Community Health Improvement Learning Collaborative

Webinar #4

Focus on What's Important

Choose Effective Policies and Programs

January 21st, 2016

Agenda Today

- Welcome
- Discussion of Concepts and Cross-cutting Tenets
- Example from the Field
- Example Tool
- Wrap-up and Next Steps

Overview of Key Concepts

WORK TOGETHER

ENGAGE THE COMMUNITY

COMMUNICATE

SUSTAIN IMPROVEMENT RESULTS

Evaluate Actions

Assess Needs & Resources

Focus on What's Important

Choose Effective Policies & Programs

Act on What's Important

Collective Vision

People

Community Developers

Businesses

Education

Government

Philanthropists & Investors

Faith-Based Organizations

Health Care Providers

Public Health

Health Insurance

Nonprofits

Key Concepts: Focus on What's Important

- **Processes and criteria** that are open, transparent, and objective are used to set priorities

- Development of goals based on an **analytic framework or logic model** that conveys known or hypothesized causal pathways, upstream social and environmental determinants, and insights about what it takes to improve population health

Q&A / Discussion

- After discussing prioritization (“Focus on What’s Important”) on the TA call and now seeing the key concepts for this phase, what questions do you have?

Key Concepts: Choose Effective Policies and Programs

- A coordinated **plan of action and alignment**, where partners may pursue different but complementary activities that are consistent with their strengths and capacities, is developed

- A selection of **evidence-informed interventions from databases** that have a clear ratings system, and can match the unique populations and stakeholders to appropriately matched interventions, is identified

Key Concepts: Choose Effective Policies and Programs

- Activities and actions chosen for implementation include a **mix of individual-based, environmental-change, and policy/systems-change interventions**

- Where evidence is lacking, select **new and innovative solutions**, combined with adequate resources for impact evaluations

Working Together and Engaging the Community in Prioritization and Planning

- **Work Together**
  - A common understanding of issues and priorities
  - Shared accountability and ownership
  - Multi-sector collaboration
- **Engage the Community**
  - Diverse community stakeholders are engaged as ongoing partners
  - People who represent the broad interests of the communities served, particularly vulnerable/underserved populations, offer input as part of the prioritization and strategy selection

Communication in Prioritization and Planning

- A process that ensures **ongoing communication** among stakeholders is established
- **Results** of each phase of the CHI process as well as key messages that build public and political support for action are **shared with the community (public)**, including evaluation results

Sustainability in Prioritization and Planning

- The actions resulting from the CHI process are valued and **maintain support and resources** (e.g., people, organizations) to continue/sustain change into the future
- A **backbone infrastructure (BBI)** is established and coordinates activities
- **Policy, systems, and environmental solutions** are included in the actions implemented for lasting change

Q&A

Examples from the Field

- Healthy St. Mary's Partnership
  - How did your partnership work together to select agreed upon strategies?
    - What worked well?
    - What were the challenges?
  - What processes, tools or other resources did your partnership use to facilitate the strategy selection process?
    - How did you find the strategies that your partnership considered?
    - What role did the HSMP play?
    - How did partners align their action to create a balanced portfolio of strategies?

Q&A

CDC COMMUNITY HEALTH IMPROVEMENT NAVIGATOR

Using the Community Health Improvement (CHI) Navigator Database

Denise Koo, MD, MPH
Advisor to the Associate Director for Policy, CDC
dkoo@cdc.gov

CDC Learning Collaborative January 2016

Centers for Disease Control and Prevention
Office of the Associate Director for Policy

Factors that affect health

Smallest Impact

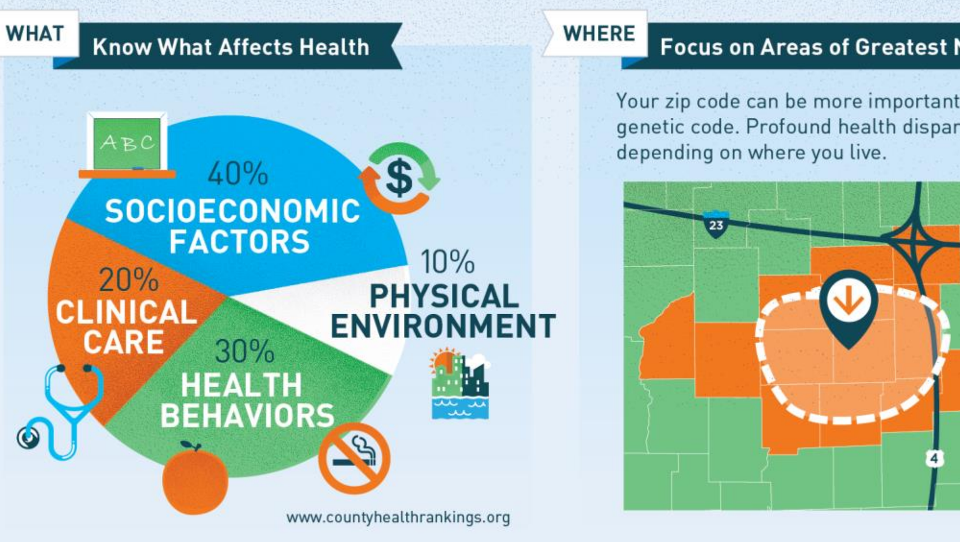
Largest Impact

Pyramid level	Examples
Counseling & Education	Eat healthy, be Physically active
Clinical Interventions	Rx for high blood pressure, diabetes
Long-lasting Protective Interventions	Immunizations, colonoscopy
Changing the Context *to make individuals' default decisions healthy*	Seat belt laws, fluoridation, smoke-free laws
Socioeconomic Factors	Poverty, education, housing, inequality

Frieden TR. A framework for public health action. Am J Public Health. 2010;100(4):590–595

INVEST IN YOUR COMMUNITY
4 Considerations to Improve Health & Well-Being *for All*

WHAT — Know What Affects Health



www.countyhealthrankings.org

WHERE — Focus on Areas of Greatest Need

Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.

