# Moving from Assessment to Action in Community Health Improvement

May 1, 2017

Presented by:

Public Health Foundation

Association for Community Health Improvement

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- The slides are available for download in the “Handouts” section on your control panel.
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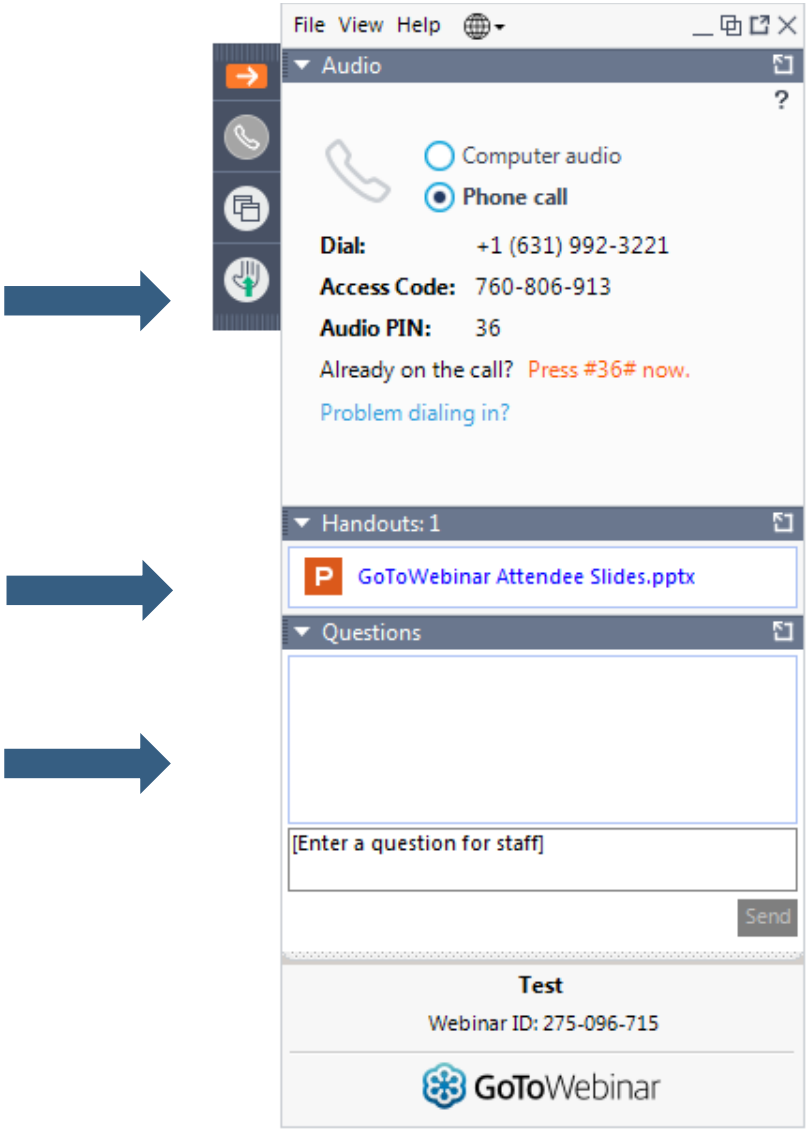
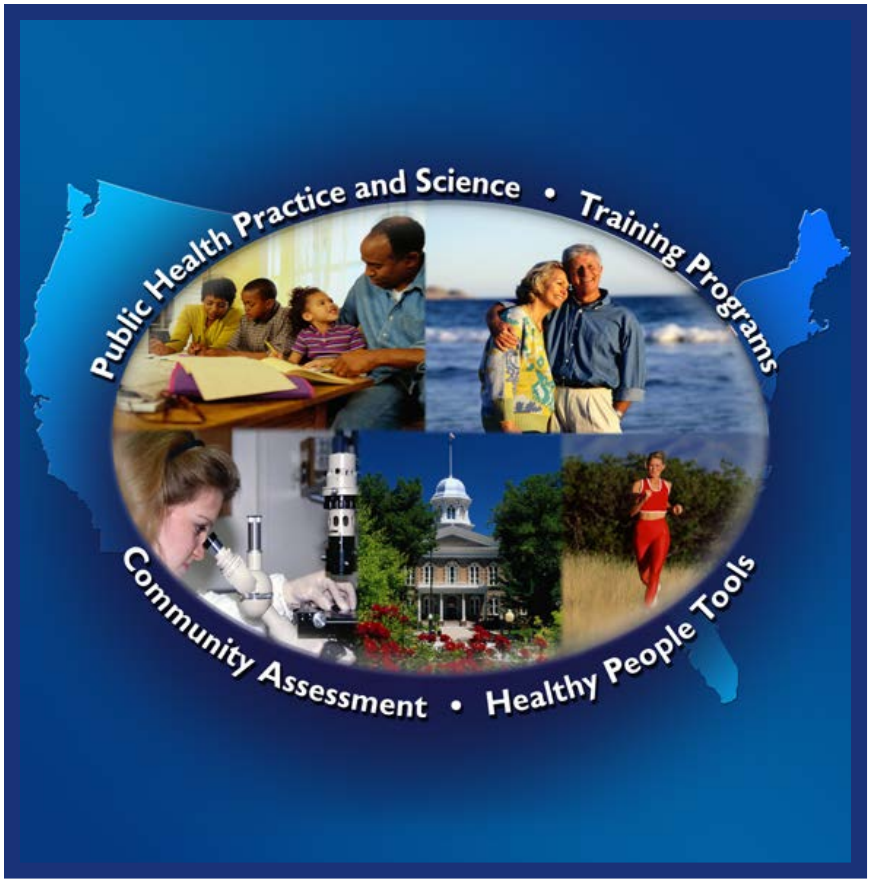


…***PHF Mission***:

**We improve the public's health by strengthening the quality and performance of public health practice**

www.phf.org



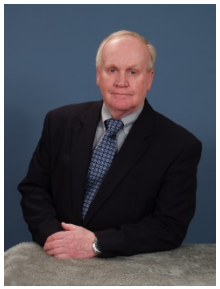

*Experts in Quality Improvement, Performance Management, and Workforce Development*

# Overview

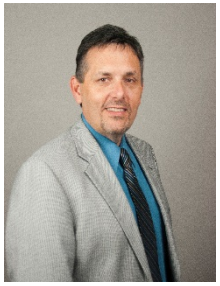
- The Community Guide and Community Preventive Services Task Force
- *Using The Community Guide for Community Health Improvement* pilot initiative
- Population Health Driver Diagram Framework
- Taking action: INTEGRIS and WellSpan Health
- Q&A

# Presenters

- **Shawna L. Mercer, MSc, PhD**
  Director, The Guide to Community Preventive Services
  Chief, The Community Guide Branch
  Division of Public Health Information Dissemination
  Center for Surveillance, Epidemiology, and Laboratory Services
  Office of Public Health Scientific Services
  Centers for Disease Control and Prevention



- **Jack Moran, MBA, PhD**
  Senior Quality Advisor
  Public Health Foundation



- **Stephen Petty, MA**
  Corporate Director, Community Health Improvement
  INTEGRIS Health

- **Kevin A. Alvarnaz, MBA**
  Director, Community Health & Wellness
  WellSpan Health

