

The CTG Action Institute brought California's public health leaders together to promote a statewide movement to address chronic disease through social, environmental and policy change as outlined in the *CCLHO-CHEAC Chronic Disease Prevention Framework*. Nearly 250 local and state-level public health leaders and their community partners from 50 health jurisdictions, as well as nationally known technical experts and funders participated in this event. It was planned jointly with CA4Health and the CCLHO-CHEAC Chronic Disease Prevention Leadership Project and co-sponsored by the Public Health Institute, The California Endowment, California Department of Public Health, Centers for Disease Control and Prevention and the *Network for a Healthy California*.

Sharing Our Strengths... Maximizing Our Impact

2nd Annual CTG Action Institute
April 23-24, 2013
Conference Proceedings April 23, 2013

Produced by Mary Anne Morgan, MPH
On behalf of the CCLHO-CHEAC Chronic
Disease Prevention Leadership Project

Sharing Our Strengths...Maximizing Our Impact

2nd Annual CA4Health Action Institute

In collaboration with the CCLHO-CHEAC Chronic Disease Prevention Leadership Project

April 23, 2013

ACTION INSTITUTE - OVERVIEW of DAY 1

Tuesday, April 23, 2013

9:00 AM	Opening Remarks
9:15 AM	Keynote: <i>The National Perspective on Chronic Disease Prevention</i>
9:45 AM	CCLHO/CHEAC Framework for Chronic Disease Prevention
10:15 AM	BREAK
10:30 AM	Framework Principles in Action: Innovative Approaches
11:45 AM	<i>Breakout Groups:</i> Local Applications of the Framework
12:45 PM	LUNCH
1:45 PM	<i>Plenary Session:</i> Building Statewide Momentum – Maximizing Impact
2:30 PM	<i>Breakout Groups:</i> Advancing the Chronic Disease Prevention Movement in California
3:30 PM	BREAK
3:45 PM	<i>Plenary Session:</i> Recommendations for Action and Next Steps
4:15 PM	Closing Remarks
4:30 PM	<i>Adjourn</i>

DETAILED AGENDA DAY 1: APRIL 23, 2013

Emcee: **Robert Berger, MSJ**, Project Director, CA4Health, Public Health Institute

9:00 Opening Remarks

Mary Pittman, DrPH, President and CEO, Public Health Institute

Wendel Brunner, MD, CCLHO-CHEAC Chronic Disease Prevention Leadership Project, and Director of Public Health, Contra Costa Health Services

Ron Chapman, MD, MPH, Director and State Health Officer, California Department of Public Health

9:15 Opening Keynote: The National Perspective on Chronic Disease Prevention

Leonard Jack, Jr. PhD, MSc, Director, Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

9:45 CCLHO/CHEAC Framework for Chronic Disease Prevention

Introduction to the Framework principles and how they create a shared vision for advancing health equity and preventing chronic disease in California across all local prevention efforts, including Community Transformation Grants and other local prevention efforts.

Moderator: Wendel Brunner, MD, CCLHO-CHEAC Chronic Disease Prevention Leadership Project, and Director of Public Health, Contra Costa Health Services

Dan Peddycord, RN, MPH/HA, Public Health Director, Santa Clara County and CHEAC Vice President

Lynn Silver Chalfin, MD, MPH, Health Officer, Sonoma County and CCLHO Chronic Disease Committee

Marion Standish, MA, JD, Senior Advisor, Office of the President, The California Endowment

Jessica Núñez de Ybarra, MD, MPH, FACPM,  Chief, Coordinated Chronic Disease Section, Chronic Disease Control Branch, California Department of Public Health

10:15 BREAK

10:30 Framework Principles in Action: Innovative Approaches

Presentations include real life experiences and lessons learned viewed through the lens of the Framework

Moderator: Robert Berger, MSJ, Project Director, CA4Health, Public Health Institute

Advancing Health Equity: Rebecca Flournoy, Deputy Director and Director of Policy, Planning, and Health Equity, Alameda County Public Health Department

Engaging Community Partners: Joan Mazzetti, MPH, Health Education Manager, Calaveras County Public Health Department, CA4Health

Implementing Cross-Sectoral Approaches: Susan Harrington, MS, RD, Public Health Director, Riverside County Department of Public Health

Sustaining Chronic Disease Prevention: Linda Helland, MPH, Program Administrator, Mendocino County Health and Human Services Agency, CA4Health

11:45 **Breakout Groups: Local Applications of the Framework**

Each group will focus on how local health departments and community organizations can apply key elements of the Framework in their communities.

Group 1: Advancing Health Equity

Group 2: Engaging Community Partners

Group 3: Implementing Cross-Sectorial Approaches

Group 4: Sustaining Chronic Disease Prevention – Local Strategies

12:45 LUNCH

1:45 **Building Statewide Momentum – Maximizing Impact**

Setting the stage for moving the discussion beyond local jurisdictions, including how to support and sustain the work through regional and state level partnerships.

Marice Ashe, JD, MPH, Founder and Director, ChangeLab Solutions

Ruth Holton-Hodson, Deputy Controller for Health & Consumer Policy, State of California

2:30 **Advancing the Chronic Disease Prevention Movement in California**

These breakout groups will focus on how we can work together to advance and sustain this movement.

Each session will generate a list of recommendations and follow-up actions.

Breakout Group 1: Building Local Health Department and Community Capacity

Breakout Group 2: Telling Our Stories to Capture the Full Impact of Our Work

Breakout Group 3: Sustaining Chronic Disease Prevention through State, Regional and Community Partnerships

Breakout Group 4: Measuring Impact and Progress toward Health Equity

3:30 BREAK

3:45 **Large Group Discussion: Recommendations for Action and Next Steps**

Recommendations for action to advance the chronic disease prevention movement and promote health equity in California will be highlighted.

Facilitators: Mary Anne Morgan, MPH, CCLHO-CHEAC Chronic Disease Prevention Leadership Project and Mary Anne Morgan Consulting

Julie Williamson, MPH, Innovations in Public Health Consulting

4:15 **Closing Remarks**

Robert Berger, MSJ, Project Director, CA4Health, Public Health Institute

Wendel Brunner, MD, Director of Public Health, Contra Costa Health Services

4:30 **Adjourn**

OPENING REMARKS

Dr. Mary Pittman, DrPH, President and CEO, Public Health Institute

Since our inaugural Action Institute last year, California's Community Transformation Grant (CTG) program has come a long way- even in the face of budget cuts and overall loss of funding-with significant transformation in rural and small counties throughout the state. CTGs aren't starting from scratch but we're expanding efforts that came before, such as The California Endowment's (TCE) Building Healthy Communities, Kaiser HEAL Communities, and others. We have the backing of the statewide leadership and a 10-year plan through the Let's Get Healthy Task Force to become the healthiest state, a state where everyone has a chance to be healthy. TCE has added real value leverage by providing funding to encourage the coordination between CTG grants statewide and our collaboration with CCLHO and CHEAC. At every level, in each school, in each department, all the work public health is doing is contributing to this movement. While we are transforming how we think about health it's going to take our collective action to move the needle on our most pressing health issues.

We have a special opportunity for innovation in our work linking clinical care and community prevention. There are a number of challenges in this area:

- Balancing our focus on preventive care, while continuing to improve the quality and coordination of care for those who aren't healthy and suffer from chronic disease
- With the shortage of primary physicians, we need to recruit more community health workers, particularly in rural communities which already have less access to care
 - CA 4Health campaigns have spent the last two years creating foundations of chronic disease self-management programs and stronger community advocacy skills
 - Nowhere is the need and promise for advanced community-clinical linkages greater than in these rural and smaller counties

As resources/funding have been steadily undermined and attacked, it's no longer enough for each health department to do great work individually. We have to find new solutions, ask each other how our work is affecting our community in a positive way, and lift up our stories to let people know why and how our work is important.