WHO — Collaborate with Others to Maximize Efforts

HOW — Use a Balanced Portfolio of Interventions for Greatest Impact

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Four ACTION Areas

SOCIOECONOMIC FACTORS

PHYSICAL ENVIRONMENT

HEALTH BEHAVIORS

CLINICAL CARE

VISIT **www.cdc.gov/CHInav** FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

MARCH 2015

Motivations for CHI Navigator Database

- Challenge moving from planning to action
- Need from C-suite for interventions that are evidence-based
- Shortage of resources to identify evidence-based interventions (including lack of awareness of sources)
- Balance of level of evidence: continuum from innovation/cutting edge to "tried and true"
- Need for "balanced portfolio" of interventions for greatest impact

Evidence Says Diet + Physical Activity Programs Reduce Type 2 Diabetes

The Community Preventive Services Task Force recommends combined diet and physical activity promotion programs to reduce new-onset type 2 diabetes

1 2 3 4

Task Force

2014 Meetings
October 29–30

2015-2016 Meetings

Annual Reports to Congress

Text Size: S M L XL

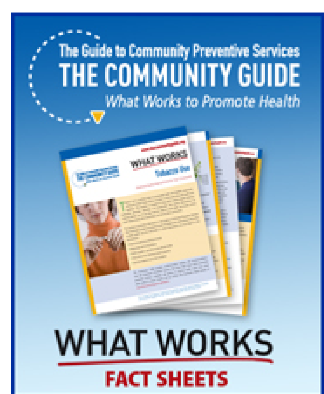
Get Email Updates

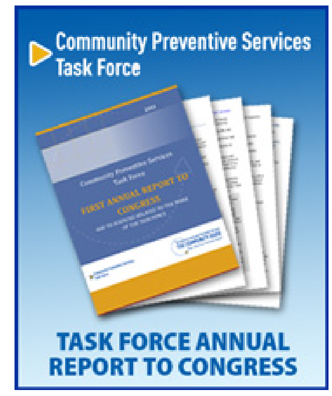
Submit your email address to get updates on The Community Guide topics of interest.

Your email address

Submit

What's this?





Topics

Adolescent Health	Diabetes	Motor Vehicle Injury	Social Environment
Alcohol - Excessive Consumption	Emergency Preparedness	Nutrition	Tobacco
Asthma	Health Communication	Obesity	Vaccination
Birth Defects	Health Equity	Oral Health	Violence
Cancer	HIV/AIDS, STIs, Pregnancy	Physical Activity	Worksite
Cardiovascular Disease	Mental Health		

What is The Community Guide?

The Guide to Community Preventive Services is a free resource to help you choose programs and policies to improve health and prevent disease in your community. Systematic reviews are used to answer these questions:

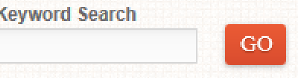
- Which program and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

Learn more about *The Community Guide*, collaborators involved in its development and dissemination, and methods used to conduct the systematic reviews.

A Robert Wood Johnson Foundation program

Using What Works for Health
Our Ratings
Our Methods
Our Sources
Choosing Your Strategy

Browse All Policies & Programs



What Works for Health

What Works for Health provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health.

WANT TO LEARN MORE? - View our 4 minute *What Works for Health* Tutorial.

To learn more about strategies that could work in your community, select a health factor of interest (the light blue boxes on the far right) in the model below.

New Policies & Programs

ADDED 10/3/2014
Prescription drug monitoring programs (PDMPs)

ADDED 10/3/2014
School-based social and emotional instruction

ADDED 10/3/2014
Conservation tillage practices

Browse New Policies & Programs

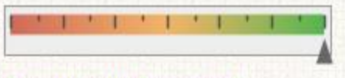
Find Policies & Programs

What Works for Health is a work in progress. If you are interested in learning about a policy, program, or systems change but don't find it here, contact us.

Browse All Policies & Programs

Activity programs for older adults

Evidence Rating



Scientifically Supported

Health Factors

Diet and Exercise
Family and Social Support

Decision Makers

Healthcare
Government
Non-Profit Leader

Programs for older adults offer educational, social, or physical activities in group settings that encourage personal interactions, regular attendance, and community involvement. Activity programs are a potential means to reduce isolation, and isolation among older adults is associated with poorer health outcomes (Coyle 2012).