# The Community Guide

- 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

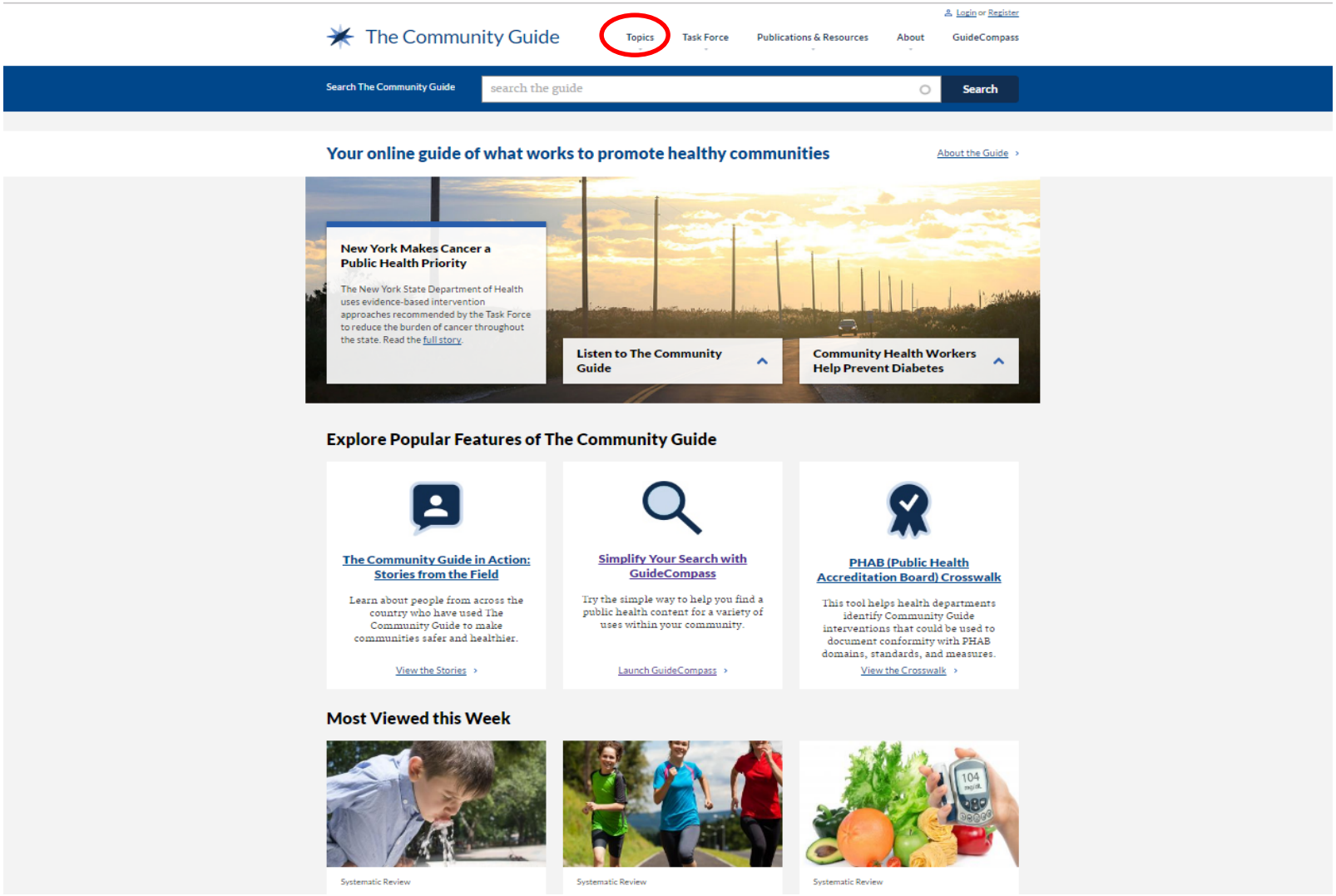
## Community Preventive Services Task Force

*...Working to Promote the Nation's Health since 1996...*
*www.thecommunityguide.org*

- A non-federal, independent, rotating panel
- Internationally renowned experts in public health research, practice, and policy
- Nomination process includes broad input from throughout public health and healthcare
- Members are appointed by CDC Director
- Serve without compensation

  - CDC is statutorily mandated to provide scientific, technical and administrative support for the Task Force

# Uses of The Community Guide




https://www.thecommunityguide.org/

# Pilot Initiative


- Two hospitals/health systems as “anchor” institutions
  - WellSpan Health – York, Pennsylvania
  - INTEGRIS – Oklahoma City, Oklahoma
- Selected a priority population health need based on the Community Health Needs Assessment and/or Community Health Improvement Plan
- Engaged health department and other community stakeholders
- Identified and implemented 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

# 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

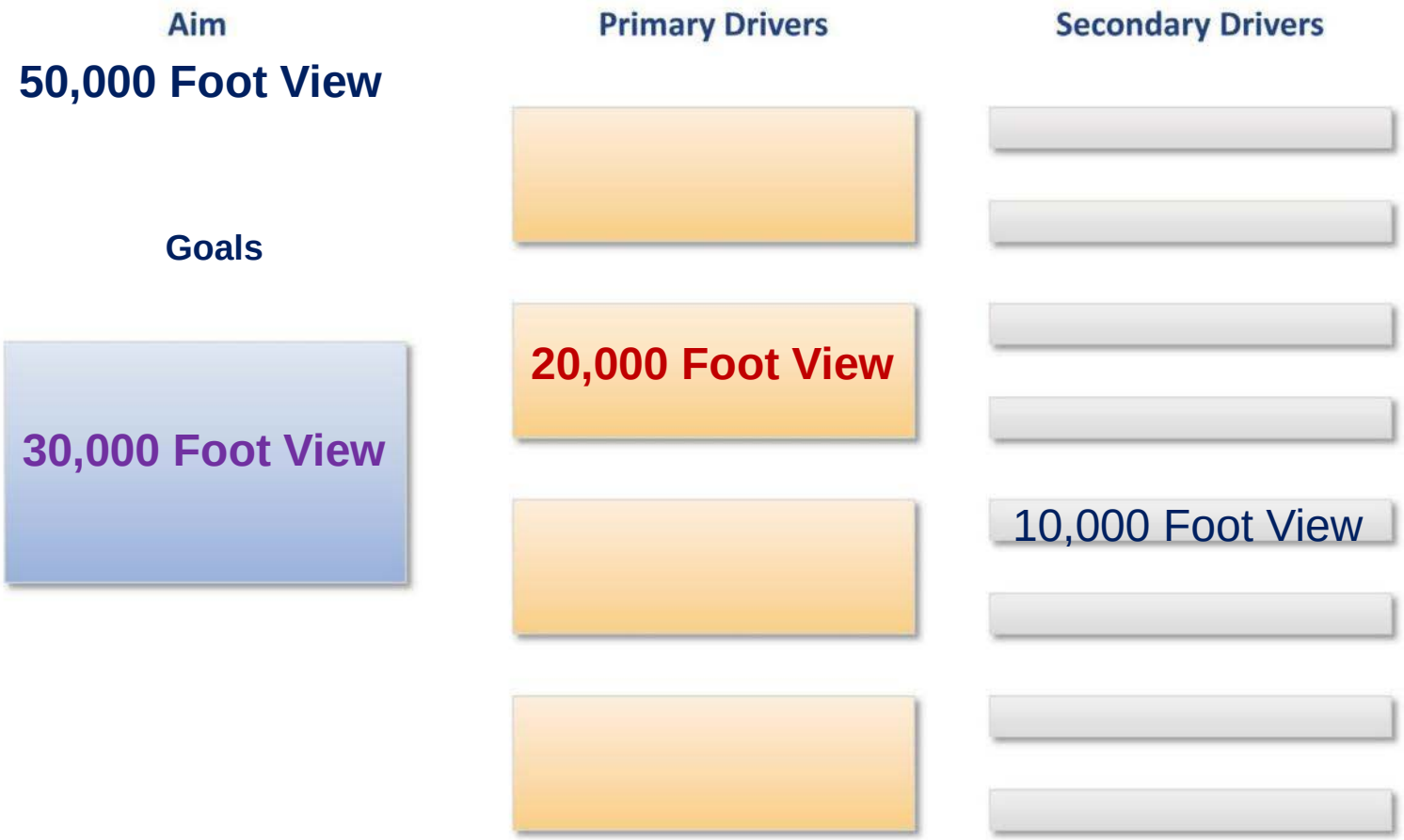
- It sets the stage for defining the "how" elements of a project – the specific changes or interventions that will lead to the optimum desired outcome

- 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

# Components of a Population Health Driver Diagram

- AIM of the Improvement Project
- Goals – Improvement Outcomes
- Primary Drivers
- Secondary Drivers

# Aim and Drivers for Improvement—template



# Public Health's Role in Antibiotic Stewardship

## Driver Diagram

Efforts to promote optimal antibiotic use should employ both the public health and healthcare systems. While some drivers of antibiotic resistance fall outside the direct control of public health (e.g., use of antibiotics in livestock food supplies), others highlighted here sit squarely within the focus of public health organizations.

