

# **Taking Action on Community Health Improvement Priorities**

May 29, 2018

Presented by:

Public Health Foundation  
Catholic Health Association

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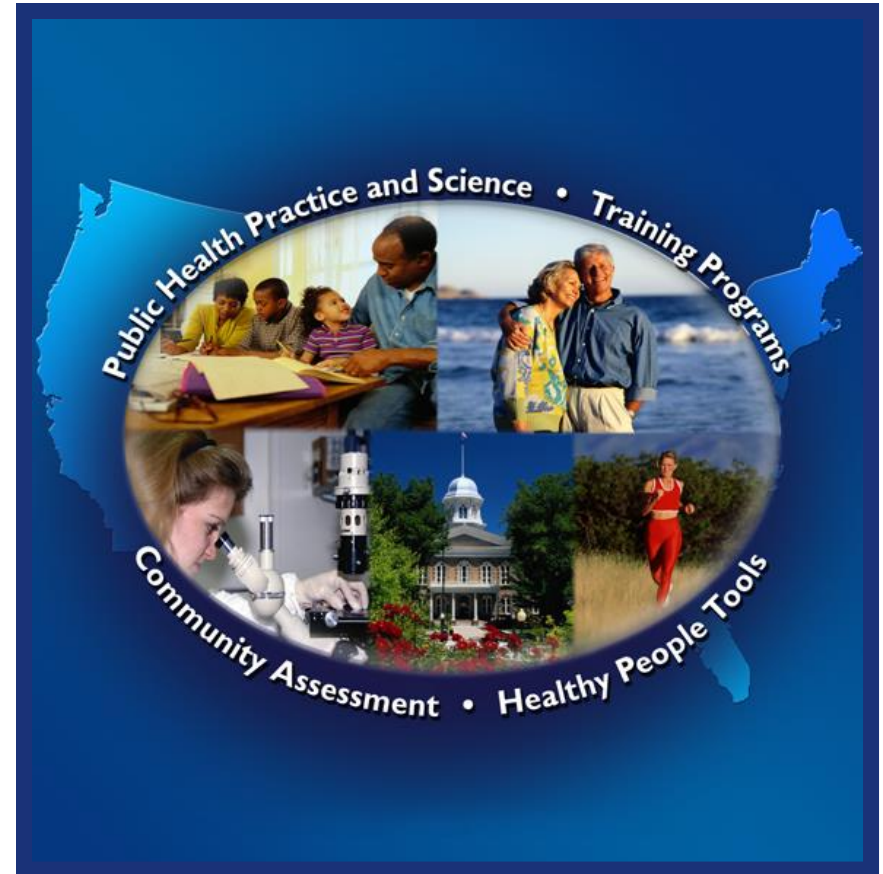


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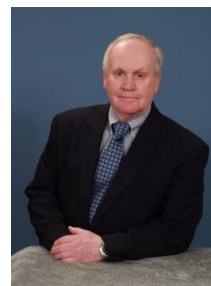


# Overview

- *Using The Community Guide for Community Health Improvement Pilot Initiative*
  - The Community Guide
  - Population Health Driver Diagram Framework
  
- Taking Action
  - Bon Secours Maryview Medical Center
  - Our Lady of the Lake Regional Medical Center
  
- Q&A

# Presenters

- **Jack Moran, MBA, PhD**  
Senior Quality Advisor  
Public Health Foundation
- **Brett Sierra, MPH**  
Director, Community Health  
Bon Secours Hampton Roads
- **Coletta C. Barrett, RN, FACHE**  
Vice President, Mission  
Our Lady of the Lake Regional Medical Center
- **Monique Marino**  
Director, Community Impact  
Our Lady of the Lake Regional Medical Center
- **Shawna L. Mercer, MSc, PhD**  
Director, The Guide to Community Preventive Services  
Chief, The Community Guide Branch  
Center for Surveillance, Epidemiology, and Laboratory  
Services  
Centers for Disease Control and Prevention