Expected Beneficial Outcomes

- Improved health outcomes
- Improved mental health
- Reduced isolation

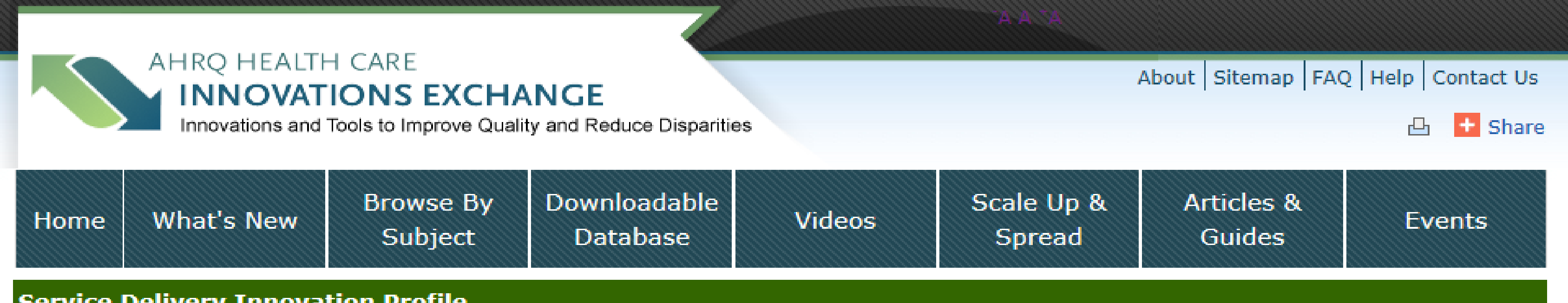
Evidence of Effectiveness

There is strong evidence that educational, social, and physical activity programs for older adults improve mental and physical health outcomes among participants (Hertzog 2009, RAND-Shekelle 2003, Glass 1999, NREPP-EnhanceWellness 2012). Such programs have been shown to reduce loneliness (Cattan 2005), protect against social isolation (Wick 2012), and improve physical, emotional, and social quality of life for older adults (NREPP-PEARLS 2012, CDC-EnhanceFitness).

Social engagement and physical activity programs can benefit cognition for elderly adults (Hertzog 2009) and can decrease their risk of death (Glass 1999). Physical activity programs have been shown to reduce falls, improve strength, and reduce depression among older adults (RAND-Shekelle 2003, Bridle 2012). Exercise classes combined with health promotion education can increase levels of physical activity, improve attitudes toward physical activity, and enhance mental and physical health (NREPP-EnhanceWellness 2012). Senior center activities can also foster new supportive friendships (Aday 2006).

Activity programs are feasible and low cost initiatives when implemented in existing community and

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care



Service Delivery Innovation Profile

Culturally Tailored Chronic Disease Education Program Improves African American Patients' Self-Management Behaviors, Blood Pressure and Blood Glucose Control, and Quality of Life

Snapshot

Summary

The Health Empowerment Lifestyle Program (more commonly known as HELP) is a culturally tailored program to educate minority populations with diabetes, hypertension, or overweight/obesity about appropriate management of these conditions. Trained patient navigators who work in participating clinics recruit eligible patients and encourage their ongoing participation, while a trained community health worker leads nine weekly 2-hour classes held in the clinics. Topics cover various risk factors for the targeted conditions; key health indicators for monitoring them, including target levels; and the benefits of managing diet, physical activity, and medication. The curriculum is designed to

Contact the Innovator

Look for Similar Items by Subject

Hypertension
Obesity
Diabetes
Chronic-disease management
Medication adherence
Improving patient self-management

SOLUTIONS | HCI PLATFORM | RESOURCES | ABOUT HCI | BLOG | CLIENT CENTER

ANOTHER KEY FEATURE OF HCI SOLUTIONS:

Readily identify priority areas for strategic initiatives.

Unlock data. Gain Knowledge.
Focus resources. Measure results.

HCI PLATFORM

The leading community and population health improvement platform helps make your programs vital and strategic.

From Insight to Action. The HCI Platform supports hospitals, public health agencies, community coalitions and other health organizations in their community and population health strategies. Mapping and data visualization tools readily identify intervention opportunities for targeting resources. A database of thousands of evidence-based programs lets you filter to find the most appropriate for your strategies. Collaboration centers bring like-minded groups together to align objectives and orchestrate core capabilities. And customizable trackers and indicators provide a "single source of truth" for measuring success.

"*The HCI Platform is as easy as 1-2-3: Gain insights on key health needs for sub-*

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Solutions for Health Departments
Solutions for Coalitions

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The Second Curve of Population Health

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Home > Promising Practices

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Promising Practices

The Promising Practices database informs professionals and community members about documented approaches to improving community health and quality of life.

The ultimate goal is to support the systematic adoption, implementation, and evaluation of successful programs, practices, and policy changes. The database provides carefully reviewed, documented, and ranked practices that range from good ideas to evidence-based practices.
Learn more about the ranking methodology.

Submit a Promising Practice

Building Organizational Capacity to Advance Health Equity (Davidson County, TN)

LOCAL

Filed under Local, Good Idea, Government & Politics / Programs, Policies, & Laws, Racial/Ethnic Minorities

GOAL: The mission of the Metro Public Health Department is to protect and improve the health and well-being of all people in Metropolitan Nashville.

IMPACT: Metro Public Health Department of Nashville/Davidson County has implemented department-wide strategies to address existing health inequities.