This diagram outlines primary and secondary drivers of optimal antibiotic use. It compliments a driver diagram being piloted in eight hospitals by the Institute for Healthcare Improvement (IHI). PHF is actively seeking comments on the driver diagram from healthcare and public health organizations already engaged in efforts to address antibiotic resistance.

### AIM

**Promote Optimal Antibiotic Use**

**Goals**

- Preserve antibiotics for the future
- Decrease demand by the public for inappropriate use
- Reduce the spread of antibiotic resistance
- Decrease adverse events associated with inappropriate antibiotic use
- Decrease costs associated with antibiotic use

### PRIMARY DRIVERS

### SECONDARY DRIVERS

**Partnerships, Communication, Reimbursement, & Stewardship**

**Appropriate Use of Antibiotics**

- Provide information on which antibiotics are most effective within your community at a certain point in time
- Provide information on which diseases are prevalent within a community at a point in time
- Develop policies that create incentives for appropriate antibiotic use
- Develop appropriate policies for daycare, work, and school on appropriate attendance during illness (staying away and going back)

**Surveillance, Analysis, Feedback, Triage, & Leveraging Resources**

**Data Monitoring, Transparency, and Stewardship Infrastructure**

- Leverage existing infrastructure to promote better antibiotic use
- Use local resistance data to inform antibiotic choice
- Explore ways to gather use and prescribing data

**Share Evidence Broadly, Provide Education, Create Urgency, & Empower Alternative Action**

**Knowledge, Awareness, and Perception of the Importance of Appropriate Antibiotic Use**

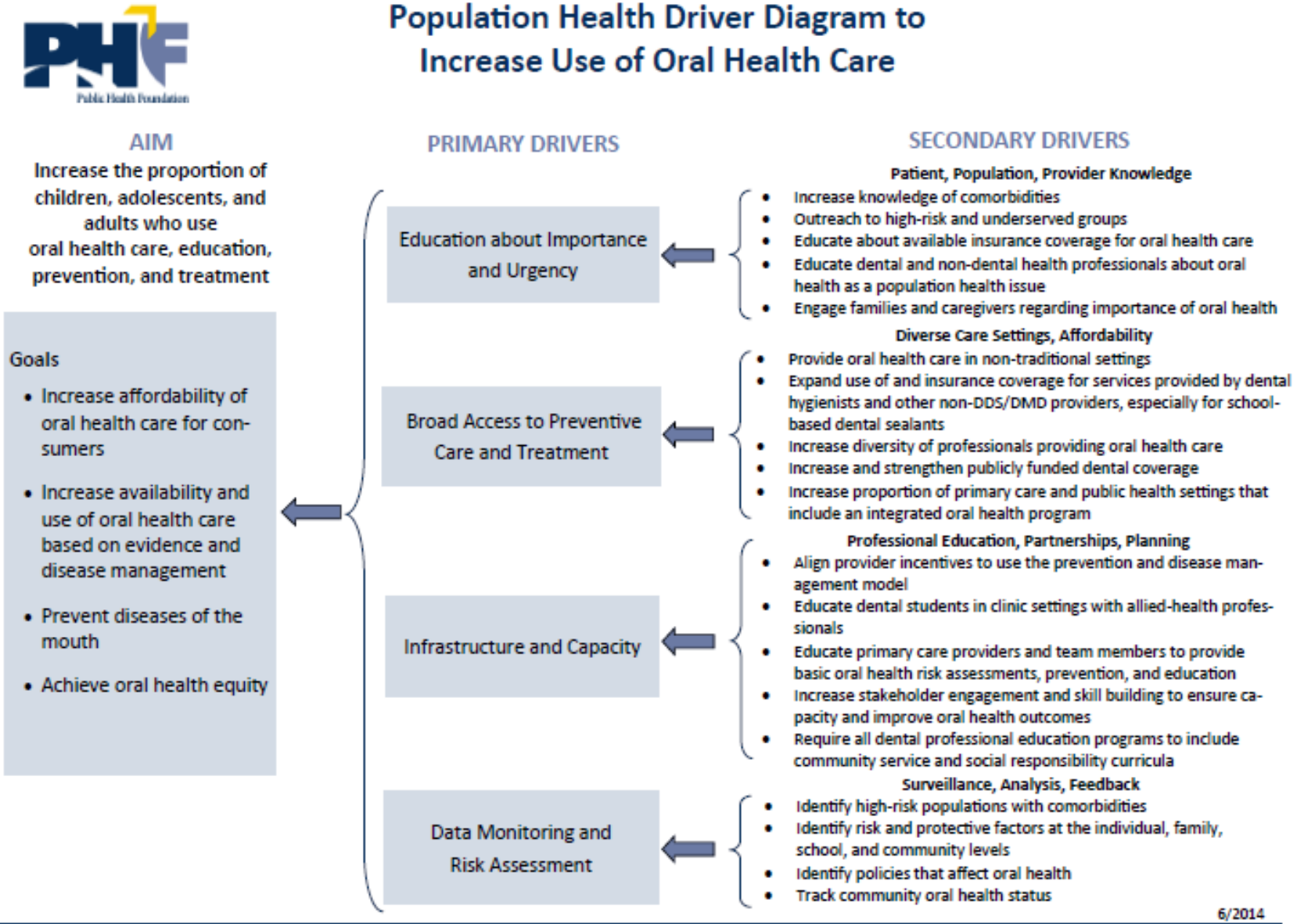
- Develop intervention plans for segmented target audiences (consumers, providers, insurers, policy makers, etc.)
- Change attitudes and perceptions about what constitutes appropriate antibiotic use
- Educate health departments and public health professionals
- Incorporate antibiotic usage into community assessment and improvement plans

**Policy, Communication, Education, Incentives, Partnerships, and Facilitation**

*This model was developed collaboratively by public health professionals with expertise in antimicrobial resistance and quality improvement. This work was funded through a collaborative agreement between the Public Health Foundation and the U.S. Centers for Disease Control and Prevention.*

March 2013 | Version 1.1

# Population Health Driver Diagram to Increase Use of Oral Health Care




6/2014

*This work was funded by the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services*

# Process To Develop and Implement Population Health Driver Diagram


IF IT WAS
EASY, WE'D
BE DONE BY
NOW

# Process To Develop and Implement Population Health Driver Diagram

## **“Start Small, Think Big and Scale Fast”**

- ✓ Come up with the right:
  - ✓ metrics to be used
  - ✓ baseline
  - ✓ improvement goals
  - ✓ timeline
- ✓ Then think forward about the mid to long-term about what you want to fundamentally change and where you want to get to
- ✓ Once you’ve got clear objectives, strategy-led initiatives can develop and progress quickly

INTEGRIS

Steve Petty, B.A., M.A.

