners updated via its website – www.ct.gov/dph/communitytransformation – and answer additional questions via its CTG email (dph.comtransfo@ct.gov).