Re/Storing Nashville (Davidson)

LOCAL

Filed under Local, Good Idea, Health / Exercise, Nutrition, & Weight, Children, Teens, Adults, Women, Men, Elderly, Families, Racial/Ethnic Minorities

GOAL: Re/Storing Nashville seeks to end hunger through creating a healthy, just and sustainable food system.

The Cooks Academy at Old Cockrill (Nashville, TN)

LOCAL

Filed under Local, Good Idea, Health / Exercise, Nutrition, & Weight, Teens, Women, Urban

GOAL: The program offers an integrated food experience to students and

Search Filters (2163 results) Clear all

Keyword Search

Search

Sorting

Sort by relevance

Ranking

- Evidence-Based Practice
- Effective Practice
- Good Idea

Featured

- Local
- CDC Community Guide
- Spotlight

Primary Target Audience

- Children
- Teens
- Adults
- Women
- Men
- Elderly

Reports

A Compendium of Proven Community-Based Prevention Programs

OCTOBER 2013

The Trust for America's Health (TFAH) and New York Academy of Medicine (NYAM) released *A Compendium of Proven Community-Based Prevention Programs*, which highlights 79 evidence-based disease and injury prevention programs that have saved lives and improved health.

"Over the past 50 years, healthcare costs have risen drastically—accounting for 18 percent of the Gross Domestic Product," said Jo Ivey Boufford, MD, president of The New York Academy of Medicine. "Some of the costliest chronic conditions have been the drivers of these costs—yet a significant number of these illnesses and injuries could have been prevented. Quite simply, disease and injury prevention programs are the key to reversing spiraling costs and safeguarding the future health and wealth of the nation."

The Compendium notes that, since 2008, the number of effective community-based programs and interventions has grown exponentially and the report identifies specific programs—that can be taken to scale—which prevent disease and create a healthier population.

"The Compendium highlights the growing number and range of successful, evidence-based approaches to prevention," said Jeffrey Levi, PhD, executive director of TFAH. "These efforts demonstrate that making healthy choices easier for people in their daily lives pays off in terms of improving health and lowering health care costs. This report documents how these programs can and do work – but we need to invest more if we're going to bring them to scale and improve the nation's health."

The Compendium is a follow-up to a 2009 report released by TFAH and NYAM, which followed a 2008 TFAH study that found that an investment of $10 per person per year in proven evidenced-based community prevention programs that increase physical activity, improve nutrition and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years—a return of $5.60 for every $1.

The report was supported by grants from The Kresge Foundation and the Robert Wood Johnson Foundation.

In conjunction with releasing the Compendium, TFAH also published several stories in the story bank of Prevention and Public Health Stories in the states, which highlight what is working in communities to make the healthy choice the easy choice: http://healthyamericans.org/health-issues/prevention-page.

REPORT MATERIALS

Access the full report here.

Access the news release here.

Read more Prevention and Public Health Stories at the state and local level here.

SEE ALSO

The State of Obesity: Better Policies for a Healthier America

Investing in America's Health: A State-by-state Look at Public Health Funding & Key Health Facts

F as in Fat: How Obesity Threatens America's Future 2013

See the Obesity initiative page for more reports, news and resources.

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- ☑ nonstop $267
- ☑ 1 stop $282
- ☑ 2+ stops $288

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Fri 5:30a - 10:00p

Take-off Boston
Sun 5:30a - 7:30p

Show landing times

Airlines

Carrier | Alliance

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- ☑ US Airways $282
- ☑ Multiple airlines

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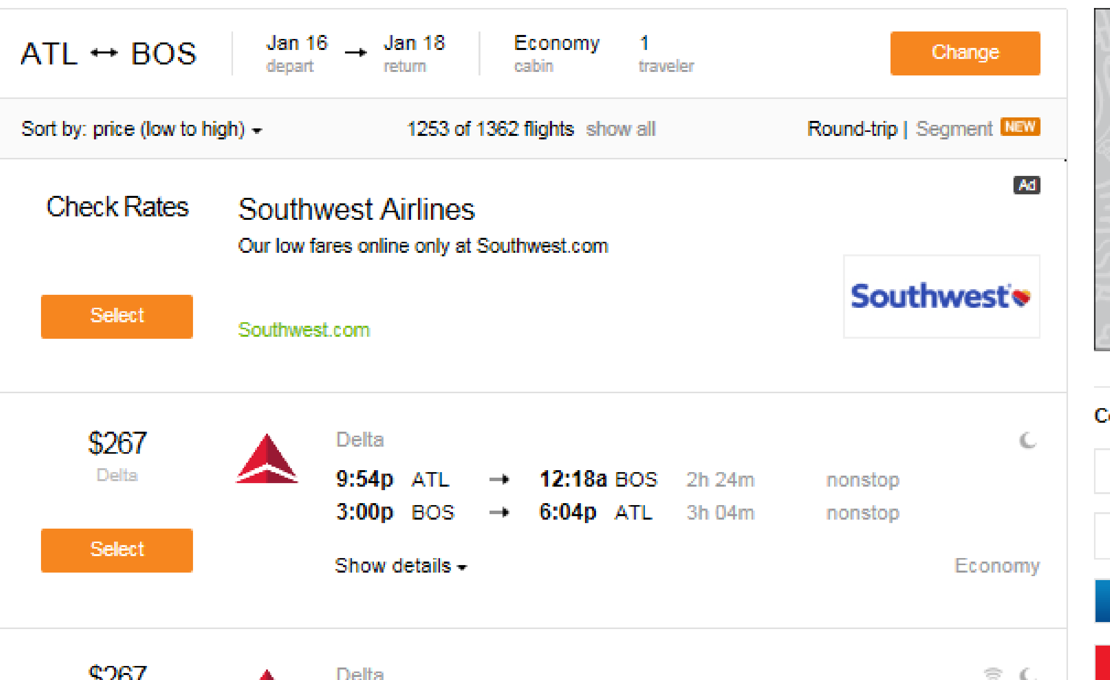