Wendel Brunner, MD, CCLHO-CHEAC Chronic Disease Prevention Leadership Project, and Director of Public Health, Contra Costa Health Services

Chronic disease is the leading cause of preventative and premature morbidity and mortality in CA, a key factor to rising health care costs, and a major driver in the health inequities that confront our state. The goal of the joint CCLHO-CHEAC Chronic Disease Prevention Leadership Project is to:

- Raise chronic disease on the agenda of local health departments
- Assist local health departments in becoming conveners and partners in their communities
- Promote the environmental, system, policy and norm change that's necessary to address chronic disease in our communities
- Increase the capacity of local health departments to address the issues

One of the goals of today's meeting is to introduce the joint CCLHO-CHEAC Chronic Disease Prevention Framework and its key themes-

- It emphasizes the importance of environmental, system, policy, and norm change to control chronic disease and associated risk factors
- While individuals need education and access to quality health care services, chronic disease cannot be addressed through these efforts alone; individual behavior change is difficult to sustain without community support
- We must address the social, economic and physical environment, as well as the community norms and attitudes that strongly influence behavior

Local health departments cannot do this by themselves, so the Framework recognizes the importance of:

- Engaging communities and partnering with local agencies not traditionally thought of as health agencies, such as cities, schools, planning departments, and recreation departments
- A Health in All Policies Approach is essential-
 - Every group takes ownership of the health agenda
 - In many cases, these partnerships will be convened by the health department
 - In other cases, the health department will play a secondary role
 - The goal is to put health on the agenda of the community as a whole and address the inequities in our communities

Ron Chapman, MD, MPH, Director and State Health Officer, California Department of Public Health

The recent CDPH publication, "The Burden of Chronic Disease and Injury," highlights some important health trends relevant to today's meeting:

- 38 percent of Californians live with at least one chronic disease
- 51 billion dollars (almost 60 percent) of CA's health care expenditures were spent on people with multiple chronic diseases
- 10 dollars per person/per year invested in prevention would yield 1.7 billion dollars annually in health care savings in CA – That's a return of \$4.80 for every one dollar spent after 5 years
- Death related to poor diet and inactivity increased 17 percent from 1990 to 2000 and these are expected to surpass tobacco as the leading attributable causes of death in the U.S.

Everyone knows what the tobacco cessation program in CA has done – making us the second lowest state in tobacco use:

- It has saved 1 million lives, 86 billion dollars in health care costs, decreased lung cancer deaths
- Using some of these tactics, we could change the rates of chronic disease in CA
 - Californians currently are not getting the recommended amount of exercise and are eating in excess of 300 calories more per person per day that they did in 1985

Social inequity causes health inequity:

- Those with low educational attainment and low income, and people of color are at greater risk for poor health and premature death
- Obesity rates correlate directly with education levels, with 18 percent of college graduates suffering from obesity and 34 percent of high school dropouts
- People of color, and African Americans in particular, suffer from more chronic diseases
- Life expectancy among blacks is an average of 10 years less than those of whites

Public health plays a role in food safety, tobacco control, infectious disease outbreaks and chronic disease prevention, saving many lives and dollars. Our work promotes making the healthy choice the easy choice by:

- Creating communities with access to healthy foods and beverages
- Making physical activity a daily part of life

OPENING KEYNOTE:

THE NATIONAL PERSPECTIVE ON CHRONIC DISEASE PREVENTION

Leonard Jack, Jr. PhD, MSc, Director, Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

We face a tremendous burden of chronic disease in this country:

- More than half of Americans are living with at least one chronic disease
- 75% of health care costs are associated with chronic disease

The Affordable Care Act positions us to do something about this problem. It makes it possible to have the Prevention and Public Health Fund and made the Community Transformation Grants possible.



We must address chronic disease, its secondary conditions and the health disparities that exist. We need to increase our evidence base around what actually works, as we create better conditions. We must reach out to rural and frontier communities.

There are several core principles to doing this work:

1. Maximize health impact
 - Population reach – think about engaging even larger systems, such as school districts
 - Potency/dose/exposure (effect size) – population-wide interventions with a health equity lens + targeted interventions to address greatest burden = best outcomes
2. Advance health equity and reduce health disparities
 - Use and expand the evidence base
 - Population wide AND targeted efforts in the communities (The Twin Approach)
3. Expand evidence-based practices
 - What are the population-wide approaches currently in play?
 - What are the targeted approaches currently in play?

CDC has made a community health portfolio and investment through: Community Transformation Grants (active funding);

KEY TAKEAWAY MESSAGES

1. Use data collection to-
 - Document where the work is already occurring
 - Determine where work should be focused in the future
 - Justify the efforts
2. Increase efforts around social and emotional wellbeing in the future-
 - By focusing on this, overall health will be affected in a positive way
3. Expand participation beyond individuals-
 - The more diverse, the better and broader the outcome
4. Promote clinical linkages
5. Today’s work positions for future funding

REACH (Racial and Ethnic Approaches to Community Health); Communities Putting Prevention to Work (CPPW); and Healthy Communities. The CTG grants touch 4 in 10 citizens through its tobacco-free living, active living and health eating, clinical and community preventive services, social and emotional wellness and health and safe physical enjoyment areas. One commitment is to spend some more time addressing emotional well-being. The federal government mandated that a certain percentage of these efforts be concentrated on rural communities – counties with >500,000 or fewer. CDC directed 24% of CTG implementation capacity building and small communities program funding to rural communities.

Advancing health equity will require that we provide equal opportunity and access to the conditions that create optimal health. One example is when one entire city of Oklahoma went on a diet. We need to mobilize communities to get the word out, make communities more walkable/bike friendly, establish things like community health centers through the dentist's office. The clinical linkage is a key component.

The CTG National Evaluation Plan requires that awardees submit goals and objectives and provide updates on a local level, in terms of what creates momentum/barriers and where the opportunities are.

CCLHO/CHEAC FRAMEWORK FOR CHRONIC DISEASE PREVENTION



Panelists: **Dan Peddycord**, Public Health Director, Santa Clara County and CHEAC Vice President; **Dr. Lynn Silver Chalfin**, Health Officer, Sonoma County; **Marion Standish**, Senior Advisor, Office of the President, The California Endowment; **Jessica Núñez de Ybarra**, Chief, Coordinated Chronic Disease Section, Chronic Disease Control Branch, California Department of Public Health

Dan Peddycord described the CCLHO-CHEAC Partnership and its intent to mirror the National Prevention Strategy in developing a framework for chronic disease prevention (CDP). He noted the

urgency of action to address this epidemic. He emphasized the influence of environmental factors in driving this epidemic and the importance of taking lessons from the successful Tobacco Prevention Model to apply to other chronic diseases.

