# A Checklist of Strategies for Health Care-Community Prevention Integration

## Leveraging CDC's Chronic Disease FOAs

*Memo Prepared by Prevention Institute*

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## Introduction

The CDC's six new Funding Opportunity Announcements[i] on the prevention of diabetes, heart disease and stroke represent an ongoing national commitment to advance the nation's chronic disease prevention and health promotion efforts. Importantly, the required strategies reflect the recognition that community environments have a significant impact on health behaviors and health outcomes, and that policy, systems, and environmental changes must reinforce health education and patient self-management strategies in order to improve health across a community. The focus on community prevention is a tribute to the success of the many community-led efforts, forward thinking health care leaders, and the expanding research base, that are reducing illness and injuries around the country through addressing the social, physical and economic factors that influence health. For promoting health equity and improving health in low-income and communities of color, such community changes are essential.

**FOA Specifics: Mutually Reinforcing Health Care – Community Efforts**

Five[1] of the new FOAs encourage or require activities that link health care improvements and community efforts. Geared towards different eligible applicants—from state and local health departments to community-based coalitions and networks, they reflect the growing national interest and commitment to building a health system that fundamentally promotes health through better access to quality care in tandem with community changes that support health. These five FOAs provide the needed resources to engage health care providers and institutions in efforts to build lasting systems of health, prevention and equity in communities across the country. **With this memo, Prevention Institute shares strategies for consideration to help spur innovations and success in leveraging partnerships and collaboration between health institutions and community change efforts through these new funding opportunities.** Although the strategies offered are applicable across the five FOAs, they focus in large part on the *State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke*[2] *(State and Local Public Health Actions)* as this FOA requires eligible state and local health departments to address a specified list of community-based and health care system strategies. And while the FOAs stipulate a chronic disease focus, our recommendations also include strategies that relate to the prevention of violence and traffic injuries in recognition that these factors can significantly impinge on the ability to adopt healthy eating and activity behaviors, particularly in low income and communities of color.[ii]

**Engaging Health Care as a Partner in Community Prevention**

Health care organizations are daily witnesses to the impact of inequality and unhealthy community environments on a health system that is overwhelmed with the treatment of preventable chronic diseases, trauma and injuries. Healthcare providers are frustrated as they know they send their patients out into communities where it is difficult to following through on treatment plans that require behavioral changes (e.g. eating healthier food, being more physically active. As the Affordable Care Act

[1] Partnerships to Improve Community Health (PICH); National Implementation and Dissemination for Chronic Disease Prevention; State and Local Public Health Actions to Prevent Obesity, Diabetes and Heart Disease; A Comprehensive Approach to Good Health and Wellness in Indian Country; and Racial and Ethnic Approaches to Community Health (REACH)

[2] Mandatory Letters of Intent for this FOA were due June 5th. The full application is due July 22nd and can be found at www.grants.gov. The following are the funding opportunity numbers for the FOAs in this report: DP14-1417, DP14-1418, DP14-1422PPHF14, DP14-1421PPHF14, DP14-1419PPHF14, DP14-1416

has catalyzed greater emphasis on improving health outcomes, it is clear that health care cannot meet these goals alone.

**Health care institutions frequently don't have the experience or full set of tools to fully participate in community prevention activities. The current CDC FOAs therefore provide a tremendous opportunity to work directly with health care institutions, their leaders and staff to leverage their credibility, interests and needs in order to make health care part of the community prevention solution.**

Prevention Institute has spent a number of years considering how health care providers and institutions can work in tandem with public health, community residents and community organizations to support community prevention efforts. The resulting model, Community Centered Health Homes (CCHH),[iii] delineates a set of practices that health care can adopt to take into account the factors that consistently undermine health messages and treatment plans—including overwhelming social circumstances and related community conditions (such as poor housing, lack of food access, and safety concerns).