$267
Delta

Select

Delta
9:54p ATL → 12:18a BOS 2h 24m nonstop
9:45a BOS → 12:51p ATL 3h 06m nonstop
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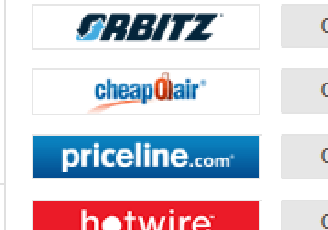
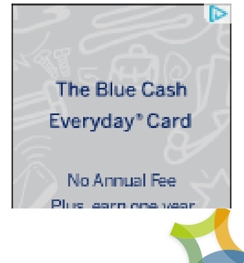
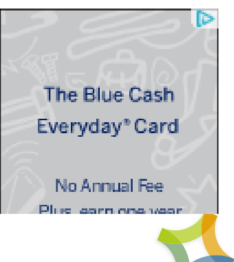
Compare Sites vs. KAYAK







Selecting Actions to Implement: Database of Interventions

Search engine of proven interventions can help move partnerships from planning to **implementation and action**, and in the end, to improved community health and well-being

- Drawn from source databases that met defined criteria for level of evidence and accessibility
- Search for interventions addressing specified risk factors associated with leading causes of illness and death in the U.S.
- Filter results by target populations, target outcomes/indicators, intervention types or settings/locations, and assets

Landing Page (www.cdc.gov/CHInav)

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

CDC Community Health Improvement Navigator

- CHI Navigator Home
- Making the Case for Collaborative CHI
- Tools for Successful CHI Efforts +
- Database of Interventions
- CHI Navigator Resources +
- Frequently Asked Questions

Recommend Tweet Share

CDC COMMUNITY HEALTH IMPROVEMENT NAVIGATOR

Invest in Your Community

Our health and well-being are products of not only the health care we receive and the choices we make, but also the places where we live, learn, work, and play. **Community health improvement (CHI) is a process to identify and address the health needs of communities.** Because working together has a greater impact on health and economic vitality than working alone, CHI brings together health care, public health, and other stakeholders to consider

Database of Interventions
(http://wwwn.cdc.gov/chidatabase)

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

CDC Community Health Improvement Navigator

Database of Interventions

SELECT
Filters

Clear all filters

TARGET RISK FACTORS

- Tobacco Use and Exposure
- Physical Inactivity
- Unhealthy Diet
- High Cholesterol
- High Blood Pressure
- Diabetes
- Obesity

TARGET POPULATIONS

- Racial/Ethnic Minorities
- Low Income
- Children/Adolescents
- Families
- Adults
- Older Adults
- Men
- Women
- Urban
- Rural

TARGET OUTCOMES OR INDICATORS

Four ACTION Areas

SOCIOECONOMIC FACTORS | PHYSICAL ENVIRONMENT | HEALTH BEHAVIORS | CLINICAL CARE

Select filters to get started

OR

Database of Interventions (cont'd)

SELECT
Filters

Clear all filters

TARGET RISK FACTORS

- [x] Tobacco Use and Exposure
- [ ] Physical Inactivity
- [ ] Unhealthy Diet
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] Diabetes
- [ ] Obesity

TARGET POPULATIONS

- [ ] Racial/Ethnic Minorities
- [ ] Low Income
- [ ] Children/Adolescents
- [ ] Families
- [ ] Adults
- [ ] Older Adults
- [ ] Men
- [ ] Women
- [ ] Urban
- [ ] Rural

TARGET OUTCOMES OR INDICATORS

- [ ] Tobacco Use and Exposure
- [ ] Physical Activity
- [ ] Healthy Food/Beverage Intake
- [ ] Cholesterol/Lipid Level
- [ ] Blood Pressure
- [ ] Hemoglobin A1c/Glycemic Control
- [ ] Body Mass Index/Weight
- [ ] Health Care Costs
- [ ] Mortality
- [ ] Treatment Adherence

INTERVENTION SETTINGS/LOCATIONS

Four ACTION Areas

SOCIOECONOMIC FACTORS	PHYSICAL ENVIRONMENT	HEALTH BEHAVIORS	CLINICAL CARE
24 RESULTS	24 RESULTS	28 RESULTS	14 RESULTS

- [x] Reviews (more info)
- [x] Individual Studies (more info)

FILTER BY ACTION AREA: Showing All — Go

Showing 1 to 10 of 72 results — Previous — Next

INDIVIDUAL STUDIES
The return on investment of a Medicaid tobacco cessation program in Massachusetts.

