Evidence to Action to Results: Using Data to Improve Health

Tuesday, March 1 – 3:30-4:45pm

Tools for Prioritization: Measuring Community & Clinical Prevention's Impact

Erin Duggan-Butto, MPH, Project Manager, Altarum Institute
Michael Maciosek, PhD, Senior Research Investigator, HealthPartners Institute for Education and Research
Anne C. Haddix, PhD, Managing Partner, Minga Analytics, LLC

Hospitals and health care systems need innovative, evidence-based methods to assess the value of preventive services that protect and improve the health of communities. The National Commission on Prevention Priorities (the Commission) helps decision-makers prioritize preventive services that maximize the impact of their investments.

The Commission guided the development of Community Health Advisor (the Advisor), an online resource that supports the CHNA process by providing tools that assist decision-makers in understanding the impact and expected return on community health improvement initiatives. The Advisor provides customized information that has preloaded up-to-date demographic and other data about the potential behavioral, health, and cost impact of implementing evidence-based interventions in the user’s community.

Complementing their work on community prevention, the Commission also identifies clinical preventive services that make the biggest impact on health and are most cost-effective. Health care providers are striving to improve patient care effectively and efficiently, but they must balance competing demands on their time and resources. To help providers set priorities, the Commission ranks evidence-based clinical preventive services recommended by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices, and will be releasing an updated ranking in 2016.

This presentation will teach attendees about tools to help prioritize efforts both within hospital walls and in the communities they serve. It will include an interactive demonstration of the Advisor, during which attendees can view results for their own localities, and learn ways they can use the results to spur action. It will also include information on the latest clinical rankings, so the attendees can see which preventive services have the greatest impact and are most cost-effective. Armed with this information, attendees will be able to create an organizational culture of decision-making that supports the use of evidence-based data when selecting programs and committing resources to improve health.

Learning Objectives

- Be introduced to tools to assist them in prioritizing investments in the health of the communities they serve.
- Learn how to use the results from Community Health Advisor, a powerful online tool that calculates the 30-year behavior, health, and cost impact of evidence-based community interventions at a national, state and county level.
- ACHI attendees will learn how to apply the National Commission on Prevention Priorities’ ranking of clinical preventive, a unique tool to help many types of decision-makers choose where to improve utilization rates by indicating which services are most consequential and cost effective.
Tuesday, March 1 – 5:00-6:15pm

**Fostering a Sustainable Multisector Collaboration to Address Food Access**
Kimberley Knox, MPA, Program Coordinator, Port Towns Community Health Partnership
David Harrington, Senior Policy Advisor for Wellness and Community Initiatives, CommonHealth ACTION
Celeste James, Director of Community Health, Kaiser Permanente, Mid-Atlantic States

Launched in 2008, the Port Towns’ Community Health Partnership (PTCHP) strives to reduce chronic illness related to poor nutrition and inactivity through addressing lack of access to healthy foods and low levels of physical activity. The Port Towns communities of Bladensburg, Colmar Manor, Cottage City, and Edmonston are located within a quarter-mile of each other near the Washington, DC border in Prince George’s County, Maryland. Chronic disease is present in these communities, which have limited access to healthy foods and inadequate spaces for recreation. These communities, largely populated by people of color, are overlooked in part due to outdated zoning and development that encourages blight. The PTCHP is implementing community education and system-level change strategies to overcome built environment, public policies, and organizational practice challenges for all sectors (e.g., business, government, healthcare, and schools). The PTCHP is part of Kaiser Permanente’s national Community Health Initiatives program, which engages community stakeholders to work together to achieve significant and measurable impact on community health. Kaiser Permanente funded CommonHealth ACTION, a national nonprofit public health organization, to build the community’s capacity to address the social determinants of health through multi-sector strategies. The three presentations will share insights on strategies, policies, and key lessons learned from an eight-year multi-sector collaboration.

Presenters will provide an overview philanthropic community investment and the significance of developing a multisector collective impact community hub, describe the ongoing learnings of coordinating the PTCHP and working with diverse stakeholders to promote health and wellness in the Port Towns and share lessons learned from delivering a broad spectrum of technical assistance support to the PTCHP (e.g., from assessing infrastructure needs to creating an effective partnership structure).