# Poll: What type of organization do you work in?



# Pilot Initiative



- Four hospitals/health systems as “anchor” institutions
  - [WellSpan Health](#) – York, PA
  - [INTEGRIS](#) – Oklahoma City, OK
  - [Bon Secours Maryview Medical Center](#) – Portsmouth, VA
  - [Our Lady of the Lake Regional Medical Center](#) – Baton Rouge, LA
- Selected a priority population health need based on the Community Health Needs Assessment and/or Community Health Improvement Plan
- Engaged public health and other community stakeholders
- Explored relevant evidence-based recommendations from The Community Guide
- Developed and implemented population health driver diagram to help align actions to address the population health priority



- Evidence-based findings and recommendations
  - About the effectiveness of programs, services, and policies
  - Help inform decision making
  - Developed by the Community Preventive Services Task Force
  
- Systematic reviews
  - All available evidence on the effectiveness of community-based programs, services, and policies to improve the public's health
  - Economic benefit of all effective programs, services, policies
  - Critical evidence gaps

<http://www.thecommunityguide.org/>



# What is a Population Health Driver Diagram?

- A population health driver diagram is used to identify primary and secondary drivers of a community health improvement objective
- Serves as a framework for determining and aligning actions that can be taken across multiple disciplines for achieving it
- Relies on public health and health care to work collaboratively rather than competitively
- Grounded in the belief that public health and health care are more effective when they combine their efforts to address a health issue than when they work separately
- Population health driver diagrams can be used to tackle challenges at the crossroads of these two sectors
  - Helps reduce the “silo effect”

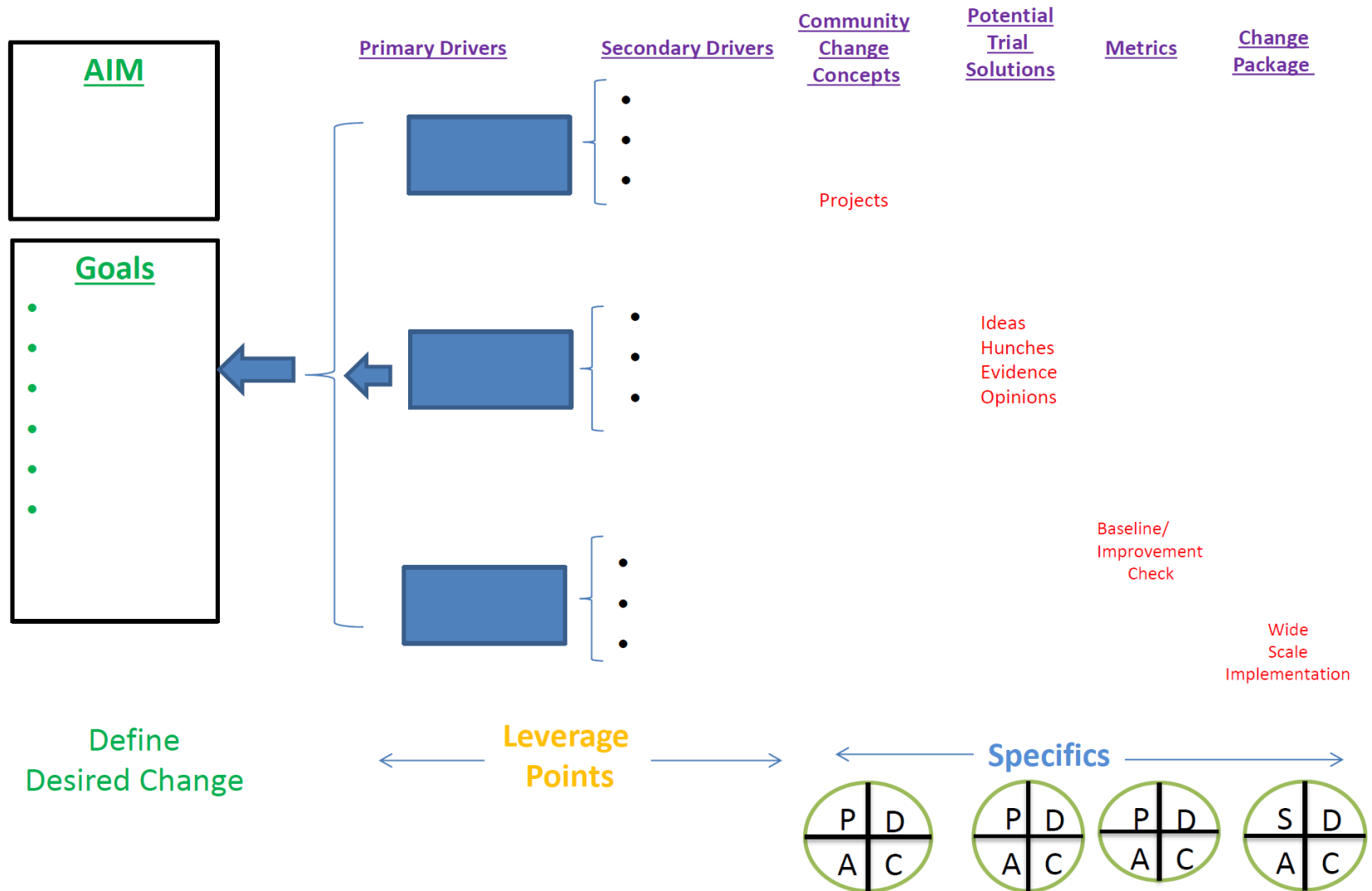
# What is a Population Health Driver Diagram?