Chronic disease is the Public Health Epidemic of our modern era, with a huge economic impact:

- U.S. accounts for more than 25% of the total global economy
- We're spending more than 18% of that on health care

There's a huge disconnect between the priority and resourcing the solution strategy. Prevention isn't happening in the U.S. We rank 77th in the world in return on investment when it comes to chronic disease. When we look at what actually drives health behaviors, the Framework's strategy actually offers a much higher return on investment because it:

- Aligns state and local strategy
- Makes CDP an urgent and high priority
- Provides a common language, vision, direction and systematic approach

Dr. Lynn Silver Chalfin outlined the Framework's priorities for preventing chronic disease:

1. Improve the diet of California residents
2. Increase daily physical activity
3. Provide healthy, safe environments that promote walking, biking and public transportation use
4. Create tobacco-free environments

Framework Recommendations

1. CDPH adopts & integrates Framework into all state programs
2. Migrate statewide to a model mirroring tobacco control program
 - Baseline funding for LHDs and community partners
 - Separate, competitive funding for local innovation
 - Funds for training and technical assistance
3. CDPH, CCLHO & CHEAC work together to coordinate a statewide agenda
4. State and LHDs collaborate to identify priorities
5. Designate future taxes to help fund chronic disease prevention
6. Leverage existing funding streams to better coordinate broad chronic disease agenda

Most people know they should be healthier, but health equity is a problem. In communities with high rates of poverty, that are car-centered and full of outlets for junk food and cheap cigarettes, healthy choices are extremely challenging. Using a health equity lens, we see that, in the past, the most successful programs have been those built into the fabric of the communities that make it easier for people to live healthfully. Successful approaches will provide equal access to resources

needed to achieve full health potential, thereby helping overcome social inequities. A spectrum of prevention strategies are needed to accomplish this, e.g. from support for an individual to stop smoking, to charging three times as much for a pack of cigarettes. The spectrum needs to include the following bands or strategies:

The Spectrum of Prevention



Health departments also need support around evaluation efforts, including a standardizing statewide approach; technology support to the local level; locally tailored evaluation plans; outside evaluators; and short and long-term data collection capacity.

Marion Standish discussed the important role of the CTG initiative in California to carrying out the broad chronic disease agenda proposed by the Framework. CTG represents the best opportunity we have to reduce the burden of Chronic Disease across the state; there is an extraordinary readiness to work on these issues together, throughout the state, including in rural communities that have not been able to do much in the way of public health. These grants are touching almost every county in the state, with California receiving over 1/5th of the CTGs funding (nearly 30 million dollars). CTG grantees have a focus on shared goals – sugary beverages, safe routes to school, community clinical linkages, etc. They have a shared technical assistance and coordination function but need to strengthen community connections.

Dr. Jessica Núñez de Ybarra gave a brief update on state efforts to advance chronic disease prevention. She described the “Burden of Chronic Disease and Injury Report, 2013”, which is available on line as a resource. CDPH is open to hearing feedback on proposed changes. Dr. Ybarra presented the goals of the draft California Chronic Disease Prevention Plan, which is being revised based on recent webinars held around the state and will be posted in revised form on the CDPH website May 24, 2013. The State’s Chronic Disease Plan’s broad vision and goals are:

- CDPH CHRONIC DISEASE PLAN**
- Goal 1: The healthy choice is the default choice
 - Goal 2: Better care, lower cost
 - Goal 3: Shared knowledge is power
 - Goal 4: Prevention first

In January 2014, CDPH intends to talk about statewide coordination of the plan, in a statewide conference co-hosted by CCLHO/CHEAC Chronic Disease Prevention Leadership Project. Moving forward, CDPH intends to focus on:

- Best practices
- Sustainability
- Technological advancements

FRAMEWORK PRINCIPLES IN ACTION: INNOVATIVE APPROACHES



Panelists: **Rebecca Flournoy**, Deputy Director and Director of Policy, Planning, and Health Equity, Alameda County Public Health Department; **Joan Mazzetti**, Health Education Manager, Calaveras County Public Health Department; **Susan Harrington**, Public Health Director, Riverside County Department of Public Health; and **Linda Helland**, Program Administrator, Mendocino County Health and Human Services

Rebecca Flournay described Alameda County's efforts to incorporate health equity throughout their agency and in their programmatic work. She defined health equity as ensuring that everyone no matter what, should have the same opportunities to live healthy, productive lives. Unfortunately, discrimination is alive and affecting many people that live in communities with no parks, grocery

stores, businesses, or public transportation to support them as healthy communities. Changing this dynamic will require policy, systems and institutional change. Community residents need to be involved in this process. Health equity must be imbedded in Programs, services, data and research.

Ms. Flournay gave asthma as an example of a comprehensive approach to advancing health equity. Their asthma program uses the spectrum of health approach and looks at how to support asthma sufferers as well as prevent future cases. They have found in their Healthy Homes effort that, while there are some things only families can do, there are other ways to reduce asthma triggers through proactive code enforcement. The health department offers support and education to families and landlords; at the same time code enforcement officials inspect rental housing and address issues proactively. The program also works on coordinating care and working with schools to offer support early on to prevent student absenteeism that can lead to truancy. Finally, work needs to be done on outdoor air quality.

Alameda County Public Health is also developing a chronic disease prevention plan. Their guiding principles include:

- Ongoing community participation
- Work across sectors to create healthy places
- Addressing social factors

Work groups are selecting their strategies, based on:

- People
- Places
- Policies and systems

Joan Mazzetti described Calaveras County which is a small, rural county with limited racial and ethnic diversity and a conservative political environment. When the Calaveras Public Health Department was approached about the CTG grant, they knew they would have to engage their community in outlining the strategies that would allow them to be successful in their small community. They recognized they would be battling the underlying belief that government shouldn't interfere in private lives, as well as battling huge departmental budget cuts. They looked to the community to develop shared goals, working successfully with workgroups; creating an orientation packet and reaching out to the schools.

Susan Harrington discussed the Healthy Riverside County Initiative, which is a cross-sectorial approach between the Department of Public Health and the county. It took more than 10 years to come to fruition, with time spent building on their existing foundation of policies already in place. A new County CEO helped advance the effort through his vision to make Riverside County the safest, most business friendly, best place to live in America.

To build on the CEO's vision, goals and leadership, the PHD decided to research what the county was already doing to

HEALTHY RIVERSIDE COUNTY INITIATIVE GOALS

- Most business friendly county in CA
- Ensure customer-centric public service
- Improve health and promote livable communities through
 - Partnerships
 - Policies
 - Services delivery systems and initiatives

promote livable communities and conducted a livable communities program and policy survey:

- 26 departments responded – 82%
- Many of these departments (92%) had at least one policy or program in place
 - Have to let them keep ownership
 - The challenge was to make each department own their improvements to the programs and policies
 - Decided to focus on just one part at a time

The PHD recognized that they needed to let departments keep ownership over what they had already accomplished and what they needed to do to further improve their programs and policies. They decided to focus on just one part at a time. Since then, Riverside County has officially adopted the framework, which can be viewed at www.healthyriversidecounty.org.

Linda Helland presented on the CTG work in Mendocino County and their efforts to sustain their chronic disease prevention work. Mendocino County has high Latino and Native American populations, high poverty rates, and like many rural counties- its residents generally mistrust government and dislike of policy and regulations. Compared to other counties, they have fewer personnel and resources. They have had to reframe the local culture as a positive – a can-do spirit!

INITIAL SUCCESSES in MENDOCINO

- Strengthened department capacity
- Youth advocacy training
- Radio spots against sugary beverages
- Mini-grantees
- Smoke-free housing, with youth presenting the benefits of smoke-free living for policy makers
- Healthy Living Workshops
- Healthy schools – biking, walking, healthy food and beverage

Mendocino County received a two-year grant from the Endowment to:

- Strengthen capacity of the department
- Prevent chronic diseases
- Promote health
- Reduce health inequities
- Strengthen community connections
- Increase access to health foods and beverages
- Engage community members in physical activity

They conducted some initial analysis to look at the retail food environment in the county and the life expectancy rates by race, ethnicity and census track. They created a Mendocino Food Policy Council, focused on a Farmers Market food stamp program, engaged youth in outreach and fundraising, educating them about healthy foods, and committed to forming deep, authentic relations with community groups.