While adopting a Community Centered Health Homes approach can benefit both health and health care in all communities, it is particularly important to partner with health care to improve community environments in low-income and communities of color where residents face the greatest challenges due to a pervasive lack of infrastructure, limited employment opportunities and ongoing discrimination, amongst other factors. With greater health as a core outcome, mission-driven health care institutions focused on building community and equity serve as perfect starting point for health care engagement. These institutions—including community and rural health centers, public hospitals, and hospital systems such as the members of Stakeholder Health—[iv, v] are deeply aware of the social and community context, understand the many reasons their patients face great challenges in following through on medical advice and recognize that the solutions lie outside the medical context. Fostering community-clinical integration is one critical element of moving towards a community-centered health system that enhances the health of all community residents.[vi, 3]

## Recommended Strategies

Each of the five CDC FOAs under consideration includes required or recommended strategies that focus on both changes to the community setting as well as health system improvements. For the *State and Local Public Health Actions* FOA, strategies are required across two components (See Appendix C). Component 1 supports "environmental and systems approaches to promote health, support and reinforce healthful behaviors, and build support for lifestyle improvements for the general population and particularly those with uncontrolled high blood pressure and those at high risk for type 2 diabetes" (pg. 2). Component 2 supports "health system interventions and community-clinical linkages that focus on the general population and priority populations" (pg. 2). As described by CDC "the strategies in both components should be mutually reinforcing" (pg. 2).

[3] A community-centered health system is a system "which includes medicine, public health and community partners, all holding each other accountable within a partnership structure for achieving greater community health and well-being."

**In practice, in order to achieve the greatest impact on community health, equity and safety, applicants for *State and Local Public Health Actions* and the other FOAs who wish to engage with health care institutions should identify opportunities to formally enlist these institutions, their leadership and staff as partners and stakeholders in carrying out the grant's community prevention strategies. Below is a checklist of specific recommendations to advance the FOAs' community prevention approaches while simultaneously making it easier for health care to deliver on its role of achieving high quality care and improved health outcomes. (See Appendix A for Spotlight Examples)**

### Provide Green Prescriptions

**(Supports Component 1: Strategies 2, 3, 4, 5, 6)**

□ Offer "green prescriptions" to the patients who will benefit from them. Green prescriptions are typically used to "prescribe" non-pharmaceutical interventions such as physical activity and eating fruits and vegetables. The concept has been extended in some innovative sites to include clinicians recommending actions for community change that support individual behavior change (e.g., an instruction to walk more would be complemented by a recommendation to the city to repair sidewalks or add lighting and ensure neighborhoods are safer for walking).

### Advance Community Improvements through Community Referrals

**(Supports all Component 1 strategies; Component 2: Strategies 12, 14)**

□ Work with healthcare institutions to connect patients to opportunities for participation in community-level improvements by also providing referrals to specified community advocacy coalitions and organizations. Not only is this community involvement critical to the success of initiatives aimed at improving the conditions that create health, research has shown that patient participation in voluntary community projects is associated with reductions in hypertension, as well as significant increases in psychological and social well-being.[vii]

### Share Healthcare Data to Map Patterns of Illness and Injury and Create Community and Clinical Improvements

**(Supports all Component 1 strategies; Component 2: Strategies 7, 8, 9, 12)**

□ Partner with healthcare institutions to collect and organize symptom and diagnosis data (with full confidentiality protections), including GIS mapping to explore the relationship between medical conditions and community determinants. Ensure community residents are part of the process to identify and prioritize improvements in community conditions.

□ Promote participation of diverse stakeholders including community residents in the non-profit hospital Community Health Needs Assessment (CHNA) process.

□ Align CHNAs with community assessments conducted by other local health care institutions, public health departments, and community organizations – including, if feasible, the assessments required by Component 1 to identify shared interests and priority environmental strategies.

□ Work with healthcare to develop optional added fields on electronic health records that provide more comprehensive information about patients' life circumstances, and community environments[viii] including housing conditions, food access, and other determinants of health. Not

only will this additional information be useful to medical teams as they develop accurate diagnoses and treatment plans (e.g., knowing that a patient lives in a home with mold is highly relevant to a physician treating her for chronic headaches), it provides important data on the community conditions that must be improved to boost health.[ix]

### Engage the Healthcare Workforce as Advocates and Partners in Community Level Changes

**(Supports all Component 1 strategies; Component 2: Strategies 9, 12, 13, 14)**

- □ Support healthcare institutions in identifying staff, including non-physician team members, whose roles can support environmental strategies to promote health. Community health workers, promotoras, and other outreach staff can collect data and reflections directly from patients on social, economic, and community conditions and barriers that impact their health and share these data back with the healthcare institution (all departments, medical director, administration, development, etc.) and the *State Public Health Actions* grantee team.
- □ Define discrete roles for healthcare staff (physicians and non-physician team members) to contribute to the achievement of Component 1 strategies, such as serving as spokespeople for the importance of environmental strategies, sharing health system data on key health conditions, and participating in community coalitions.
- □ Work with pharmacists and pharmacies to address the challenges hypertensive patients face by improving the retail environments of pharmacies. A growing number of pharmacies are removing tobacco products from their stores and pharmacists can be strong advocates for this critical business strategy. The potential also exists for healthier food options.