**Learning Objectives**
- Describe strategies for working with diverse sectors on community education and system-level change
- Understand the role of technical assistance in building a collaboration’s capacity to improve community health
- Learn about the importance of building a collective impact partnership for sustainability

Wednesday, March 2 – 8:45-10am

**Don't let DATA be a Four-letter Word!**
Renee Romberger, MHS, Vice President, Community Health Policy and Strategy, Spartanburg Regional Healthcare System
Kathleen Brady, PhD, Vice Chancellor, Planning, Institutional Research and Metropolitan Studies, University of South Carolina Upstate

This session is targeted to community health professionals who don’t believe that Data is the foundation of Community Health work. This fun and interactive session will use real world examples to underscore the importance of data not only in Community Health assessments but also in identifying solutions and in tracking and reporting meaningful outcomes. The presentation will include different scenarios to emphasize the Power of Data and how the misuse and misunderstanding of data can lead to poor decisions and unanticipated outcomes. The presentation will also include an interactive session to allow participants the opportunity to challenge presenters on identifying measurement standards for strategies that seem "unmeasureable". Lastly, presenters will discuss Data resources available at the local, state, and national level. The session will drive home the concept that Improving Health is impossible without Data, and hopefully turn non-believers into Data-driven leaders.

**Learning Objectives**
- Participants will gain a deeper appreciation for the Power of Data (the benefits and the pitfalls)
- Participants will develop a better sense for how to use data appropriately to drive decisions.
- Participants will develop a better understanding of why data is critical in getting and keeping organizational and community buy-in.
Participants will identify potential measurement standards for some of their hardest to track community health initiatives.

Wednesday, March 2 – 10:30-11:45am

Follow the Data: Implement Evidence-Based Substance Abuse Prevention Interventions
Anne De Biasi, MHA, Director, Policy Development, Trust for America's Health
Leslie Aldrich, MPH, Associate Director, Massachusetts General Hospital’s Center for Community Health Improvement
Kirstin Craciun, MPP, MSW, Director of Community Outreach, The Center for Health Affairs
Jane Sanville, Chief, Prevention Branch, Office of Demand Reduction, Office of National Drug Control Policy, Executive Office of the President

Hospitals are identifying substance use disorders (SUDs) as a top concern in the CHNA process. This session will show how data can drive a focus on SUDs and will explore how to translate the data to implement evidence-based programs.

Hospitals, however, don’t always have an expertise in treating individuals with SUDs. Patients are often treated for their acute needs and then end up readmitted for other medical complications, which drives up health care costs. Hospital and patients could benefit if patients with a SUD were managed as are patients with other chronic diseases, such as diabetes and hypertension.

Care needs to begin and end in the community. Community-based prevention, to early intervention and treatment, to chronic disease management is a robust and complex system of care. This session discusses how hospitals can work with community partners to prevent substance use. Working with experts to help match evidence-based interventions to the problems identified in your assessment is key to success. Developing multi-sector coalitions, analysis of local data including risk and protective factors, braiding multiple funding sources together and changing the management of care efforts require numerous skills.

What are the latest and most effective prevention strategies? What interventions within communities and schools could be included in an implementation plan? Who would you need to partner with? How would you learn from and contribute to the research base to help prevent SUDs or improve the care for those with a SUD? An example of a hospital that is shifting its strategic priorities to focus on SUD will be presented. Findings of the National Collaborative on Education and Health’s Working Group on Substance Use in Schools, including models of technical assistance, evidence-based interventions and policy recommendations for advancing substance abuse prevention though connections between health and health care, will be presented.

Learning Objectives
- Learn how one hospital shifted its strategic plan to focus on substance abuse after identifying it as a top community issue via their CHNA and hear about their results.
- Hear the conclusions of the National Collaborative on Education and Health’s Working Group on Substance Use in Schools on how hospitals can engage in substance use prevention and early intervention efforts with schools and communities.
- Discuss how to translate the evidence into action to reduce and prevent substance abuse, improve academic outcomes and influence many other positive outcomes.

Wednesday, March 2 – 2:45-4:00pm

Improving Health of Communities through Community Health Improvement Evaluation
Terry Foust, AuD, FAAA, Director, Community Health Improvement, Intermountain Healthcare
Elizabeth Joy, MD, Medical Director Community Benefit, Intermountain Healthcare

This presentation will:
- Describe the development of the CHI evaluation process which included extensive evaluation methodology review and research, establishment of a system wide evaluation committee, committee goals, evaluation tool development, implementation, feedback and evaluation.
Present and describe examples of measuring the impact (improved community health) of hospital community benefit implementation plans and community health improvement initiatives.