Since it is difficult to be in the public sector right now, they try to nurture relationships and keep the vision alive: “to make life better for our communities, our families”. It helps that most of the staff are from the community itself. The county could not do this work without their community partners. In the future they hope to further empower youth to be advocates of healthy living.

MORNING BREAKOUTS: LOCAL APPLICATION OF THE FRAMEWORK



12 facilitated breakouts were held in the following theme areas:

- Advancing health equity
- Engaging Community Partners
- Implementing Cross-Sectorial Approaches
- Local Strategies for Sustaining Chronic Disease Prevention

Detailed notes from these sessions are attached separately at the end of this report.

AFTERNOON PLENARY: *BUILDING STATEWIDE MOMENTUM-MAXIMIZING IMPACT*

Ruth Holton-Hodson, Deputy Controller for Health & Consumer Policy, State of California; and **Marice Ashe**, Founder and Director of Changelab Solutions

Ms. Holton-Hodson opened by stating that the State Controller cares about rising costs and that CDPH has identified health care as a huge cost, with obesity costs accounting for 1/3 of our state budget. Three questions are central to this discussion:

- How do you put prevention back on the front burner?
- Who would make a policy maker/opinion leader listen where they haven't before?
- Who would have a vested interest in lowering healthcare costs?

EMPLOYERS ARE THE STAKEHOLDERS MOST INVESTED IN LOWERING HEALTH CARE COSTS

- 52% of workers still get insurance through their employer (12.1 million Californians)
- Employers are invested in finding ways to lower the cost of health care without-
 - Compromising care
 - Shifting the cost onto employees
- Prevention is a key piece of the puzzle
 - Data is needed to make the case for how much can potentially be saved by tackling chronic disease
 - For example, over 22% of CalPERS medical expenditure was spent on chronic disease
- Well-designed and targeted wellness programs can help

Evaluation is the key to the program's success:

- Compare with a control group
- Try to measure changes in productivity
- Relate the data to cost savings: Relating the savings to the changes, will be the success
- Success in CA would send a strong message throughout the US.
- Let policy makers know the extent of the problem and give them the solutions for their districts

Marice Ashe began by acknowledging that there are challenges in doing this work, but pointed out our success in generating local data that demonstrates improved health outcomes and economic savings that have been realized from chronic disease prevention and social and environmental change efforts:

- We have spent 2.4 billion in tobacco control in CA over 20 years
- We have **saved** 134 billion saved in related health care costs, an enormous return on the investment
- 25% fewer tobacco-related deaths
- 1 million spent on transportation projects, which shows that public health strategies are creates jobs for the community
- Equity data illustrates that how long you'll live depends on where you live

We have to work with a “Health in All” policies approach to get this data because we can't possibly get the data that transportation and housing agencies can generate, for example. We need to be able to create policy arguments for prevention.

It's critical to strategically choose our targets, where we can effect change without lobbying or engaging directly in prohibited policy advocacy/change:

- Government policies and protocols
- Procurement policies
- Create and improve open space/parks
- Safe routes to school, bike parking
- Regulation – smoke-free housing, sugary beverages – resources and technical support for these programs

Pre-emption is a big issue nationally. States are preventing local governments from working on the social determinants of health and other elements of public health to stop the work that's going on in other states. We need to stick together, establish trusted partnerships and work to bridge differences to promote innovation.

**PUBLIC HEALTH CAN
CREATE POLITICAL WILL-
EVEN WITH FEDERAL
DOLLARS- THROUGH:**

- Coalition building
- Educational campaigns – explain the advantages and disadvantages of policies
- Sharing best practices and success stories with elected officials
- Testifying at hearings about public policy
- Broadly sharing evidence-based policy approaches, as information only, not

An audience member asked Ms. Ashe about the State possibly expanding the Brown Act regulations to include coalition meetings and other kinds of community partnerships, particularly when elected officials participate. She offered to look into it.



AFTERNOON BREAKOUT SESSIONS: *ADVANCING THE MOVEMENT IN CALIFORNIA*

12 breakout sessions were conducted in the following theme areas:

- Building local health department and community capacity
- Telling our stories to capture the full impact of our work
- Sustaining chronic disease prevention through State-local and regional partnerships
- Measuring impact and progress toward preventing chronic disease

Detailed notes from these groups are attached at the end of this document.

LARGE GROUP DISCUSSION: RECOMMENDATIONS FOR ACTION AND NEXT STEPS

Facilitators: Mary Anne Morgan, MPH, Mary Anne Morgan Consulting and CCLHO-CHEAC Chronic Disease Prevention Leadership Project, Julie Williamson, MPH, Innovations in Public Health Consulting

Breakout Group Recommendations: There were 14 recommendations generated by the 11 breakout groups. Facilitators from each theme area reported back on 2-3 shared recommended actions for next steps as follow up to this conference. Recommendations **d below were informally identified for priority action:

Measuring Impact and Progress toward Health Equity

1. **Provide technical assistance with data collection, analysis, interpretation, messaging and communications ****
2. Increase access to data through different data sources
3. Develop tools for data standardization at the sub-county level*

Telling Your Stories Effectively

1. Create a central hub where people can find data, success stories
2. Launch unified communications program capable of making a **huge** impact against the tobacco and sugary beverage industry
3. **Provide assistance to help communities communicate/demonstrate links between changes and outcomes****

Sustaining Chronic Disease Prevention through Regional and State Partnerships

1. Create a 10-year disease prevention plan
2. **Streamline funding streams and contract requirements from state branches****
3. **Create TA hub to help locals with implementation of policy work****
4. **Develop unified messaging re: ACA and prevention, role of LHDs****
5. Establish mechanism to integrate state and local cross-sectorial actions, e.g. connecting HiAP work at state level to local efforts

Building LHD and Community Capacity

1. Create a collective chronic disease community across CA
2. **Develop shared language, integrated approach across state, including health equity; policy, environmental strategy, etc. ****
3. Centralized communications and information sharing system
4. Develop strategies for incorporating prevention and LHD role into *Recover CA**

Overarching Themes: Several themes s

Next Steps: These recommendations will be discussed with the conference sponsors for potential follow-up (CA4Health, TCE, CDPH, and the CCLHO-CHEAC Chronic Disease Prevention Leadership Project). It was pointed out that the areas of building and supporting local data capacity and creating a unified statewide message and communication plan are two of the priority goals in the State CDPH Chronic Disease Prevention Plan. They will be working with the CCLHO-CHEAC Project on how to move these goals forward over the next 6-12 months.

Actions to Take Back Home: Some meeting participant shared their intentions for actions they will commit to take back home

In the next month:

- Publish the essays written by 4th and 5th grade students on healthy eating and active living in the local newspaper
- Invite nontraditional partners to the table. Find out what's happening in our communities and identify key stakeholders.
- Crash one community meeting a month

Next six months:

- Convene a dialogue around chronic prevention framework with local funders
- Get seven community members and three different people from different community organizations to help advocate for priority policies

A year from now:

- To have East Bay MUD as a partner in drinking water promotion

CLOSING REMARKS AND ADJOURNMENT

Dr. Wendel Brunner, Public Health Director, Contra Costa County Health Services and Robert Berger, Project Director, CA4Health, Public Health Institute

Dr. Brunner and Mr. Berger acknowledged the outstanding turnout of local health departments from all over California (50 jurisdictions were present) and the very active participation of the State CDPH staff. They impressed upon the important opportunity to continue to build a statewide chronic disease prevention movement and to work together in local, regional and statewide venues to advance the effort.