### Offer Trainings to the Full Health Care Workforce on Community-Based Prevention, Equity and Community-Determinants of Health

**(Supports all Component 1 strategies; Component 2: Strategies 8, 12, 14)**

- □ Provide trainings on equity-focused community prevention and the role of social, economic, and community determinants of health in hypertension, diabetes, and other preventable chronic conditions for health care leadership and staff (including non-physician team members), board members, and other interested partners. (See Appendix B for recommendations on advancing equity)
- □ Create dedicated time and space with health care staff for reflections and discussion of population health and to deepen understanding of community prevention practices.
- □ Sponsor trainings and coaching for public health and community prevention leaders to communicate and work effectively with the health care sector.

### Develop an Effective Community-Health Care Collaboration Framework

**(Supports all Component 1 and 2 strategies)**

- □ Engage a diverse range of health care, public health, local government, and community partners, ensuring that the community voice is emphasized. Strengthen partnerships among local health care organizations.

- □ Coordinate activities among community and health care partners to advocate for community changes to improve health.
- □ Establish an Accountable Community for Health, creating a framework for health care organizations and community partners to take ownership of the health of community residents across their service area and work at a community level to boost health.[x, xi]

### Develop Funding Mechanisms for Sustaining Community-Clinical Collaboration Activities
**(Supports all Component 1 and 2 strategies)**

- □ Explore development of a state or regional prevention trust to support broad, population-focused prevention and wellness activities. The potential resources for a Trust can come from the public and private sectors and specifically those who stand to benefit from improved health in the population (employers, insurers, government, etc.).
- □ Identify existing taxes and fees connected to unhealthy behaviors, including alcohol and tobacco taxes and "close the loop" by combining with prevention related health savings and reinvesting substantial parts of these revenues in prevention initiatives.
- □ Explore waivers and related payment mechanisms that allow for more flexible payments to health care providers covering activities related to addressing community–related health factors.

### Implement Healthy Organizational Practices across the Health Sector to Benefit Staff, Patients and Visitors & Influence Norms across the Community
**(Supports Component 1: Strategies 1, 3, 5, 6)**

- □ Ensure that healthy foods and beverages are available and promoted in cafeterias, vending machines, coffee carts, and other concessions and adopt standards for the provision of healthy food and beverages at all meetings and events.
- □ Establish procurement policies for geographic preference of locally and regionally grown healthy foods.
- □ Prioritize physical activity for staff, patients, and visitors. Design facilities so that they encourage active use by creating open, inviting stairways with signage. Show movement videos in waiting rooms and equip them with exercise bicycles or play areas. Encourage walking staff meetings. Provide staff with showers, lockers, and bicycle racks to help normalize physical activity and remove some of the barriers employees face integrating exercise into their daily routines.
- □ Encourage and incentivize the use of public transit, walking, and cycling. Partner with local transportation authorities to ensure that there are safe routes to the facilities for all methods of transportation.
- □ Make all facilities baby- and mother-friendly. Provide comfortable, private spaces for nursing or pumping milk. Perinatal facilities should adopt the Ten Steps of the Baby-Friendly Hospital Initiative to help all mothers achieve their breastfeeding goals.
- □ Implement Wellness Benefits that support staff in engaging in physical activity and other healthy preventive health practices

## ABOUT PREVENTION INSTITUTE

Prevention Institute was founded in 1997 to serve as a focal point for primary prevention practice—promoting policies, organizational practices, and collaborative efforts that improve health and quality of life. As a national non-profit organization, the Institute is committed to preventing illness and injury, to fostering health and social equity, and to building momentum for community prevention as an integral component of a quality health system. Prevention Institute synthesizes research and practice; develops prevention tools and frameworks; helps design and guide interdisciplinary partnerships; and conducts training and strategic consultation with government, foundations, and community-based organizations nationwide and internationally.