Demonstrate how Intermountain moves from community health improvement pilot projects to promising practice and then to established programs (pilot to re-aim).

Learning Objectives
- Understand and be able to identify 3 elements of developing an evaluation program
- Describe Intermountain’s evaluation process
- Describe the evaluation tool and its components

Wednesday, March 2 – 4:30-5:45pm

Utilizing Local Data to Catalyze Coalitions, Address Disparities, and Improve Health
Vickie Boothe, MPH, Acting Senior Evaluator, Division of Community Health, CDC
Eva Wong, PhD, Clinical Assistant Professor, Epidemiology, Public Health, Seattle & King County
Kristina Kintziger, Environmental Consultant, Public Health Research Unit, Division of Community Health Promotion, Florida Department of Health

The final 2014 IRS regulations for Community Health Needs Assessment (CHNA) included a number of new challenges including:
- Community Input for Identifying and Prioritizing Needs: The hospital must “solicit” and “take into account” input from members of medically underserved (disparately impacted), low-income, and minority populations.
- Expanded “Health Needs” Definition: “…financial and other barriers to accessing care, preventing illness, ensuring adequate nutrition, or social, behavior and environmental factors that influence health in the community.”
- Impact Evaluations: After 12/29/2015 CHNAs must “include an impact evaluation of the actions taken by the hospital on significant health care needs it identified in its previous CHNA.”

Attendees will learn how measures of sub-county level life expectancy and associated health determinants can be used to identify, measure, and better understand growing and persistent neighborhood level health disparities. The session will include a summary of the current scientific understanding on how social, environmental, and behavioral factors drive community health and create persistent health disparities. Practical resources and tips for identifying, implementing, and evaluating the impact of evidence-based interventions and promising practices designed to address upstream determinants will be shared. The presenters will also share case studies of how multi-sectoral collaborations utilizing a collective impact framework can meaningfully engage community members and effectively reduce disparities and improve community health by implementing sustainable policies, systems and environmental interventions.

Learning Objectives
- Utilize neighborhood level measures of population health (life expectancy) and known social and environmental determinants to identify and assess the modifiable underlying factors driving health disparities;
- Catalyze multi-sector coalitions and empowered communities to collectively address upstream health determinants, reduce disparities, and improve overall community health; and
- Employ data visualizing and messaging best practices to raise public and decision maker awareness on the role of multi-sector, place-based factors (e.g., income, housing, employment, transportation, and community development) in creating health and eliminating health disparities.

Thursday, March 3 – 9:15-10:30am

CMS Equity Plan for Medicare - Data to Action
Madeleine Shea, PhD, Deputy Director, Office of Minority Health, Centers for Medicare and Medicaid Services
Joseph Betancourt, MD, MPH, Director, The Disparities Solutions Center, Associate Professor of Medicine, Harvard Medical School

This session will provide an overview of CMS’s inaugural plan to increase equity in Medicare over the next four years. We will present six CMS Equity Plan priorities that will expand data resources, evidence based solutions and opportunities to accelerate data driven action to move from health care to healthy communities. We will demonstrate how participants
can use two new racial and ethnic stratified Medicare quality, patient experience and outcomes data resources. We will then guide participants in how to move from understanding community health disparities to equity solutions by presenting a new toolkit to reduce disparities in Medicare readmissions in minority and vulnerable populations. Strategies in this toolkit include collecting data to develop a strong radar and to identify the target, deploying a team, designing interventions that address social determinants of health, coordinating with community based organizations, and identifying cultural competent, communication sensitive, high-risk scenarios. Finally, we will engage the audience in a discussion of how these new resources may be locally used and adapted by community health improvement practitioners.

Learning Objectives

- Learn about the 2015-2019 CMS Equity Plan for Medicare and six new priorities that will expand data, solutions and action to improve the health of vulnerable populations.
- Understand new sources for stratified health data, how to access these data and maps and how the resources can be used to drive community health improvement action.
- Describe a set of team-based, collaborative and community focused activities that can help hospital leaders take action to address and reduce readmissions in diverse populations.