2nd Annual CA4Health Action Institute

Day 1: April 23, 2013
Break Out Group Notes

MORNING BREAKOUT SESSIONS

Advancing Health Equity: Group 1

Reactions/Reflections on Panel

- “Never take no for an answer”
- Technical experts available to help you
- Finding different ways to work, non-traditional

What others are doing

- Fresno—broke down by zip, looked at differences; east/west, followed income level; lack resources 16-50 years+; align resources
- Orange—mirror natural causes approach; look at geographic disparities, accreditation assessment informed by disparities
- Monterey—community forums, good idea □ recognize efforts. Tailor to needs and perspectives of community
- Contra Costa—health disparities data, \$1/person in Contra Costa, housing, crime increasing
- Monterey—forum in March, diverse team, Bay Area grant, county leaders—we want: policies need to go through health impact assessment; anchored in equity □ show data; connect public health □ land use
- Tobacco Control—unit uses equity lens for smoke-free multi-unit housing issue, opposition
- CA Convergence—resident capacity-building, empowering residents at all levels
- City of Richmond—Building health communities 1. Health policies, 2. Full service community schools, 3. Health data report cards
- Monterey—Inviting Richmond City Manager and Mayor to come speak about their equity work to their peers and forum they held; resident involvement
- Conference—diverse representatives; non-profit alliances in Monterey
- technical assistance to NPOs for health equity; health equity statement for county

Opportunities

- Engage community—less planning alone/in silos; approach to governance; communities engage; residents clamoring, provide education
- The more counties take on equity work, help others doing the work every time, City adopts something that helps
- More health disparity data; conversation on climate change; link research abroad here locally
- Partnering with JCs and universities
- Community coalition training, health
- Challenge—bringing non-traditional partners to get on same page about health inequities
- ACS—access to care, healthy food, tobacco control, connect state to local

Non-Traditional Partners

- Planning departments can become go-to resource
- Economic councils
- Municipal water district: Tap water drinking water, new to being part of health conversation; water testing at school sites
- Positive partnerships help when problems come up; example→ water shut off in foreclosures
- Monterey Bay area governments→ as they develop plans, asking for equity feedback. Relationships are key to engage, trust.
- To partner, offer what you can do for them: positive press, include them in materials, make them look good.

Specific Actions/Next Steps

- Health equity curriculum
- (Orange) “Unnatural Causes” viewing, ask staff to reflect on inform work;
- (Monterey) emotional impact in this model, some staff may be those in the video
- Chico State, make sure new grads know about this
- (Alameda)UC Berkeley, class on health equity, just launching, share info on what teaching→ hopeful
- (Contra Costa) Film and Media—build capacity, food justice film series monthly, fun, convene professionals, residents and dialogue
- Develop relationship with association of governments; make sure have health equity lens
- As planning housing and transportation, make sure equity and health are there. SB 375: Sustainable Community Strategy
- Implement health element in county general plan, have cities do same (mimic Richmond); embed equity at policy level; even though may not use language of health equity, that is what it is, for very specific

Engaging Community Partners: Group 2 breakouts (combined comments)

Note: Rural: “neighborhoods” means entire community. Not welcome in far flung areas

Opportunities for advancing your situation-how is it different or similar to presentations

- Mendocino- where are communities that can help
- Small communities- easy to make connections; but not for behavior change. Walking to schools is an issue; cause for resistance- car culture
- Challenge: in diverse communities-to connect
- Another challenge: open enrollment schools-eliminates “neighborhood” schools
- Youth Engagement Ideas- CX3, youth engagement, advocacy of health (YEAH), Childhood Obesity Initiative (COI)
- Resident engagement (Humboldt)
- Kaiser – works with cities on policy goals (re solutions for advocacy)
- College students are great for outreach and fun; Dietetic internships where speaking is required
- Work with community leaders, don’t bring in an agenda; listen
- Youth engagement:
 - Must deal with political realities; use of youth is helpful here

- School Wellness policies include Nutrition Advisory Councils-can give youth a venue for expression
- Subcontract with youth groups (surveys, etc.); also peer educators, youth advocacy training using practical scenarios
- “Hydration Nation”- filtered water and water bottles done by students- “owned by kids”
- Youth Speaks (national Org.) Led through diabetes training workshops, then made slam poetry competitions
- Engage youth in walkability assessments and photos thereof
- Incorporate 4 prong approach of CTG:
 - Housing- leadership team involvement; approached property management firm
 - Safe Routes: Piggybacking on other coalitions to encourage parents to come in
 - Engaging the YMCA to bring in youth
 - Trail building Project- building on success (use champion in one area for other areas)
 - Use business approach- planning, business plan for impact; marketing using focus groups; showing economic impact to BOS; create videos on impacts
 - Tobacco free living-released radio ads, bus ads to gather interested people for meetings

Chronic Disease Framework

- Community engagement: new federal-name active transportation
- Work with bike coalition-ex. of collaboration
- A need to lobby-from the community
- Government involvement- ok to work with partners even if it’s not specific to CTG Strategic Direction

Theory of Change

- a curve demonstrating the tipping point of change action (need the name of the model)
- SSB work→ youth groups and presenting to local govt officials
- Identify an achievable goal: ex- walkability to school-behavior change; have drop off locations-identify creative ways to change

Successes/Elements/Benefits in Community Partnerships

- Benefits:
 - Expands knowledge base
 - Networking
 - Integrating resources toward common goals
 - common goals leads to strong, lasting relationships
 - Making connections and filling in the gaps
 - Finding resident voices, incorporating them into framework: makes the language more accessible
- Community Outreach:
 - Address Issues: Anticipate and overcome obstacles (food, service hours, advertise, meeting times and locations based on needs; childcare)
- Outreach Strategies:
 - use of social media, other online tools to recruit
 - Harness the power of existing community events
 - PR, make it a story
 - Tap into community members/groups talents and passions to gain ownership
- Effective engagement steps:
 - Tap into talents and passions

- Wait/work toward consensus
- Tell them what you want too
- First meetings should be face-to-face
- Ensure programs are culturally tailored; don't be afraid to tailor them differently
- Make things accessible
- Engaging Community Partners: Lessons Learned/common themes:
 - You get what you give
 - Make participation accessible
 - Provide educational and networking opportunities » mutual benefit for organizations and community members

Specific Actions: what you can do back home to advance an issue

- Project LEAN idea- engage parents, trainings, through PTAs on importance of issues
- Mendocino- engage property owners on smoke-free policies
- SRTS-grants for schools or non-profits to make policy change
- ALA TA provider: look at residents of MUH who are champions, to change policies
- Look at circles of influence and determine 5 yr. goals, e.g. parents
- CA Advocacy group: how residents can make a difference, ex- Resident Leadership Academy, Baldwin Park
- Solano Co (Diane, Anne, Tamara): work with med assistants. And volunteers on clinical linkages
- Solano cont'd: SSB » reach out to parent groups to get them engaged more
- Solano: use public employees as champions, including Co BOS (walks, diets, etc.) Identify champions to implement MUH surveys, assessments
- Educating and engaging youth- walkability assessments; they can help overcome schools feeling that "this is just one more thing" because the youth don't see that as an issue
- Parent engagement and capacity building-connecting them with policy makers
- Coffee clubs; working with existing parent leaders
- Business model concept
- Connect with the School Wellness Policy
- Calendar of local community groups-then link their goals
- In very small areas- subcontract with small groups
- Identify natural allies, such as elder groups, disability groups
- Have venues for non-profits to share what they are doing

State CDPH-communication

Provide TA on messages, get available data and share; post state plan

Implementing Cross-Sectorial Approaches (Group 3)