REVIEWS
Increase the Price of Tobacco

REVIEWS
Reduce Cost for Tobacco Cessation Therapy

REVIEWS
Promoting Health Equity Through Education Programs and Policies: Comprehensive, Center-Based Programs for Children of Low-Income Families to Foster Early Childhood Development

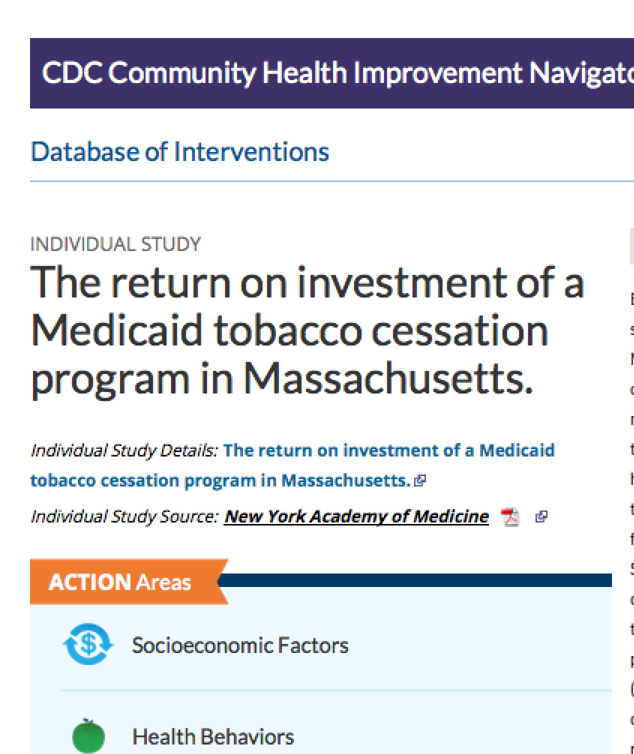
Database of Interventions (cont'd)

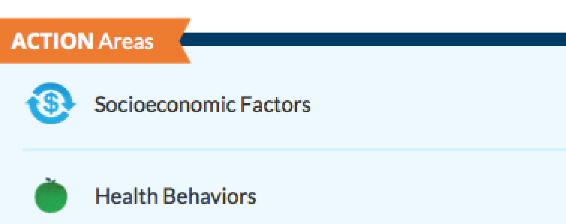
CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC Community Health Improvement Navigator