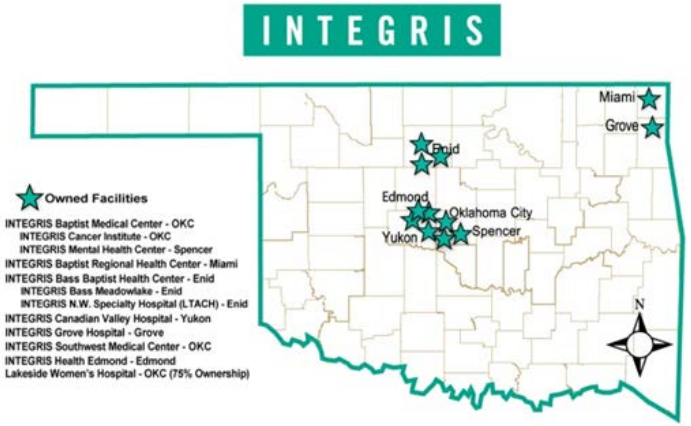
System Administrative Director
Community and Employee Wellness

Sara Barry, LBP

Business and Community Development,
INTEGRIS Mental Health and the James L Hall Jr Center for Mind Body and Spirit

# INTEGRIS Health

- INTEGRIS Health is the state's largest Oklahoma-owned health care corporation
- One of the state's largest private employers (about 9,500 employees statewide)
  - 12 Hospitals
  - Rehabilitation centers
  - Physician clinics
  - Mental Health facilities
  - Independent living centers
  - Home health agencies
  - Daycare facilities



# INTEGRIS Community Wellness

- In an effort to fulfill our mission to improve the health of the communities in which we serve, INTEGRIS Community Wellness offers the following programs for all ages.
  - Hispanic Initiative
  - Men’s Health University
  - Third Age Life (Senior Services)
  - I-CREW
  - INTEGRIS Community Clinics

# Caring for our Communities

- **INTEGRIS Health provided $53,457,847 in community benefits.** This includes our returnship efforts, community building , uncompensated charity cares services and unpaid cost of Medicaid programs.

- **Returnship - $5,320,995**
- **Community Building - $396,491**
- **Uncompensated Services/Charity Care/ Unpaid costs of Medicaid programs equaled - $28,438,627**

- **In addition, INTEGRIS Health incurred bad debt with an estimated cost of $19,301,734 based on the overall hospital cost-to-charge ratio.**

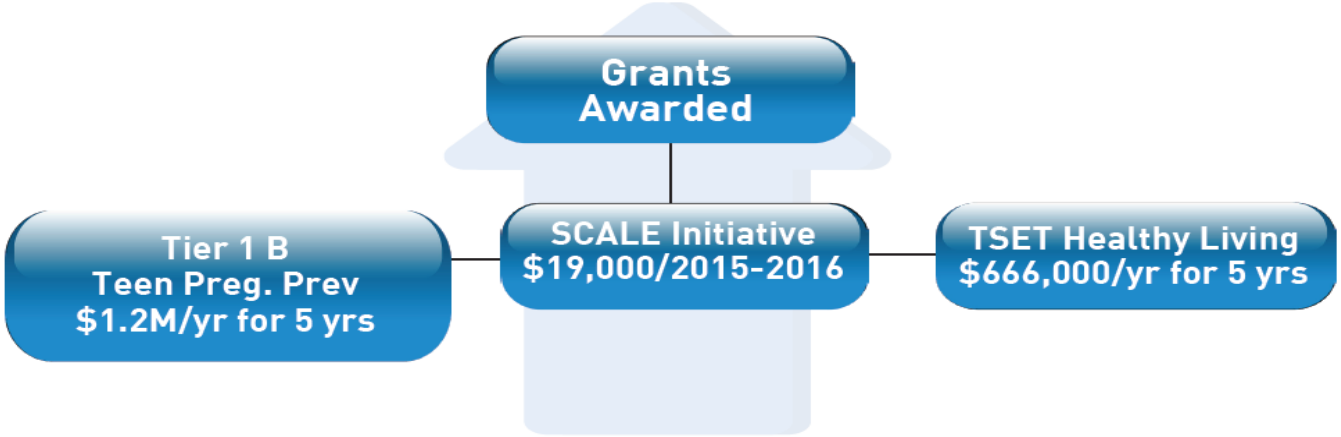

# WELLNESS NOW

Carrie Blumert, MPH
Community Partnerships

# WELLNESS NOW

- Wellness Now Coalition - Work Groups
  - Adolescent Health – Teen Pregnancy Prevention
  - Care Coordination
  - Health at Work
  - Faith Based
  - Mental Health and Substance Use Prevention
  - Physical Activity and Nutrition
  - Tobacco Use Prevention

# 2017 Wellness Now Organizational Chart

# Wellness Now Purpose and Vision

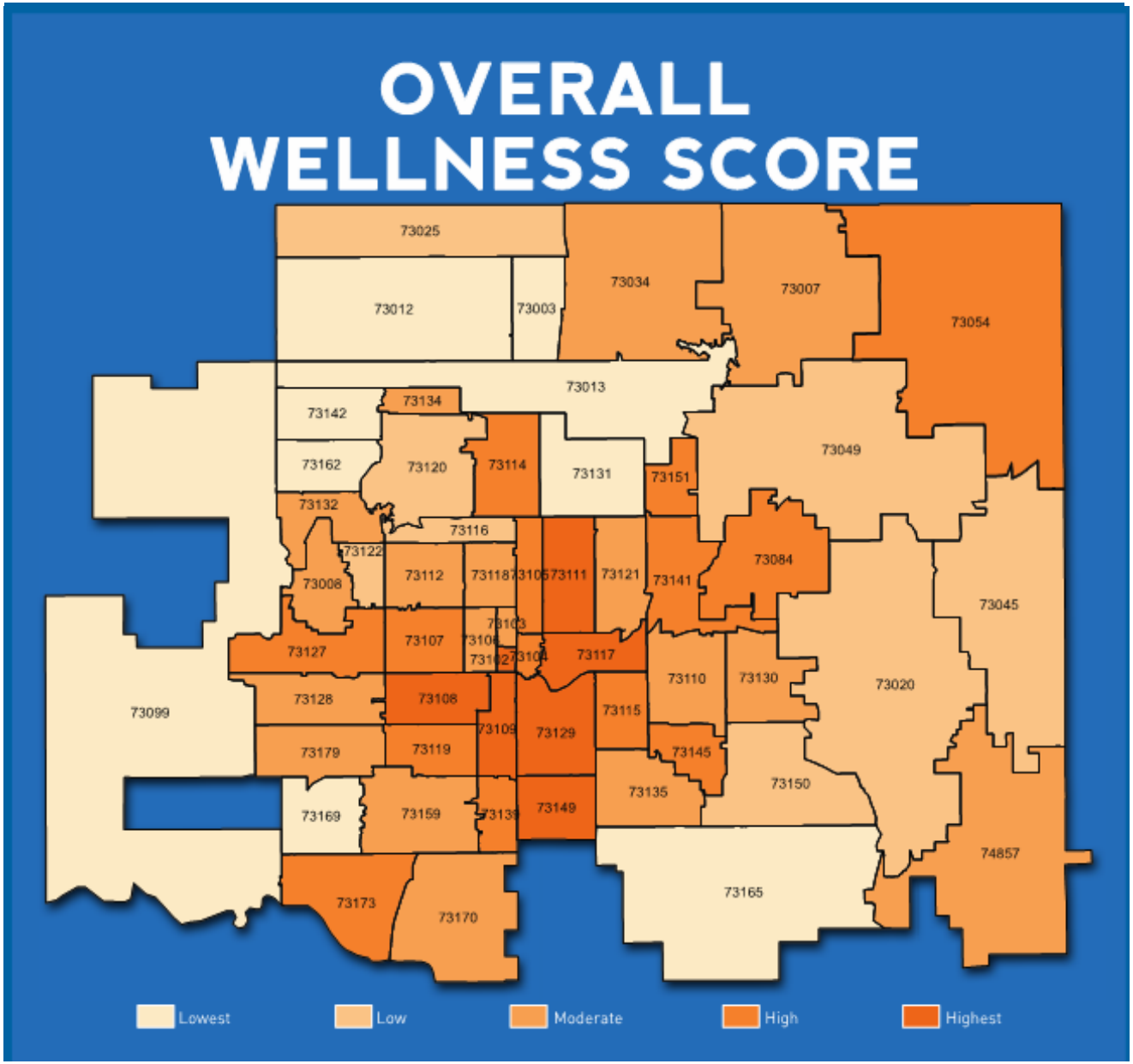
- Our Mission: To improve the health of Oklahoma County through community partnerships that create policies, systems, and environments that make living well easier
- Our Vision: A community that supports and enables all people to be healthy and well