- A population health driver diagram represents the team members' thinking on theories of “cause and effect” in the system – what changes will likely cause the desired effects
- It sets the stage for defining the “how” elements of a project – the specific changes or interventions that will lead to the optimum desired outcome
- It helps in defining which aspects of the system should be measured and monitored, to see if the changes/interventions are effective, and if the underlying causal theories are correct

## Aim and Drivers for Improvement—template

Aim	Primary Drivers	Secondary Drivers
50,000 Foot View		
Goals		
30,000 Foot View	20,000 Foot View	
		10,000 Foot View

## Expanded Population Health Driver Diagram Template



## ENHANCING PHYSICAL ACTIVITY OPPORTUNITIES FOR ALL

### AIM STATEMENT

Reduce disparities in access to physical activity opportunities

### Goals

- Address barriers to physical activity.
- Increase community walkability and bikeability.
- Reduce burden of chronic disease.
- Build community support for walking and physical activity.

### PRIMARY DRIVERS

Increase Access to Physical Activity Opportunities

Transportation, Land Use, and Community Design

Social Support and Movement Building

Knowledge, Awareness and Perception of Physical Activity Guidelines

### SECONDARY DRIVERS

#### Partnerships & Communication

- \*Develop formal agreements between agencies addressing the same or similar concerns.
- \*Develop policies that create incentives for using existing resources.
- \*Improved marketing and partner communication of existing resources and facilities (i.e. through Network of Care).
- \*Improved collaboration to meet the needs of underserved populations (i.e. share funds, work together).

#### Built Environment Analysis, Safety & Advocacy

- \*Educate community members, elected and appointed officials in recognizing built environment needs, impact, choices and resources available.
- \*Build advocacy skills and incentives for community feedback on city and county plans (i.e. through advisory boards and committees).
- \*Examine street safety for walkers, bikers and rollers.
- \*Educate pedestrians, cyclists and other small motorists on street safety and rights.
- \*Develop a policy on facility design to improve walking and biking access.
- \*Ensure public health and health care professionals contribute to city and county development plans.

#### Organize Resources & Identify Leaders

- \*Develop and support walking groups throughout the county and in each municipality.
- \*Improve referrals to needed resources.
- \*Develop policies for group physical activity to be integrated into work and school day.
- \*Create a network of people who will lead a culture of physical activity where people live, learn, walk, pray and play.