Database of Interventions

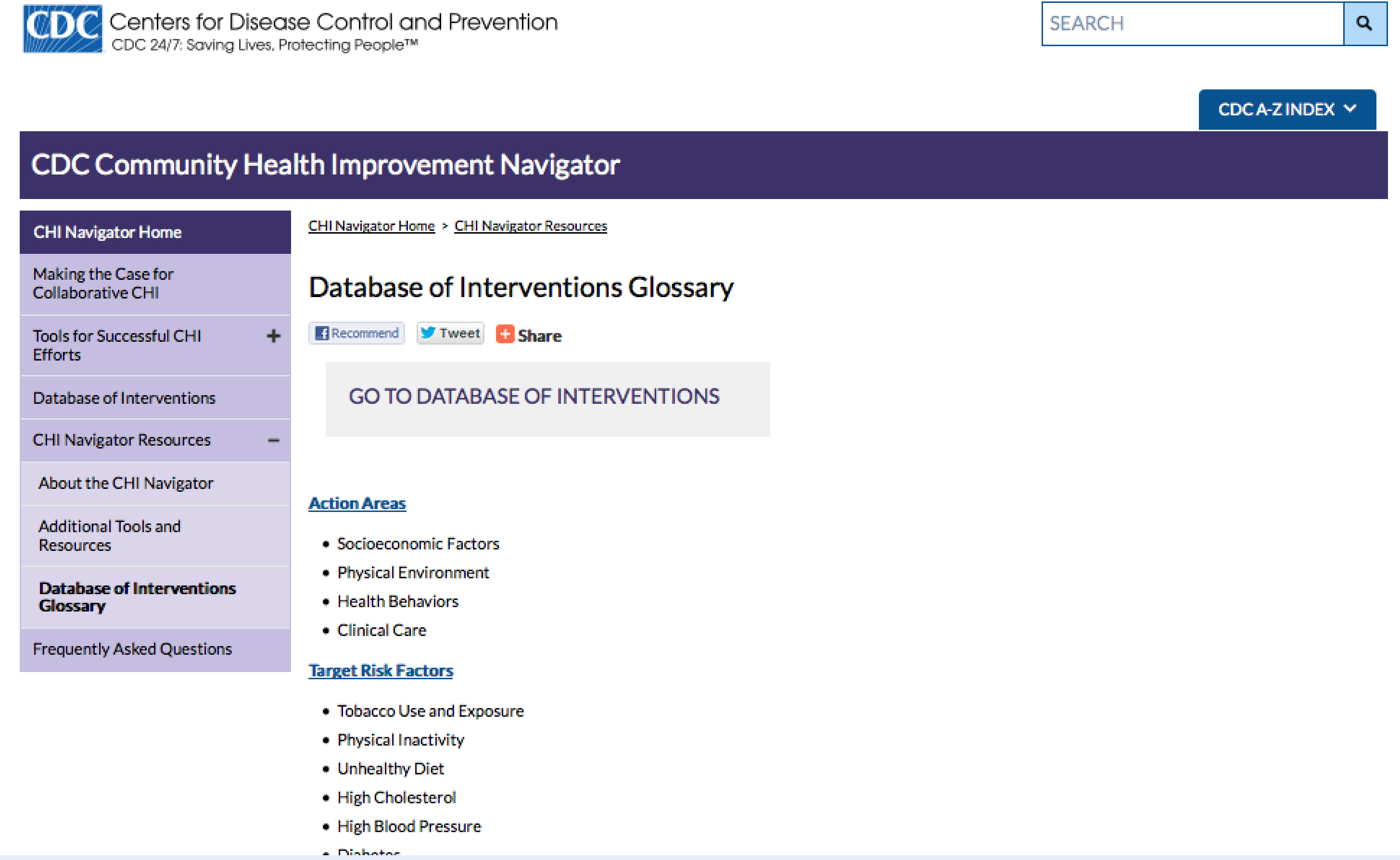




DESCRIPTION

BACKGROUND AND OBJECTIVE: A high proportion of low-income people insured by the Medicaid program smoke. Earlier research concerning a comprehensive tobacco cessation program implemented by the state of Massachusetts indicated that it was successful in reducing smoking prevalence and those who received tobacco cessation benefits had lower rates of in-patient admissions for cardiovascular conditions, including acute myocardial infarction, coronary atherosclerosis and non-specific chest pain. This study estimates the costs of the tobacco cessation benefit and the short-term Medicaid savings attributable to the aversion of inpatient hospitalization for cardiovascular conditions. METHODS: A cost-benefit analysis approach was used to estimate the program's return on investment. Administrative data were used to compute annual cost per participant. Data from the 2002-2008 Medical Expenditure Panel Survey and from the Behavioral Risk Factor Surveillance Surveys were used to estimate the costs of hospital inpatient admissions by Medicaid smokers. These were combined with earlier estimates of the rate of reduction in cardiovascular hospital admissions attributable to the tobacco cessation program to calculate the return on investment. FINDINGS: Administrative data indicated that program costs including pharmacotherapy, counseling and outreach costs about $183 per program participant (2010 $). We estimated inpatient savings per participant of $571 (range $549 to $583). Every $1 in program costs was associated with $3.12 (range $3.00 to $3.25) in medical savings, for a $2.12 (range $2.00 to $2.25) return on investment to the Medicaid program for every dollar spent. CONCLUSIONS: These results suggest that an investment in comprehensive tobacco cessation services may result in substantial savings for Medicaid