# Wellness Now Purpose and Vision

- Began in 2010 with a community health assessment by zip code.  Created to be a grassroots effort driven by the community
- Propensity for action by identifying needs and creating sustainable solutions to health problems through:
  - Policies
  - Environment changes
  - Evidence based programs
  - Awareness building/culture shifting
  - Education
- A platform for partnerships to bring resources together for a greater impact

# Oklahoma City County Health Department's Role in the Coalition

- OCCHD provides work groups with epidemiological data at the zip code level
  - This data is real time and updated every 3 years
- The Wellness Score is released every 3 years to show which zip codes have worst health outcomes
- Work Groups are encouraged to focus their efforts on the zip codes with the worst health outcomes
- OCCHD funds each work group up to $10,000 per year


OVERALL
WELLNESS SCORE
73025
73012
73003
73034
73007
73054
73013
73142
73134
73162
73120
73114
73131
73151
73049
73132
73116
73122
73112
73111
73121
73141
73084
73008
73045
73127
73107
73117
73110
73130
73020
73128
73108
73115
73099
73109
73129
73179
73119
73145
73150
73135
73169
73159
73149
74857
73165
73173
73170
Lowest
Low
Moderate
High
Highest

# 2013 WELLNESS SCORE
## OUTCOME DATA

| OUTCOME | 2010** | 2013* | +/- |
|---|---|---|---|
| **All Cause** (per 100,000 population) | 883.8 | 873.5 | -1.2% |
| **Stroke Mortality** (per 100,000 population) | 43.7 | 42.0 | -3.9% |
| **CVD Mortality** (per 100,000 population) | 277.0 | 269.1 | -2.9% |
| **All Cancer Mortality** (per 100,000 population) | 184.9 | 183.2 | -1.0% |
| **Lung Cancer Mortality** (per 100,000 population) | 54.1 | 52.2 | -3.5% |
| **Breast Cancer Mortality** (per 100,000 population) | 15.0 | 14.3 | -4.7% |
| **Prostate Cancer Mortality** (per 100,000 population) | 8.8 | 8.2 | -6.8% |
| **Diabetes Mortality** (per 100,000 population) | 26.1 | 27.7 | +6.1% |
| **Flu & Pneumonia** (per 100,000 population) | 19.5 | 15.2 | -22.0% |
| **Homicide** (per 100,000 population) | 9.2 | 8.6 | -6.5% |
| **Suicide** (per 100,000 population) | 12.0 | 16.6 | +38.3% |

*2010-2012
**2008-2009

# Full Coalition Accomplishments

- Grown to 200 partner organizations
- Received $4.4 million in local, state, and federal funding
  - Community Transformation Grant 2012-2014
  - Tobacco Use Prevention 2011-2015
  - Nutrition & Physical Activity 2012 – 2015
  - Suicide Prevention 2012 – 2014
  - SCALE Initiative  2015 – 2016
  - TSET Health Living 2015 – 2020
  - Tier 1 B Teen Pregnancy Prevention 2015 -2020

# WELLNESS NOW

The Mental Health work group was chosen as the focus of the Driver Diagram project in partnership with INTEGRIS Health.

The Mental Health work group has 15-20 mental health professionals and advocates that have been working as a team for 5 years.  They represent over 10 agencies in the OKC area.

# Mental Health and Addiction Recovery Driver Diagram
## Oklahoma City and County

***Stigma*** refers to negative attitudes and beliefs that lead others to avoid living, socializing, or working with, renting to, or employing people with mental or addictive disorders. It deters people from seeking care and funding services.
***Recovery*** refers to the process in which people are able to live, work, learn, and participate fully in their communities.
***Resilience*** means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope.

### AIM STATEMENT

Promote optimal mental health for Oklahoma City and County by: increasing residents' abilities to successfully cope with life's challenges; facilitating recovery; and, building resilience.

**Goals**

- Reduce the stigma of seeking care for mental health and addictive disorders.
- Address mental health with the same urgency as physical health.
- Improve access to mental health and addiction screenings.
- Improve access to mental health and addiction treatment
- Decrease the number of poor mental health days (Baseline)
- Decrease the suicide rate (Baseline)

### PRIMARY DRIVERS

**Improve Knowledge and Awareness of Mental Health & Addictive Disorders for Providers and Residents**

### SECONDARY DRIVERS

- Reduce stigma through education and advocacy. (PNFC: 1.1)
  - School systems, higher ed, chambers, rotary, Lyons club, senior centers, active military, veteran service groups, faith organizations, correctional and justice system
- Develop a comprehensive media campaign with consistent messaging (Tagline: Just Do It or Just Say No or My Mind Matters).
  - Promote messaging about ACES/PACES and Dimensions of Wellness
- Promote forums to build individual and community resilience.
- Implement universal screenings for mental health and addictive disorders in primary care, across the lifespan, and connect to treatment and supports
  - ✓ Prevention in Practice model
  - ✓ PNFC 4.4
- Promote and advocate for policy and legislative changes that support mental health and addiction recovery services

**Increase Availability & Access to Evidence Based Mental Health & Addiction Recovery Services**

- Increase funding and improve public/private/tribal partnerships
- Increase efficiency by reducing duplication of services /efforts
- Improve and expand evidence based school mental health programs
- Increase access to and utilization of community health workers/navigators and care coordination
- Improve Access to mobile crisis services
- Expansion of telehealth technology
- Catalog existing programs and identify gaps to improve collaboration/cooperation among community partners/stakeholders
- Increase availability and access to evidence-based mental health and addiction recovery programs and services and evaluate existing programs/services
- Promote research and evaluate existing programs

**Promote Data Sharing, Monitoring, and Transparency**

- Education on the need to share data among police, hospital, health dep, non-profit, faith orgs
  - ✓ Target specific education to populations– public, partners, providers
- Develop and centralize data sharing agreements
- Institute periodic reporting of Oklahoma City and County data among police/first responders and health care sector
- Build in accountability