#### Share Evidence Broadly & Provide Education

- \*Develop intervention plans for segmented target audiences.
- \*Ensure education on PA guidelines is integrated in existing PA marketing campaigns (i.e. Find Your Fit, 5-2-1-0).
- \*Identify and develop resources to support providers and healthcare professionals in promoting PA.
- \*Incorporate Community Needs Assessment PA data into community health improvement plans



# Bon Secours Maryview Medical Center

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Brett Sierra, MPH

Director of Community Health, Bon Secours

## Background

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- Bon Secours Maryview Medical Center is the only public hospital in Portsmouth, Virginia.
- Bon Secours worked closely with Healthy Portsmouth, a city-wide health and wellness initiative committed to changing policies, systems, and environments to improve the health of Portsmouth citizens.
- Based on the health disparities present in Portsmouth and local efforts that were underway, obesity became the focus of the population health driver diagram process.



# Driver Diagram



## AIM STATEMENT

Reduce obesity in Portsmouth, VA through education, prevention, and treatment by promoting healthy life styles

### Goals

- Reduce admission rates for diagnosis related to obesity
- Decrease BMI by 5% in Portsmouth
- Increase the number by 5% of those screened for obesity
- Increase by 5% the number of private middle school students enrolled in Heart Health Academy in 2017
- Promote active and safe communities
- Decrease by 1% the number of children in the BMI Obese category by 2019
- Increase physical activity in adults from 56.3% to 60%
- Increase the number of children in Park and Recreation activity

## Portsmouth, VA Obesity Driver Diagram

### PRIMARY DRIVERS

Collaborating to Make the Healthy Choice the Easy Choice

Promote Active Life Styles

Promote Healthy Eating  
(Will work closely with Healthy Portsmouth Eating Group)

Establish Prevention Communication

### SECONDARY DRIVERS

- Get City and Faith Leaders to serve as Champions
- Meet people where they are.
- Continue making impressions on children throughout school years.
- Navigators on the Medical Mobile Health Van
- Get municipal departments to consider health in strategic planning

- Promote all physical activity opportunities in Portsmouth
- Develop "Incentives"
- Promote active and safe communities
- Worksite Wellness Programs (Healthy Portsmouth)
- Large Scale Coordination of Policy Development and Implementation

- Improve Access
- Address Affordability Issues
- Incentives and Pricing Strategies – *Quality not Quantity*
- Educational Programs – *Making the Right Choices*
- Improve Consumer Behavior and Engagement
- Help Organizations Develop or Expand Healthy Choice Policies

- Educational Awareness
  - Diabetes Prevention Program
  - Weight Management Programs
  - Nutritional Access and Affordability

## Impact to Date

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- We have been able to address many of the secondary drivers through collaboration and mapping what work was already being done throughout Portsmouth.
- The process has provided Healthy Portsmouth partners with more opportunities to collaborate on joint projects to address the health disparities experienced in Portsmouth.
- Future Plans - Expand our collaborations to enhance early intervention strategies for obesity.

# Thank you!

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Regional Medical Center



Heart & Vascular Institute



Children's Hospital



Senior Services



Academic Medicine



Cancer Center



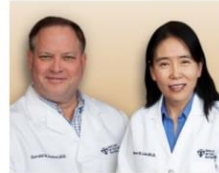
Livingston



Assumption Community



Franciscan Missionaries of Our Lady University



Physician Group



LSU Health Baton Rouge



Community



*We are, with God's help, a healing and spiritual presence for each other and for the communities we are privileged to serve.*