Database Glossary Page



Investment Time Horizon— slides adapted from Paul Stange

	Social Determinants	Physical Environment	Health Behaviors	Clinical Care

Long

Horizon of Impact for Intervention

Short

Early Childhood Development

Healthy Start in Life

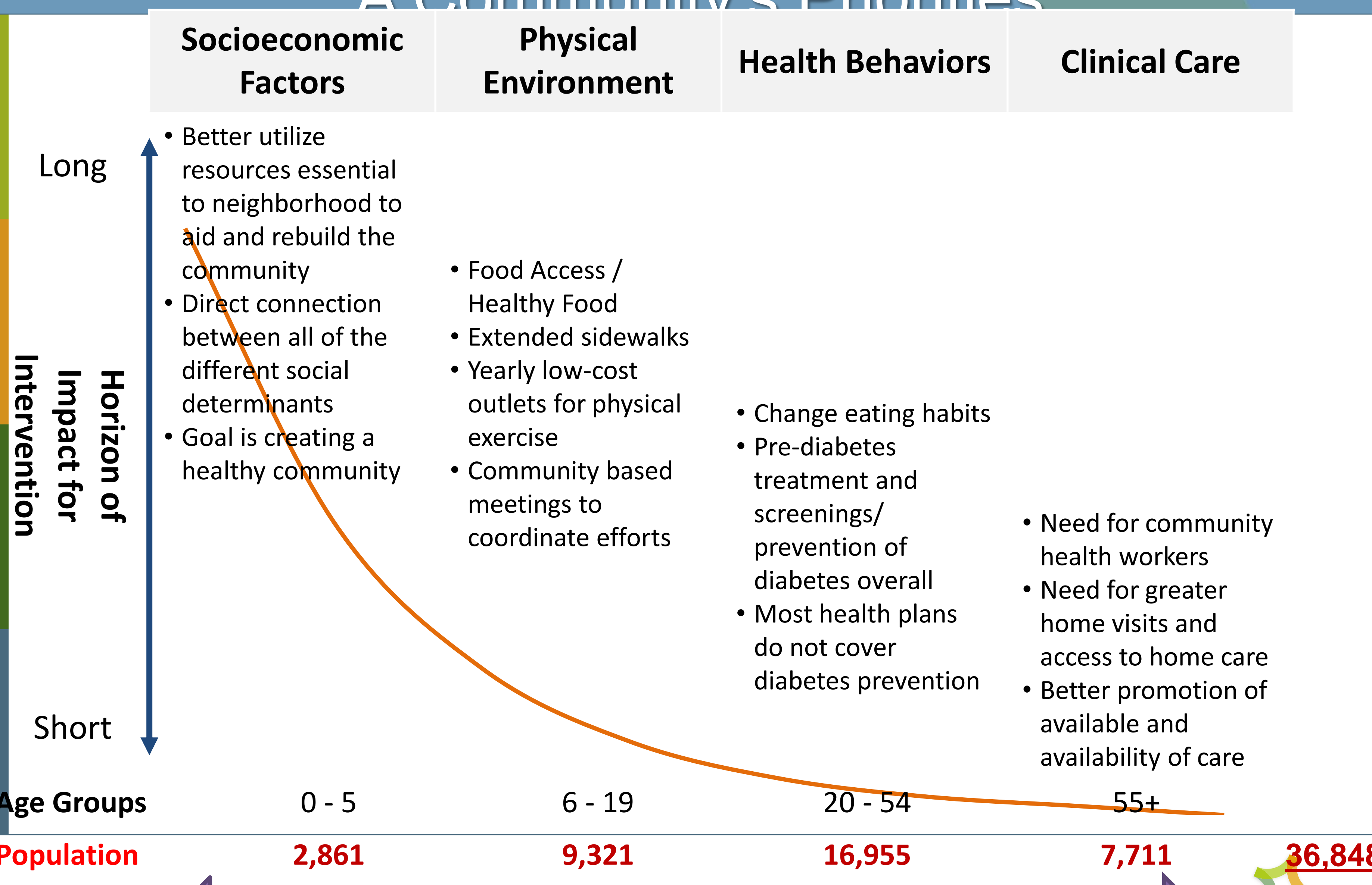
Safe Streets

Support Healthy Lifestyles

Manage Complex Social / Physical Needs

Age Groups	0 - 5	6 - 19	20 - 54	55+

A Community's Priorities



CDC CHI Navigator

(Looking for Urban, Low Income Diabetes and Obesity Interventions)

Horizon of Impact for Intervention	Socioeconomic Factors	Physical Environment	Health Behaviors	Clinical Care
Long ↑ ↓ Short	• Comprehensive Early Childhood Development • Early Head Start • Parents as Teachers	• School Nutrition Policy • Promoting Physical Activity • Corner Stores: Healthy Food • Effect of Changes to the Neighborhood Built Environment on Physical Activity in a Low-income African American Neighborhood	• Every Little Step Counts • Nurse Family Partnership • Diabetes Prevention Program • The Healthy Diabetes Plate	• Advancing Diabetes Self Management • Transitions From Hospital to Home • Mobile Clinic • Public Health Led Disease Mgt. • Social Worker Led Treatment Adherence • Telemedicine-Based Diabetes Mgt.
Age Groups	0 - 5	6 - 19	20 - 54	55+

Thank You

- Visit the CHI Navigator at www.cdc.gov/CHInav
- Email comments and/or questions about Navigator to healthpolicynews@cdc.gov
- dkoo@cdc.gov

Next Steps

- Overview of February and next steps
  - Next TA Call #3: Tuesday, February 2nd 1 – 2pm EST
  - Next Webinar: Monday, February 8th 1 – 2:30pm ET
  - TA Call #4: Tuesday, February 16th 2 – 3 pm ET
  - Final Webinar: Tuesday, February 23rd 1 - 2:30pm ET
  - ACHI convening: Monday, February 29th
    - Optional networking and brown bag lunch: 12 – 1pm ET
    - Convening: 1 – 5pm ET

Homework

- By Friday, January 29th, have a 30-minute call with your partnership pair (list to be emailed after this webinar and posted on the Wiki).
- Moving from prioritization and planning to implementation (the focus of our next webinar) can be challenging. Discuss the following questions with your partnership pair:
  - What processes and/or structures need to be in place in order to ensure successful transition from planning to implementation?
  - How do/would you determine who is accountable for implementing the strategies selected for implementation?
  - How do you/would you maintain ongoing communication and engagement across the partnership during implementation?
  - If you have prior experience with implementation, what challenges did you encounter? What's one piece of advice you'd offer to a new partnership?
  - If you do not have prior experience with the implementation phase of the CHI process, what challenges would you anticipate? What questions do you have for other partnerships who have prior experience with the implementation phase?
  - Are there any tools or resources that have been helpful for your partnership's implementation phase? Are there any tools on the CHI Navigator site that might be helpful to you in future planning or implementation phases?
- Please post responses on the Wiki by the end of the day January 29th

ACHI Convening (Baltimore, MD)

- **Monday, February 29, 2016**, approximately 12pm – 5pm
  - ACHI Conference: March 1 – 3, 2016
- Travel grant of **up to** $1,400 is available to cover the travel of **1 designated attendee** per partnership
  - Attendee will be reimbursed by NNPHI (travel guidelines & reimbursement instructions have been circulated)
  - E-mail Brittany Bickford (bbickford@nnphi.org) with name(s) of attendees from your partnership
- The convening can accommodate up to 5 people per partnership to attend, if others are planning to be at ACHI
- Register for the conference and book your hotel ASAP
- In the evaluation of today's webinar, please share your ideas for the convening agenda

THANK YOU!

For questions about the Learning Collaborative, please contact Allyson Auerbach at aauerbach@hria.org.