# Driver Diagram session with Mental Health work group

# Driver Diagram session with Mental Health work group

# Driver Diagram session with Mental Health work group

WELLNESS NOW

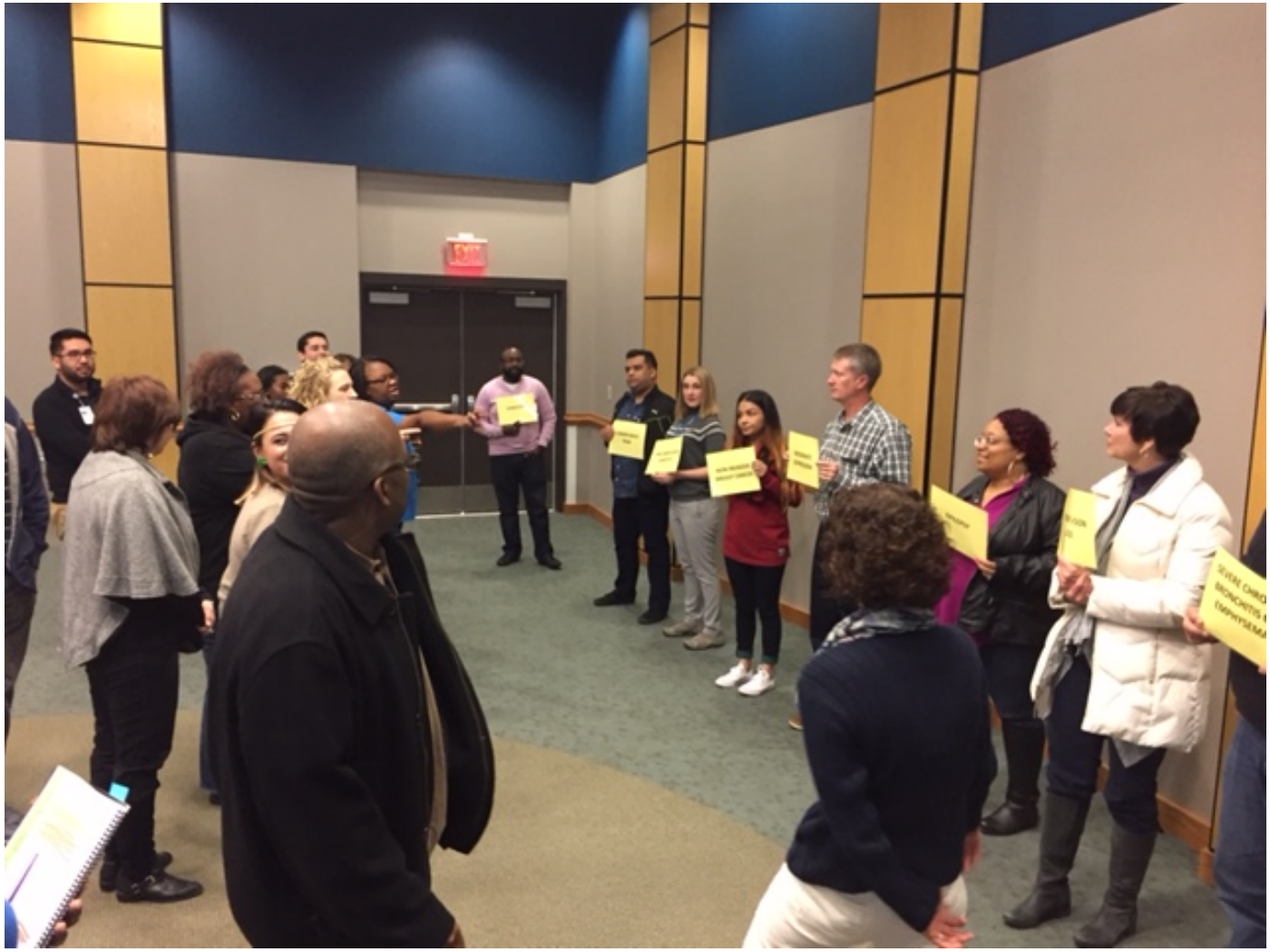
# MENTAL HEALTH

- The Mental Health work group now uses the driver diagram to determine its projects and initiatives
- The 4 areas of focus for the group in 2017
  - Question Persuade Refer suicide prevention trainings
  - Mental Health First Aid trainings
  - Mental Health and Addiction online screenings
  - Community forums and film screenings

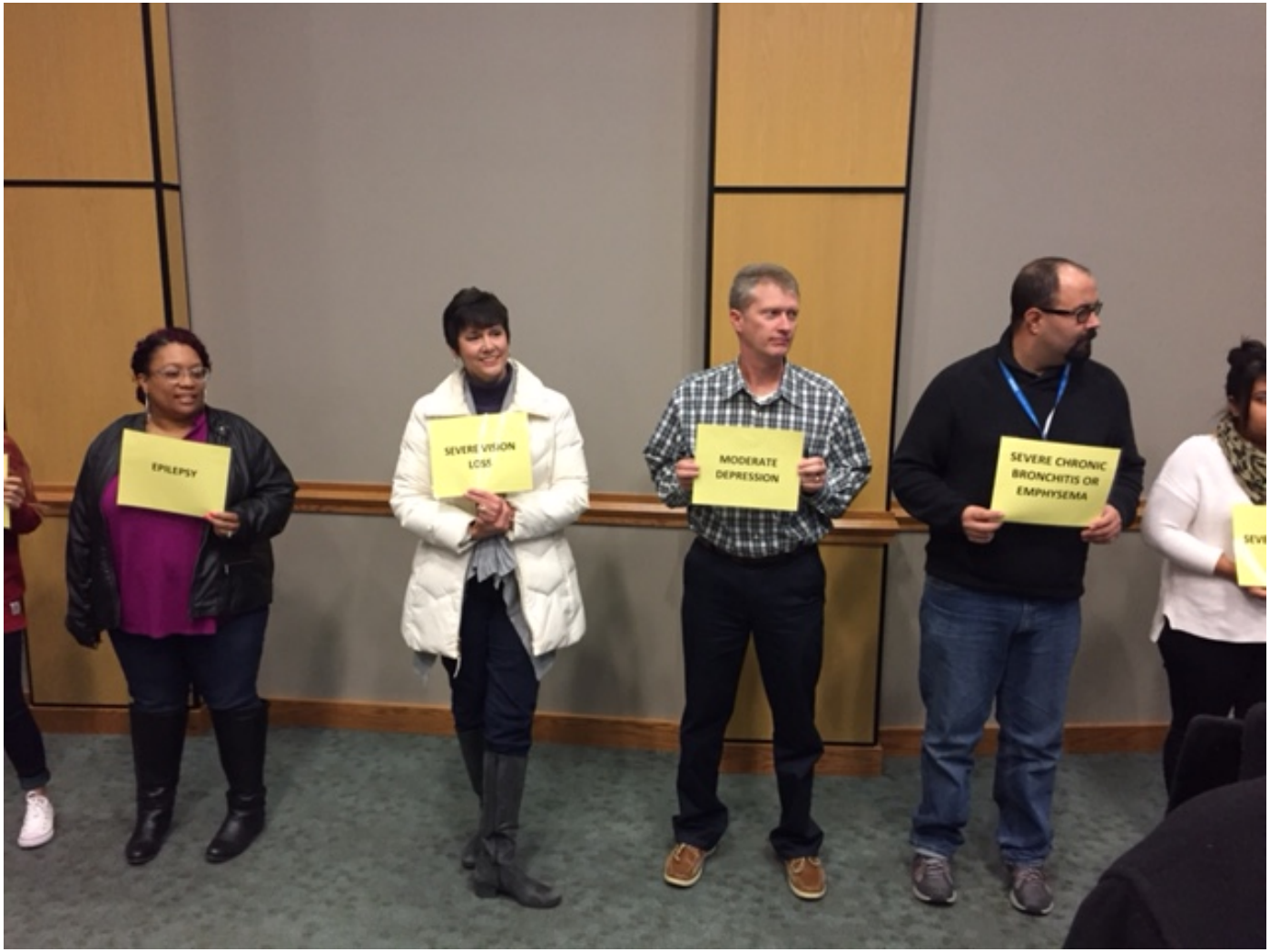
# Mental Health First Aid

- 5 members of the group are trained in Mental Health First Aid
- Working to form a partnership with Metro Library System to train library employees in MHFA in 2017
- Trainings completed in the last year for:
  - Community Health Workers in emergency room settings
  - EMTs, nurses, county jail employees
  - School social workers
  - Corporate chaplains
  - Private licensed therapists
  - And others!