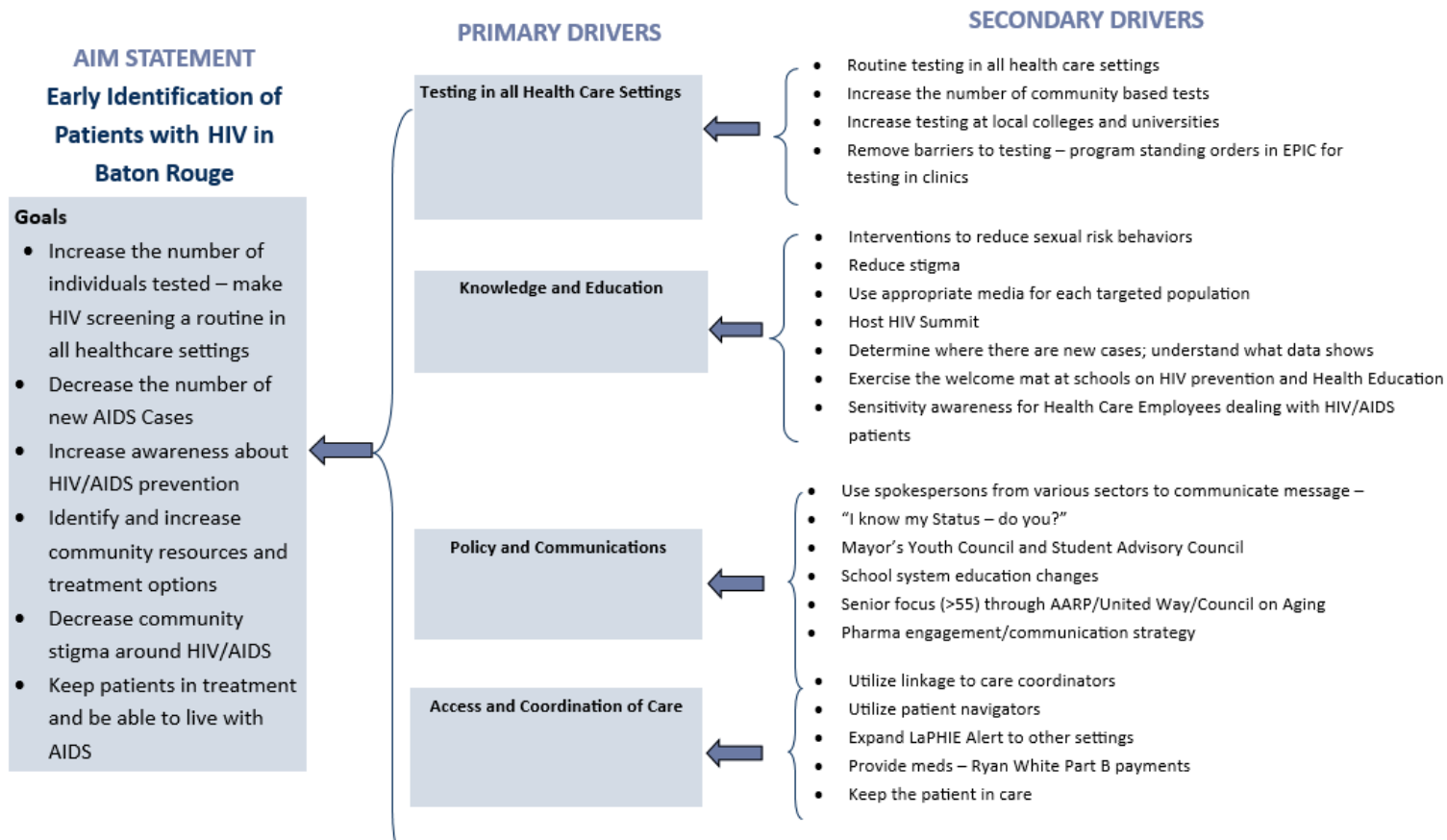


# Population Health Measures – HIV

		2014 Baseline	2018 Goal		2015	2016	2017	2018
<b>Population Health Measures</b>	Sexually Transmitted Infections (CHR)	744	400		584	608.7	648.9	758.7
	Estimated HIV Case Rate (CDC)	38.1	33		32.0	30.2		
	Primary and Secondary Syphilis Rate per 100,000	10.3			15.4	14.5		
	Chlamydia Rate per 100,000	498.0			585.7	581.3		
	Gonorrhea Rate per 100,000	151.4			204.8	210.4		
	Reported HIV Case Rate per 100,000	40.9			32.0	30.2		
	Reported Stage 3 AIDS Case Rate per 100,000	20.7			16.0	17.8		