Reflections on Panel

- What motivates elected leaders? Personal experiences?
- Need to imbed public health into transportation planning
- Media- CCLHO having media training in 2 weeks

Key Elements in Effective Cross-Sectorial Collaboration

- Walk the talk
- Survey Dept. Heads
- Find passionate champions

- Persistence- collective impact- all sectors
- Capitalize on can do spirit; messaging to fit local politics
- Establish relationships to be sustainable beyond turnover
- Look at data more broadly to see how it correlates
- Assess/track health needs-connect
- Health can be catalyst and support for cross-sectorial partners
- Know your partners, keep relationships strong, link people and resources
- Clear, consistent messages-strong communication
- Break silos, think outside of box, build alignment and win wins
- Build Champions
 - Build relationships before you need something
 - Engage them in your work/activities
 - Quarterly presentations to BOS
 - Health Leaders (community-based) sit on Leadership Team
 - Former City councilman sits on LT and presents their “Asks” to the Council
 - Get broad representation on team-champions

Roles/Interests for New Partners

- Partners can help collect-and share data- to drive program and design
- Resource for data and community engagement
- Come to the table because of cost avoidance/return on investment
- Talk about prevention as an investment strategy

Key Partners/Types of Cross-Sector Partners to Include

- Invite Transportation Planner- e.g., to SG Conference (Pay their way) build relationships
- PHNs assist realignment releases
- Relationships with city planning: incorporate health into plans; just show up!
- Apply for grants (SRTS)
- College bike/pedestrian plan needs to coordinate with city and county
- Elected Officials
 - Leadership from Mayor was critical to cross-sector/interagency work
 - What motivates elected leaders? Personal experience
 - Bloomberg is a 4 letter word in my county » data works better
 - Conducted HiAP assessment and are presenting local data to BOS
 - Council members can also be effective champions
- Community/Parents/Youth
 - Talking to community during strategic plan increased our political buy-in from BOS
 - Community voices, e.g. mom with kids- to tell story can anchor data****
 - Youth engagement: we have had success with advocacy trainings-elected officials listen
 - Youth can also collect data
 - REACH/YMCA funding
- Other govt. agencies
 - Our PHD proactively reaches out to stakeholders-schools, mayors, fire and police
 - Parks and Rec struggles with assessing health outcomes-need help collecting data
 - HD staff can walk the walk, e.g. being visible on bikes
 - Need to engage city planners, especially around safety and infrastructure issues (lighting, connectivity)

- City managers are important-have authority to get things done
- Health element in general plan is invaluable to create buy-in. They and other planners are making connections to health
- Associations of govts are great allies
- Business community
 - Can play role in improving safety; community ambassadors; eyes on the streets
 - Pop up shops-idea for community revitalization with lower barriers to entry
 - National Association of realtors recognizes importance of active transportation environments and amenities to create great places to live-capital investors are key partners
 - Need to reach tipping point of investment to bring investors back to abandoned communities
 - Business case for prevention-need to build our lexicon “General Motors spends more on pharmaceuticals than steel for cars”

Successes/Examples of work being done now locally

- Monterey Health in all Policies- in strategic plan
 - Help Dept. think in terms of HiAP
 - Include all in discussion of why all sectors are responsible (cities, county, decision makers, planners)
 - BOS as champions
 - Policies: vending, meetings
 - Surveys, training, customer service skills (let community know important)
- Fresno- engages non-traditional business partners
- Tulare- HiAP Advisory Committee is building close relationships with employment
- Nevada- Re-establishing relationships as result of turnover; PA champions used for PA work in schools-alternative drop-offs
- Butte- Collaboration Customize Approach
- CDPH- Insurance plans, systems, etc...
- Mendocino-HiAP policies in Agency strategic plan
- Monterey- health education and MAA to sustain and support work
- Santa Cruz- providers plus alliance as partners to sustain community health workers
- San Joaquin-work with cities
- Shasta-better utilize existing coalitions
- Orange- Transit Authority relationship building
- Partner with universities (PH, i.e. UCI; Urban/city planning) for t.a.; lesson planning; presentations with students, etc.
- Healthy Shasta- Build capacity of planning city staff (attend conferences, etc.) with implementation at home (present lessons learned); increased advocacy etc., with training the right people; they learn the language of PH (bi-lingual)
- Community needs assessments (community-hospitals)
- PITCH Model- Board directive (health in planning); work with planning boards, etc...
- Direct work with planners
- Youth engagement (increased leadership investment)
- Connecting existing programs (Cal Fresh, CX3, NEOP, CTG) focused on social services
- LA’s Healthy Design Workgroup (PH, Planning, commercial, parks, etc., gave increased permission to engage in health
- Write potential partners into grants (incentive)

- Engagement of business community (Prevention Institute publication), e.g. around worksite wellness opportunities
- HIA (health impact assessments) across sectors/depts...
- Connect with law enforcement through community work in jails

Challenges and Solutions

- Clinical vs. PH » need to merge “upstream”; how to define PH work (scope); one successful ex. Is Redwood Health Coalition
- Potential partners in other/different depts...- seek more integration
- Use media/communication to support public health messages, e.g. under Health Emergency Preparedness requirements
- “Turf ‘ concerns preventing collaboration
- Political challenges- who sits on BOS
- Capacity of partners to implement proposals/etc. to directly support community (language, “know how”
- Need partners to have shared priorities and the infrastructures needed to collaborate
- Need to navigate different and new partners/stakeholders who can support efforts BUT from a different vantage point
- Engagement of community leaders (authentic voices back in community)
- Org change (walk the talk) with partners- support long-standing collaboratives vs. short-term funded programs; they can help in lieu of larger legislative “wins” (e.g. soda tax vs. org guidelines), that promote healthy environments on the ground
- So many hats, overloaded with work; decline in resources; “one more meeting”
- Many hats provides perspective and can leverage partnerships, coalitions
- Break out of silos
- Aligning efforts and build from mutual efforts» develop tools/matrix to map everything out, ID leverage points
- Trust and relationships are key components; Open communication
- Find the best partner to do the work
- Competing agendas/priorities between agencies
- Messaging; funding, esp. for non-profit providers
- Formal community council
- Alignment in activities, funding, requirements, etc...

Strategies to Apply

- Inclusionary Zoning- protects low income residents and makes sure they have access to services, transportation
- SF Fed Reserve- Community Development Investment Review has articles on lending and health outcomes
- Liechtman Equation-ROI on early childhood education
- Learning from MADD Advocacy strategy » going to impacted groups (insurance, ER docs)
- Track intended and unintended impacts of large scale policy changes (e.g. change speed limit » fewer deaths » fewer available organs for transplants OR increased MD education on pain management » more opiate use » more addiction
- Effective communication of data to public is needed-
 - “health happens here” is good, but we need more sophistication

- Learn from marketing principles like ‘means to end’ theory- for example, wanting to be a part of a group, wanting to be a good parent
- Tobacco control was good at this because a dedicated funding source allowed for development
- Need same for obesity prevention

Connecting to CTG Strategic Directions

- Chronic disease self-management- convince hospitals to assess cost of highest users- avoid unrecoverable costs. Need to discuss strategies for self-management. In one county, 24 individuals drive costs.
- Tobacco- American Cancer Society, tobacco coalition, apartment managers/owners, retail (get youth participation and driven); make appointments to talk to owners/managers; resident surveys by youth, subcontract with youth advocacy groups
- Healthy Eating: groceries, farmers markets, festivals; community friendly grocer
- SRTS- Assessments by youth, create photo and story of neighborhood; quantitative and qualitative streets assessments; share with elected; create art gallery; drop off assessment; grant apps; bike safety day; Walking Wed with BOS walkers; funding RTPA; bike retailers to check bikes and helmets; Triple A donates helmets
- Support business; bike or walk to work; receive incentives (\$21 time)
- CPS-CDSMP- training; finding home and funding stream for sustainability; HS Obesity Prevention Initiative where assessment drives program design-right questions are critical and to know all players; need funding source; effort to make strategic community-wide initiative ; training HD clinic staff through classes and Master Trainers training.