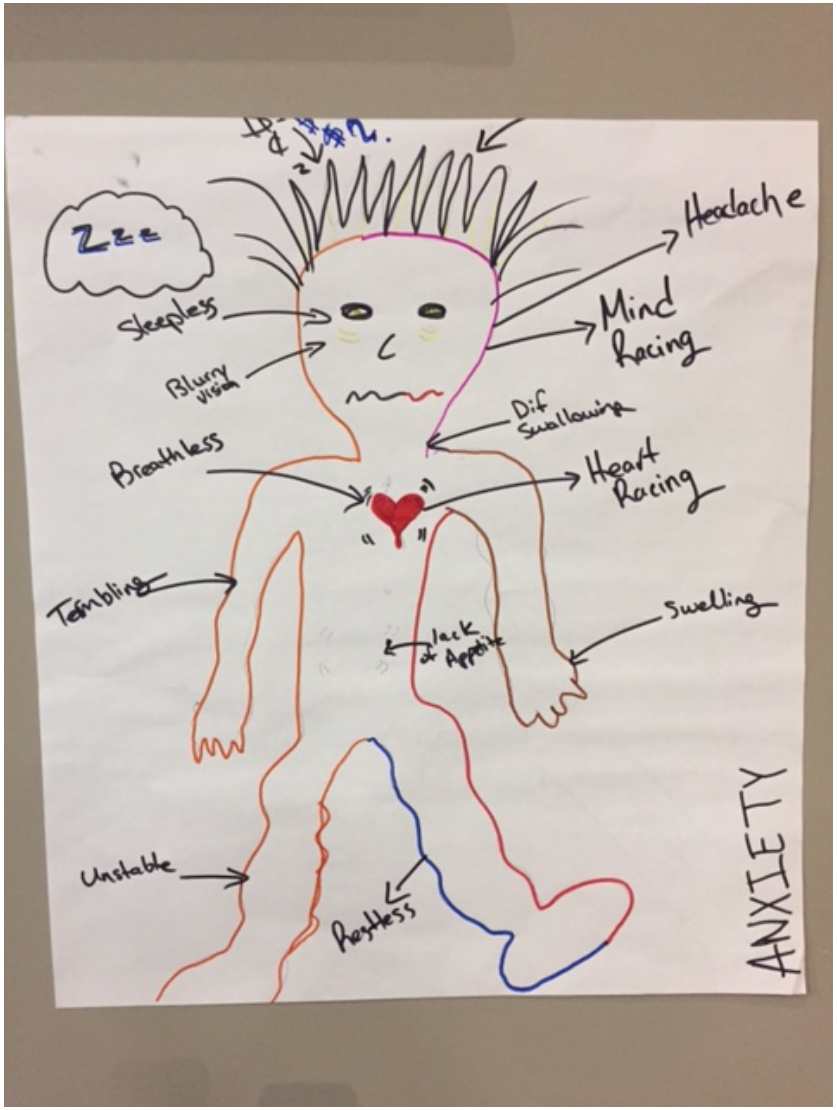
# Mental Health First Aid

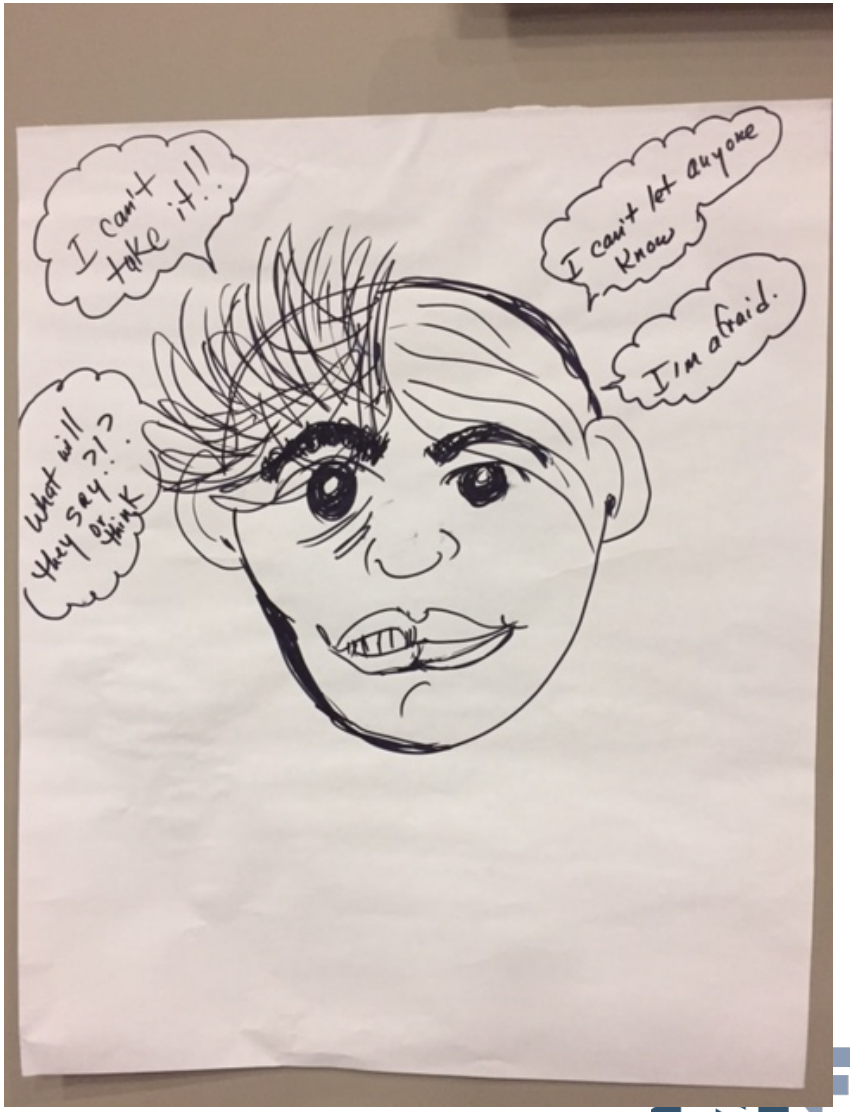


# Mental Health First Aid



# Mental Health First Aid



# Question Persuade Refer

- A majority of group members are trained to provide QPR Suicide Prevention Trainings, approx. 5-8 members are trained
- A few of the trainings in 2016 included
  - University administration and business professors
  - County health department employees
  - Pregnancy resource center employees
  - General community members

# Mental Health and Addiction screenings

- Free online screening platform paid for by INTEGRIS
- The group attends community events and health clinics to administer the screenings and provide referrals
  - Metro Libraries
  - LOVEOKC
  - Documentary showing about addiction
  - Local play about suicide
  - Paid ads for the screenings on Facebook

# LOVEOKC free mental health screenings

# LOVEOKC free mental health screenings

# Screening of addiction documentary and talk back panel after

# Screening of addiction documentary and talk back panel after

# Onsite resources and screenings at documentary showing

# Onsite screenings and referrals at metro libraries

# Impacting Mental Health through the Use of a Driver Diagram

Kevin A. Alvarnaz, MBA
Director, Community Health & Wellness
WellSpan Health

# Who We Are?

- WellSpan Health is an integrated health system that serves the communities of central Pennsylvania and northern Maryland.

- The organization is comprised of a multispecialty medical group of more than 1,200 physicians and advanced practice clinicians, a home care organization, six respected hospitals, more than 15,000 employees, and more than 130 patient care locations.

- WellSpan is a charitable, mission-driven organization, committed to exceptional care for all, lifelong wellness and healthy communities.