## Population Health Driver Diagram – Early Identification of Patients with HIV





## Population Health Driver Diagram – Early Identification of Patients with HIV

### AIM STATEMENT

#### Early Identification of Patients with HIV in Baton Rouge

##### Goals

- Increase the number of individuals tested – make HIV screening a routine in all healthcare settings
- Decrease the number of new AIDS Cases
- Increase awareness about HIV/AIDS prevention
- Identify and increase community resources and treatment options
- Decrease community stigma around HIV/AIDS
- Keep patients in treatment and be able to live with AIDS

### PRIMARY DRIVERS

Testing in all Health Care Settings  
*MHCI – Healthy BR 2018 CHNA*  
Ochsner & BR General ED  
Opt Out Testing program commitment

Knowledge and Education  
*90-90-90-0*

Policy and Communications  
*Fast Track Cities Commitment*

Access and Coordination of Care  
*ViiV*

### SECONDARY DRIVERS

- Routine testing in all health care settings
- Increase the number of community based tests
- Increase testing at local colleges and universities
- Remove barriers to testing – program standing orders in EPIC for testing in clinics

- Interventions to reduce sexual risk behaviors
- Reduce stigma
- Use appropriate media for each targeted population
- Host HIV Summit
- Determine where there are new cases; understand what data shows
- Exercise the welcome mat at schools on HIV prevention and Health Education
- Sensitivity awareness for Health Care Employees dealing with HIV/AIDS patients

- Use spokespersons from various sectors to communicate message – “I know my Status – do you?”
- Mayor’s Youth Council and Student Advisory Council
- School system education changes
- Senior focus (>55) through AARP/United Way/Council on Aging
- Pharma engagement/communication strategy

- Utilize linkage to care coordinators
- Utilize patient navigators
- Expand LaPHIE Alert to other settings
- Provide meds – Ryan White Part B payments
- Keep the patient in care





# Sexually Transmitted Infections / HIV

The Fast-Track Cities Initiative (FTCI) is a global partnership between the City of Paris, Joint United Nations Program on HIV/AIDS (UNAIDS), United Nations Human Settlement Program (UN-Habitat), and the International Association of Providers of AIDS Care (IAPAC), in collaboration with the local, national, regional and international partners and stakeholders.

**90%**

of people living  
with HIV (PLHIV)  
knowing their  
HIV status

**90%**

of PLHIV who know  
their HIV-positive status  
on antiretroviral  
therapy (ART)