Sustaining Chronic Disease Prevention at the Local Level: Group 4

Reflections on Similarities/Differences to Panel Experiences

- Trying to get policy makers to focus on cd prevention; building public will and policy makers on issue
- Lack of resources, leveraging existing resources, some have grants (CTG, ACHIEVE, CPPW)
- Working with cities
- Some communities have access to better resources -health systems, local foundations, CBOs
- Partnerships
- Political situation » anti-gov’t sentiments nationwide
- There IS support for govt. programs that support business/job creation
- Link PH to the economy
- Personalize PH
- Translate PH message into other dialects (e.g. safety) that is just as compelling
- Empowerment vs. providing services
- Creatively build partnerships
- Data-importance of community-generated data; translation
- Determine how to tap into skills and abilities
- Translate message to be fluent in other sectors

Opportunities

- Research/data to support efficacy of policy change
- Activate clinicians through best practices
- Listening to affected communities: feedback, building enthusiasm; engagement
- Common goal identified: ID common path forward

- Workforce development: working better with partners
- Changing institutional policies (child care facilities, procurement policies)
- Leveraging existing resource (embedding strategy through assessments; long term planning across programs; embedding CDP focus)
- Reinvestment in existing realignment \$\$\$
- Integration across H & HS programs (health, SS, MH, AOD)
- Creation of community coalitions (not necessarily PH led)
- Cross sectorial work (labor, childcare, healthcare)
- Non-traditional partners (transportation planners; sheriff for internal staff health issues; universities/higher education that can advocate for politically sensitive policy change; water districts)
- Engage Chambers of Commerce and service clubs
- Ratchet asks
- Present data
- Bridge topic of health with local communities that don't have HDs, provide specific actions
- Don't have to reach out to everyone, but need to know/strategize key connectors

Challenges

- Appropriateness of policies in affecting change
- Enforcement: who will do?
- Implementation challenges
- Lack of community trust
- Program silos
- Small LHD limitation on oversight and contract admin and on staff
- In low pop density counties: difficulty staying connected with outlying community champions (an untapped pool); and knowing what's happening where
- Managed Care future? How will CHWs fare?
- Small workforce in PH but some larger employers (e.g. forestry)
- Trying to do more with less...after the grant

Strategies/Solutions to Challenges

- Make connections/build relationships- bring something to the table when resources are available to sustain relationship when resources are gone
- Skills assessment of human resources within PHD
- Remember your roles as a resident
- PH representation on commissions
- Build capacity of non-traditional "do-ers" , e.g. never going to have new \$ for; engage leaders to continue the work
- Focus on policy so when champions leave:
 - Permanent change is in place (e.g. SRTS Master Plan in Imperial)
 - Parent voice needed here to "keep up" compliance and demand good choices by decision makers
- Training to help build skills so people feel competent to participate
 - Peer taught for teens (Mendocino Project)
 - Positive/fun approaches
 - Unusual trainers (Imperials' Border Patrol and SATS)
- Spin conservative to can-do approach; FRAME not illness/treatment vs. prevention
- Community feedback loops (how are we doing); quiet voices need to be heard

- Circle back to policy...pro/con groups key
 - Who is most influential group to help advocate? Or block?
 - Don't leave out private sector
 - Be patient, take incremental steps
 - Communication is key to create positive environ for change (different channels needed)

Specific Steps

- Risk management
- Unions- outreach/challenges (find ways to maximize reach)
- Rethinking older approaches
- Incentives: award system
- Social marketing to drive demand to healthy retail conversions »customized to neighborhoods (youth?)
- Elected officials convenings, to address PH

Sustainability

- Push farmer's markets and EBT card use
- Assessment and integration of existing efforts
- Healthy competition, internal and external
- Partnerships same
- CHEAC/CCLHO/CSAC advocacy on realignment reinvestment
- Environmental solutions- smoke free campus
- Mental health nexus w/cd is an opportunity
- Collective impact model
- Emotional tug campaigns
- Integrate CDP into managed care model
- How to effectively leverage existing resources- a lack of strategic web in PH , always chasing \$\$
- ACA opportunities for reinvestment in PH

Applying to CTG Directions

- Include tobacco in land use efforts
- Stepwise approach, e.g. tobacco-free where you learn work and play » what about where you live? disclosure ordinance as marketing strategy
- Demonstrate business advantage of PH strategies
- Utilize youth (tobacco example)
- Residents own health, not PHDs or hospitals everyone has a role

AFTERNOON BREAKOUT SESSIONS

Building Local Health Department and Community Capacity: Group 1

Top Level Leadership needs to supports capacity building

- Credentials of leadership
- Need leaders within PH to take risks
- Educate policy makers at state/CDC about realistic goals for conservative counties

- Leadership needed across depts. and starting at the top
- Support needed at all levels

Content and Skill Areas for Training

- Advocacy/lobbying training at all levels, with clarity about allowable activities, roles for all stakeholders; need state to support local action
- Need CBO/PH relationships to understand capacity of each
- PH needs to explain its capacity to CBOs, sell its services, say what we cannot do
- Offer field-specific training
- Building evaluation and epidemiology capacity; data collection
- PH 101
- Cross-sectorial language training e.g. transportation, business
- Expanding the view of people working in categorical programs
- Coalition building/facilitation/creating partnerships: education, translating data, strategy training for community partners
- Determining what resources already exist in your community and how to connect communities to maximize resources
- ACA/health care reform
- From learning terminology to reaching the tipping point-making a program part of the social fabric
- From policy training to implementation***
- How to identify champions within your own organization and within community

Capacity Building within the Community:

- Reinventing public health/chronic disease prevention
 - Education
 - Health care navigation
 - Training for health care reform
- Coalition building through education
 - Training for translating data
 - Strategy training for community partners
 - What resources already exist in your community?
 - Connect communities to maximize existing resources

Venues for Learning

- Peer learning- works in rural communities-needs to be local or semi-local
 - Work with elected, media, regional collaborations
- Opportunities for regional training, sensitive to urban/rural issues; not all rural counties are the same
- Support local level work that cuts across categorical focus/funding, e.g. retail (State role)
- Technological
 - Avoid death by power point
 - Include 2 way video so participants don't multi-task
 - Encourage interaction
 - Training about technology is needed
 - Facebook- often blocked for local HD

Challenges to overcome

- Identifying training resources for staff/how to pay for it/funding capacity building
- Educate funders (e.g. food)
- Permission to travel written into funding; community partners have fewer travel restraints
- Flexibility on who takes on what work-very context specific
- Can't use word policy-need to have different approach-spin according to conservative values (fiscal savings, jobs)
- PH profession is challenged to learn in fields that are not traditional PH
- T.A. providers need to know more about local situations/needs

Opportunities

- Use PH accreditation process
- Use students
- Share resources across programs

Resources available

- Midwest Academy and Alameda Center Training are recommended resources
- How to integrate info/material from this Action Institute into current work
- CA4Health providers need way to communicate with counties directly
- BARHII toolkit

State role

- Educating health care providers from state level
- Statewide effort to make realignment understandable to the community

Actions in 6-12 months locally to build capacity

1. Working with Cover CA (California's version of ACA)- help answer questions, find our (PH) place within
2. Training on Framework-webinars
3. Pick key issues for every county to focus on
4. More targeted peer exchanges of what works, what doesn't
5. Resources to help track progress/evaluation
6. Passing policies: ensuring enforcement, behavioral change, education=implementation

What can you do in 1 month-2 yrs.?