**For information on additional resources, partnership and technical assistance opportunities, please contact Sana Chehimi, sana@preventioninstitute.org**

## APPENDIX A

### SPOTLIGHT EXAMPLES

### Asian Health Services*

Asian Health Services, a comprehensive community clinic, became aware of high rates of pedestrian injury and fatality due to automobile traffic in Oakland's Chinatown neighborhood after an elderly man was hit and killed by a car. "Youth from the clinic's leadership program conducted research, including mapping of crash locations and photo documentation of pedestrian/vehicle conflicts." While traffic lights and walk signals were timed to reduce traffic and move trucks through the community, the light timing and wide streets did not allow sufficient time for pedestrians to cross the street safely. With a collaborative effort from the community and local partners, "scrabble" intersections that allow people to cross the street in all directions were created, the timing of traffic lights changed, and signage in the area improved. These changes reduced pedestrian/vehicle conflicts by nearly 50%, improving health conditions for the community and reducing risk of injury or death.

*Mikkelsen L, Cohen L, Frankowski S. Community-Centered Health Homes: Engaging Health Care in Building Healthy Communities. *National Civic Review*. Avialable at: 2014. http://onlinelibrary.wiley.com/doi/10.1002/ncr.21179/pdf Accessed June 25, 2014.

### Minnesota Health Reform*

Minnesota has plans "to drive health care reform in the state and to test the Minnesota Accountable Health Model" using the $45 million in grant funds that the state has received from Centers for Medicaid and Medicare Services (CMS). "The goal of this model is to ensure that every citizen of the state of Minnesota has the option to receive team-base, coordinated, patient-centered care that increase and facilitates access to medical care, behavioral health care, long term care, and other services." Fifteen "accountable communities for health" will develop and test care integration motels, and will be supported through the expansion of Minnesota's current Medicaid Accountable Care Organization demonstration. Over the next 3 years, it is expected that the program will provide care to nearly 3 million Minnesotans and that the model will save approximately $111 million.

*Health Reform in Minnesota: The Minnesota Accountable Health Model. *Health Reform Minnesota: A Better State of Health.* Available at: http://mn.gov/health-reform/health-reform-in-Minnesota/ Accessed June 25, 2014.

## SPOTLIGHT EXAMPLES (CONTINUED)

### Buncombe County Community Health Assessments*

In 2010, Buncombe County completed a comprehensive Community Health Assessment, resulting in the selection of six priorities by a diverse group of community stakeholders who drew from data and information gathered during the process to make their decisions. These priorities offered opportunities for dramatically improving health impact based on the data that was collected and analyzed. The CHA Steering Committee engaged 68 community leaders throughout Buncombe County to review the evidence, listen to community members' input, and select priorities that will help us attain our community health vision. In 2012, Buncombe County had the opportunity to partner across the region and with its local non-profit hospitals, (Mission Hospital, Park Ridge Health, and Care Partners) in new ways through the development of WNC Healthy Impact. In order to enable full participation in WNC Healthy Impact, the decision was made to transition the Buncombe County CHA timeline to match that of the region and meet the needs of local non-profit hospital partners.

*Buncombe County Community Health Assessment: Executive Summary. 2012. Available at: http://www.buncombecounty.org/common/health/CHA/CHA2012_ExecSum.pdf Accessed June 25, 2014.

### Boston "Prescribe-a-Bike" program*

The "Prescribe-a-Bike" program, supported by the City of Boston in partnership with Boston Medical Center, allows doctors at Boston Medical Center to "prescribe low-income patients with a yearlong membership to Hubway, a bike share program, for only $5." An annual Hubway membership normally costs $85. The prescription gives participants unlimited bicycle trips lasting 30 minutes or less along with a free helmet. Kate Walsh, Executive of Boston Medical Center, said, "Regular exercise is key to combating [the chronic disease] trend, and Prescribe-a-Bike is one important way our caregivers can help patients get the exercise they need to be healthy." Qualified participants must be at least 16 years of age and "enrolled in some form of public assistance, or have a household income of no more than four times the federal poverty level."