**90%**

of PLHIV on ART  
achieving viral  
suppression

**0%**

**ZERO DISCRIMINATION  
AND STIGMA**  
against people living  
with HIV







## Population Health Driver Diagram – Early Identification of Patients with HIV

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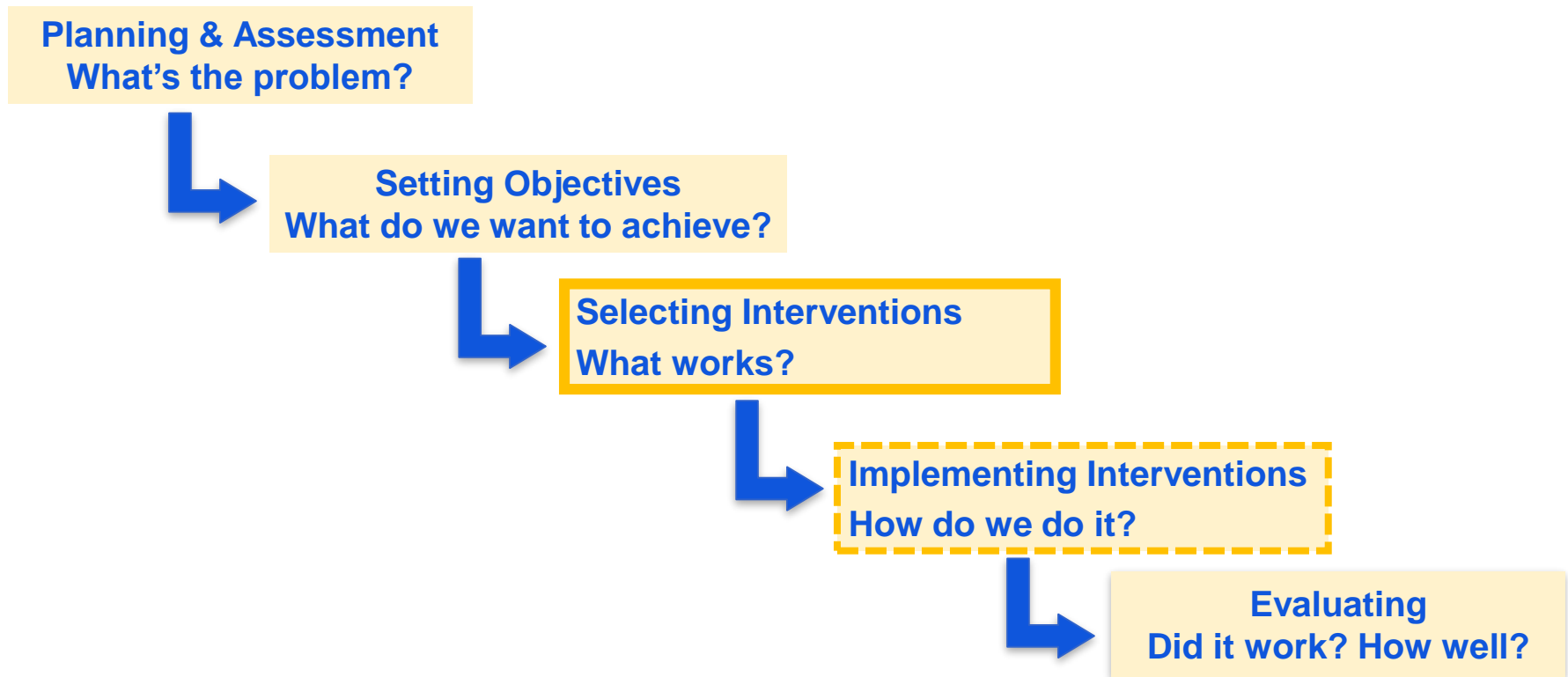


- ...works to improve the health and safety of communities in the United States by identifying proven interventions that can be implemented in communities.



- ...is a collection of all Task Force recommendations, and the evidence on which they are based—providing decision makers in communities across the U.S. with evidence-based options they can select to meet their specific needs.

# The Community Guide's Role in Community Health Improvement Planning



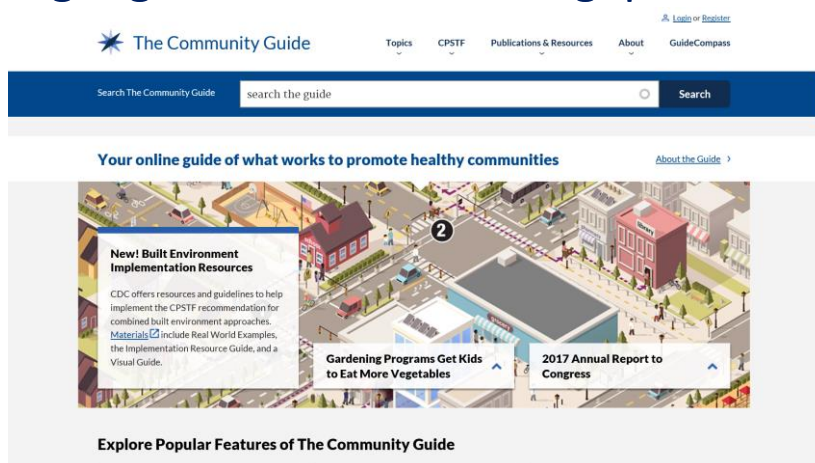
# Community Guide Components

- Collection of the Community Preventive Services Task Force's evidence-based recommendations and other findings that
  - Identifies effective population-based programs, services, and policies
  - Provides menus of options that decision makers can select from and implement to meet their specific needs