# The Behavioral Health Climate

- Recent CHNA results and a subsequent regional health plan focus
  - Prevalence of anxiety/depression
  - Poor mental health days rate
  - Low provider to patient ratio
- Fractured behavioral health / mental health system
- Recent affiliation with strong regional behavioral health care provider

## GOAL: DECREASE THE NUMBER OF POOR MENTAL HEALTH DAYS PER MONTH

### OBJECTIVE 1 – INCREASE THE PERCENTAGE (%) OF ADULTS WHO ARE SCREENED FOR DEPRESSION

*2015 Baseline:*
*Diagnosed with a depressive disorder*
- *Adams County* 20%
- *York County* 21%

Strategy 1 – Develop a standardized screening process for use throughout the community

Strategy 2 – Encourage regular screenings of adult patients among primary care providers (PCP)

Strategy 3 – Identify opportunities for community organizations (non-medical) to engage in appropriate depression screening

### OBJECTIVE 2 – PROMOTE THE APPROPRIATE UTILIZATION OF AVAILABLE RESOURCES AND SERVICES.

*Baseline:*
*No measureable baseline data available at this time.*

Strategy 1 – Create an inventory of available resources and services that assist in the management of depression, and identify any service gaps

Strategy 2 – Develop and implement a process (or processes) by which individuals suffering from some degree of depression are connected with the appropriate care/ management resources

### OBJECTIVE 3 – IMPROVE / INCREASE THE MENTAL HEALTH PROVIDER-TO-PATIENT RATIO

*2015 Baseline:*
*Mental Health Population/Provider Ratio*
- *Adams County* 1,493:1
- *York County* 1,155:1

Strategy 1 – Identify advocacy opportunities that support equitable funding and/or provider recruitment

Strategy 2 – Explore and, when possible, implement alternate models for providing depression counseling (e.g., tele-psych, doctoral interns in PCP offices)

# Our Team


WellSpan
HEALTH


Hanover Hospital


FamilyFirst
HEALTH


Healthy
York County
Coalition


COMMUNITY CARE
Behavioral Health Organization


YORK
PENNA
1741


trueNorth
WELLNESS SERVICES


Susquehanna Valley
Community Mental Health Services


Philhaven
Promoting hope, healing and wholeness


YORK COUNTY
PENNSYLVANIA


CATHOLIC CHARITIES
DIOCESE OF HARRISBURG, PA. INC.


YORK COUNTY
COMMUNITY FOUNDATION


York County Libraries
ANSWERS FOR LIVING. KNOWLEDGE FOR LIFE.


PENNSYLVANIA
2-1-1

# Population Health Driver Diagram
## WellSpan Health

### AIM STATEMENT

Improve the way people in York County, PA function while experiencing Mental Health/ Behavioral Health issues

**Goals**

- **Increase the quantity of entry points to behavioral health services**
- **Decrease the number or poor mental health days/month (3.4)**
- **Promote appropriate utilization of available resources and services**
- **Improve the Mental Health Provider to Patient ratio (2015 – 1,155:1)**
- **Increase the number of adults managing depression symptoms**

### PRIMARY DRIVERS

### SECONDARY DRIVERS

**Knowledge and Awareness of Depressive Symptoms**

- Normalize depressive symptoms and establish intervention strategies that celebrate resiliency and connect to appropriate supports
- Improve broad-base community knowledge of mental and behavioral health
- Increase visibility of resources
- Engage and collaborate with community organizations to understand and strengthen their ability to help
- Increase the number of community members trained in Mental Health First Aid or an evidence-based training
- Educate the community to enhance their capacity to respond to a mental or behavioral health concern

**Development and Implementation of a Standardized Community-wide Approach to Screening and Management**

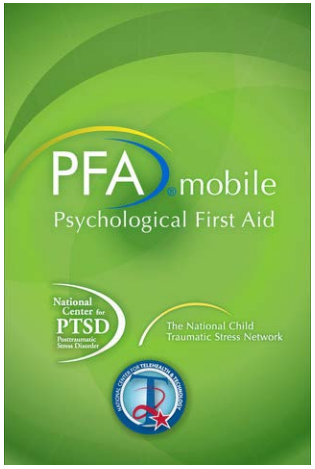
- Utilize a standard screening tool – PHQ2 or PHQ 9
- Utilize the Collaborative Care Model for care and treatment of behavioral health issues
- Integrate and utilize decision support tools for health and human service providers
- Rethink engagement of individuals having behavioral health problems

**Community Resource Redesign**

- Improved navigation and distribution of behavioral health resources
- Improved behavioral health provider to patient ratio
- Enhanced patient experience throughout the behavioral health system
- Broad-based advocacy to support a comprehensive behavioral health system

# Driver #1: Increased Awareness

feelingblue





- Promote and expand educational programs
- Develop and implement a communication plan
- Establish network of organizational partners

the campaign to changedirection

# Driver #2: Screening and Management Process

HELP!!!

This has been our most difficult area to develop strategies and is partially contingent on progress with the other two drivers.

- Next Steps: Review and adapt a workflow algorithm developed by a neighboring county.

# Driver #3: Community Resource Redesign

## Secondary Drivers

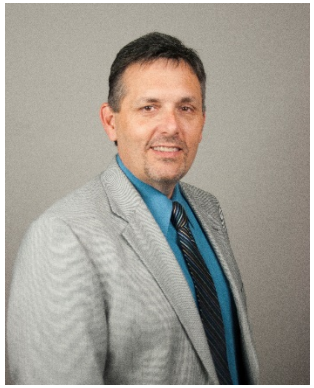
- Improved navigation and distribution of behavioral health resources
  - Build upon existing PA211 resources available through UWYC
  - Stratify list of existing resources
- Improved behavioral health provider to patient ratio
  - Integration of doctoral psychiatry interns into primary care practices
  - Engagement of local academic institution to develop a midlevel provider training currriculum
- Enhanced patient experience throughout the behavioral health system
- Broad-based advocacy to support a comprehensive behavioral health system

# Lessons Learned

- What is the scope of work that can be accomplished? Behavioral health vs. mental health
- You don't need to be the expert – you just need to have the right people at the table!
- Keep your group size manageable!
- Having solid data and direction helps expedite the process.
- Learn about the conditions causing the issue.
    - Example: Telepsychiatry regulations vs. telehealth ones
- Learn from others doing similar work.  (i.e., Let's Talk Lancaster)
- Time, time and more time is needed.  Our work has only begun!

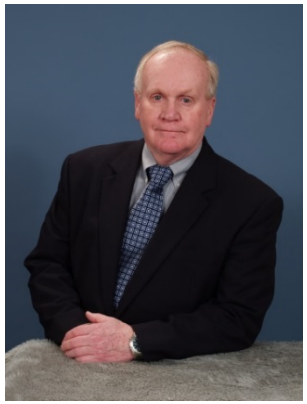
# Questions?

Shawna Mercer



Stephen Petty

Kevin Alvarnaz



Jack Moran

Ron Bialek

# Future of Population Health Award

- Purpose: Recognize exemplary practice by hospitals and health systems that are collaborating with public health departments and other community partners on health improvement strategies and implementation efforts
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FUTURE OF POPULATION HEALTH AWARD

WELLSPAN HEALTH

FUTURE OF POPULATION HEALTH AWARD

INTEGRIS

# Additional Resources

- *Using The Community Guide for Community Health Improvement* pilot initiative
- The Community Guide
- ACHI's Community Health Assessment Toolkit
- Using Driver Diagrams to Improve Population Health
- Driver Diagram Development for Community Health Challenges
  - Contact Margie Beaudry, mbeaudry@phf.org or 202-218-4415
- Other Performance Improvement Services for hospitals, health systems, and health departments
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