* Gaitan C. New City Program lets doctors "prescribe" bike-sharing memberships. *The Boston Globe*. 2014. Available at: http://www.bostonglobe.com/metro/2014/03/27/new-program-will-allow-boston-medical-center-doctors-prescribe-bike-sharing-program/zjwfLfCEtAEGfWYxVn4CiN/story.html Accessed on June 25, 2014.

**APPENDIX B**

## Advancing Equity:
## Recommendations from CDC *Practitioner's Guide for Advancing Health Equity* *

"Build multi-sector partnerships to change institutional practices that have a disproportionate effect on certain population groups."

"Prioritize professional development, continuing education, and training opportunities for staff working in underserved communities."

"Use health and equity impact assessments to identify potential unintended negative consequences of all community improvement efforts."

"Ensure public input is inclusive, timely, and representative of community experiences."

* Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.

## Appendix C: *State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke* Component 1 and 2 Strategies

### Component 1 Strategies

**Environmental strategies to promote health and support and reinforce healthful behaviors**

1. Implement food and beverage guidelines including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and other key locations such as hospitals
2. Strengthen healthier food access and sales in retail venues (e.g., grocery stores, supermarkets, chain restaurants, and markets) and community venues (e.g. food banks) through increased availability (e.g. fruit and vegetables and more low/no sodium options), improved pricing, placement, and promotion
3. Strengthen community promotion of physical activity though signage, worksite policies, social support, and joint-use agreements
4. Develop and/or implement transportation and community plans that promote walking

**Strategies to build support for lifestyle change, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts**

5. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change. Implement evidence-based engagement strategies (e.g. tailored communications, incentives, etc.) to build support for lifestyle change
6. Increase coverage for evidence-based supports for lifestyle change by working with network partners

### Component 2 Strategies

**Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities**

7. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., implement advanced Meaningful Use data strategies to identify patient populations who experience CVD- related disparities)
8. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor health care disparities and implement activities to eliminate health care disparities)
9. Increase engagement of non-physician team members (i.e. nurses, pharmacists, nutritionists, physical therapists and patient navigators/community health workers) in hypertension management in community health care systems
10. Increase use of self-measured blood pressure monitoring tied with clinical support
11. Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes

**Community clinical linkage strategies to support heart disease and stroke and diabetes prevention efforts**

12. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes
13. Increase engagement of community pharmacists in the provision of medication-/self-management for adults with high blood pressure
14. Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g. EHRs, 800 numbers, 211 referral systems, etc.)

## References


[i] Centers for Disease Control and Prevention. New: FY 2014 Funding Opportunity Announcements. May 23, 2014. Available at: http://www.cdc.gov/chronicdisease/features/funding-opportunity-announcements.htm Accessed June 25, 2014.

[ii] Cohen L, Davis R, Lee V, Valdovinos E. Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living. *Prevention Institute*. 2010.

[iii] Cantor J, Cohen L, Mikkelsen L, Pañares R, Srikantharajah J, Valdovinos E. Community-Centered Health Homes: Bridging the gap between health services and community prevention. *Prevention Institute*. 2011.

[iv] Health Systems Learning Group (HSLG) Monograph. *Methodist Healthcare.* 2013. Available at: http://www.methodisthealth.org/about-us/faith-and-health/research/learning-collaborative/ Accessed June 25, 2014.

[v] www.stakeholderhealth.org

[vi] Fukuzawa DD. Achieving Healthy Communities through Community-Centered Health Systems. *National Civic Review.* 2013; 102 (4): 57-60.

[vii] Burr JA, Tavares J. Mutchler JE. Volunteering and Hypertension Risk in Later Life. *J Aging Health.* 2010; 20 (10): 1-28.

[viii] Manchanda R. *The Upstream Doctors: Medical Innovators Track Sickness to Its Source.* TED Books. 2013.

[ix] National Research Council. *Key Capabilities of an Electronic Health Record System: Letter Report*. Washington, DC: The National Academies Press, 2003.

[xx] Austen BioInnovation. Healthier By Design Creating Accountable Care Communities. Faegrebdc Consulting.2012. Available at: http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf Accessed June 25, 2014.

[xi] Health Reform in Minnesota: The Minnesota Accountable Health Model. *Health Reform Minnesota: A Better State of Health.* Available at: http://mn.gov/health-reform/health-reform-in-Minnesota/ Accessed June 25, 2014.