# Community Guide Components (cont'd)

- State-of-the-science systematic reviews that
  - Form the basis of the Task Force recommendations
  - Analyze all available evidence on the effectiveness of community-based interventions in public health
  - Assess the economics of effective interventions
  - Highlight critical evidence gaps



[www.thecommunityguide.org](http://www.thecommunityguide.org)

# Aiming for Impact: Who are the Priority End Users of The Community Guide?

- State, tribal, local, and territorial health departments
- Large organizations and agencies accountable for the health of their populations, or who benefit from their populations being healthy
  - CDC Programs
  - Other federal agencies and operating divisions (e.g., Military, Centers for Medicare and Medicaid Services, Health Resources and Services Administration)
  - Hospitals and healthcare systems
  - Large employers



# Task Force Recommendations and Other Findings

- >230 compiled in The Community Guide
- 21 priority health topic areas



# The Community Guide: Evaluating the effectiveness of four types of community preventive services

## Informational and Educational

- Small media (such as pamphlets) for increasing colorectal cancer screening

## Behavioral and Social Sciences-Based

- Combined diet and physical activity promotion programs to prevent type 2 diabetes among people at increased risk

## Environmental and Policy

- Reducing structural barriers (providing transportation and translation assistance, modifying hours of service, etc.) for increasing colorectal cancer screening

## Health System

- Provider assessment and feedback interventions for increasing colorectal cancer screening



**Poll: Has your organization implemented new or enhanced community services or interventions in the last 3 years?**



**Poll: If yes, what was the *primary driver* behind the selection of the new or enhanced service(s) or intervention(s)?**



# **Poll: What resources does your organization use to identify and select community services or interventions?**



# Questions?



Jack Moran



Brett Sierra



Coletta Barrett



Monique Marino



Shawna Mercer



Ron Bialek

# Additional Resources

- [Using The Community Guide for Community Health Improvement](#) pilot initiative
- [The Community Guide](#)
- CHA's [Community Benefit Resources](#)
- ACHI's [Community Health Assessment Toolkit](#)
- [Using Driver Diagrams to Improve Population Health](#)
- [Performance Improvement Services](#) for hospitals, health systems, and health departments
  - Contact Ron Bialek, [rbialek@phf.org](mailto:rbialek@phf.org) or 202-218-4420
- Stay informed with [PHF E-News: www.phf.org/e-news](http://www.phf.org/e-news)

# Upcoming Webinars

- Building Academic Health Department Partnerships in Rural Areas
  - Wednesday, June 6, 2018 from 2-3pm EDT
  - Explore building AHD partnerships in rural areas with Granville Vance Public Health (NC)
  
- Tackling Big Challenges with a Full QI Culture Shift
  - Tuesday, June 19, 2018 from 3-4pm EDT
  - Explore how to leverage the public health accreditation process to spark creativity, innovation, and staff involvement in performance improvement efforts with Springfield-Greene County Health Department (MO)

*Questions?*

*Contact Kathleen Amos at [kamos@phf.org](mailto:kamos@phf.org)*

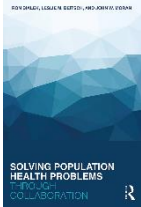


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Improving Public Health and Population Health Practice to Support Healthier Communities



- Competencies for Population Health Professionals: [www.phf.org/populationhealthcompetencies](http://www.phf.org/populationhealthcompetencies)



- New Book: Solving Population Health Problems through Collaboration: [www.phf.org/populationhealthbook](http://www.phf.org/populationhealthbook)

- Population Health Webinar Series: [www.phf.org/populationhealthwebinars](http://www.phf.org/populationhealthwebinars)



- TRAIN Learning Network: [www.train.org](http://www.train.org)



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