- Utilize technology/social media/media
- Get support for soda tax=funding stream (contact policy makers for funding streams)
- Tracking tools
- Utilize existing resources
- Advocacy for realignment

Telling Our Stories to Capture the Full Impact of Our Work: Group 2**How to communicate the message**

- Piggyback on existing meetings; use mailing lists from Community Services Dept.; public in local papers; deputize partners to get message out (Tulare)
- Photo voice with smartphones, work with youth, show photos at art galleries (Orange)
- Fotonovellas/videos made from perspective of target population (Madera)
- Tell story from as many angles as possible and in as many ways as possible

- Update the public incrementally so they can stay up to date and participate in the process, to ensure accountability

How can our stories advance the work?

- Inform and motivate future advocates
- Touch hearts, make it personal and relatable
- Connect decision makers to constituents
- Must use credible data and acknowledge those areas where we are not sure
- Stories are needed behind the #s, the cold data
- Keep public updated with positives; letting them know what we're doing with the taxpayers \$. Down the road, we'll be engaging these relationships to step up and run with the next steps.
- Give kudos to community partnerships
- Code enforce-relate it to asthma and kids/environment; keep them in school and out of hospitals
- Build communities faith in their neighbors to move forward with responsible action
- Link to equity and disparity-these issues don't happen in a vacuum

Challenges

- Getting heard over the competing voices
- Getting the "right message" that talks to the whole community
- Deciding what mechanisms/media to use
- Time and staffing constraints; time to build relationships
- Turnover in public officials
- Finding local statistics
- Getting local agencies to buy in to SSB programs
- Demonstrating relationships/impact between obesity and parks, etc...
- Concern about Public response: Yeah but if we do it will they really use it or buy the healthier foods, etc...; lay-off employees vs. spending \$ on parks; mixed responses from public officials depending on what they support or who they work for
- Safety concerns- getting parents to believe that it is safe to walk to school
- Multi-lingual needs, everything needs to be translated
- Foreign to locals = concept of working together to plan for positive community change. Pulling ALL our stories together to produce community and political will...It's OK to spend taxpayer \$s
- Where it is accepted that \$ would be spent on parks, when it is in a low-income or racially diverse area, it becomes...why do they need that?
- Different strategies-communicate together or separately?
- Been doing the work for a long time, local vs. statewide how to frame the messages; branding locally is better
- Work of others can cause slower moving communities and can backfire
- Lessons from failures in communication: timing; atmosphere influences; arguments of the opposition (need to strategize and craft our message)
- Communicating what PH is globally instead of through single events
- Getting residents and the community to talk about benefits personally/community
- CTG funders want the work identified as "CTG" but in the community, grading efforts locally is the value so residents will own the change. Branding is needed to engage the professionals
- Health is harder to spot than illness, in showing "your tax dollars at work"

Successes/ How have you told your stories?

- Took traffic engineers on walkability audits (Orange)
- Did some RTP workshops in Spanish- do more of this; feed stories to media (Madera)
- Public health answering questions from parents about nutrition for kids; serving as a resource (Tulare)
- Leveraging surveys of school food environment into legislation and policy (Project LEAN)
- Continued dialogue with local media, keep feeding them stories (Mendocino)
- Getting real world stories with benefits of changes published: take the big issue to the public using individual stories (Tulare)
- Walk the talk helps with credibility
- 1st year, spent fair amount of data to show that our county had the highest % tobacco use in CA
- Use “success stories” - 16 year old meth addict homeless, improved trail to access soccer field/sports and aided in his recover; “How I got my life back” story
- Local radio station, newspaper reporters; protect personal data
- City managers review- email blasts/list serves (used by about half participants)
- Facebook, twitter but time intensive, must be kept current so can’t wait for “success” but must celebrate and highlight all the steps to success
- We tend to work hard and hope someone notices
- YMCA Youth Leadership group will develop and maintain the social media, we will monitor it
- Local colleges interns-students do the social media piece and get credit
- Public Information Officer
- Coordinated strategies are having a greater impact and tell the broader story
- Annual Healthy Shasta report; business and employees to join
 - Top down and bottom up approach, where top leaders meeting a couple times a year to feel good, show support, validate funding
 - Top leaders now think about Healthy Shasta automatically before signing every agreement
- Creating one unified Leadership Group for the PH efforts- one CHIP where all priorities feed into it, using collective impact; backbone is DPH, servant leader to build trust, with a side group of elected officials (SF)
- Don’t show partners’ logos, use one unified local presence/logo/identity, while honoring organizational needs for recognition
- Timing is everything in public perception
- Map of city online, show what’s going on in the city, healthy stores, parks, workplaces, bike racks

Resources to support your work

- Case studies help people see that it can be done by someone like you
- Gives evidence to decision makers to spur action » Data!» link to place and maps
- Anecdotes» quote from stakeholders
- Market research to learn what will reach your audience
- Youth voice, essay contest (Tulare)
- Have solutions ready be clear in your ASK; be prepared

RECOMMENDATIONS: How to advance the work collectively

- Share successes and policies
- Create more access to highly localized data that we can use when telling our stories
- Reframe as “years of life gained” for the positive angle and then quantify health instead of illness
- Help in framing causality between healthy resources (parks) and healthy behaviors/outcomes
- Training in incremental storytelling, learn how to tell “mid-stream” stories to keep the public engaged

- Develop communication strategies to combat soda/alcohol ads
- Training in understanding and utilizing social media
- Media campaign focusing on years gained (group 3)
- Communicate statewide the community-level successes such as SRTS, fed transportation \$, maps/data
- Establish statewide website- info to CDC collected in CA first, to see statewide impact
- Communication message about economic gain, including in-kind

Sustaining Chronic Disease Prevention through State, Regional and Community Partnerships: Group 3

What local, regional or statewide supports or efforts already exist to help sustain the work?

- SoCal Health Departments (LA, San Diego) take a cross-jurisdictional approach, and network to share best practices regionally. They do more with less, tap regional expertise; look at transportation and data across the regions; unified across sectors; united in procurement.
- Central Valley, 6-7 years ago, 8 counties, community groups and health department. Many worked in house. Experiments in health communities to find best practices. A regional hub was founded with the community groups, took individual funding to come together at community level.
- CA Convergence
- BARHI-Bay Area Regional Health Inequities Initiative, health equity group, share best practices.

Where are there gaps?

- Not a lot of opportunity to come together cross-regionally.

What partnerships/collaborations would help leverage and sustain our local work and advance it statewide?

- CA Convergence Network evolving, 7 regions, value and welcome health departments; have regional liaisons; contact your liaison/connector

What role can the state health department play to ensure sustainability? What role can partners play?

- Regional workshops, outreach, work with local health departments, people want to hear each other's stories, no one is gathering
- Bigger data role—collection, analysis and distribution
- More transparency
- Changing the environments, state needs to know what's going on in communities
- Chronic disease prevention plan, opportunity for input; evidence-based practices; roadmap of what to work on; capacity, political environment, data analysis, post and share data

What are some recommendations for specific actions that could be take over the next 6-12 months?

- Every county needs guidance from state, 10-year plan to sustain, build capacity
- Different branches at state level coordinate, not duplicate; streamline and unify funding streams and contract requirements
- Work with institutional, have state provide leadership, model statewide for local partnerships
- Do we really need a coalition for everything? At local level, it's a lot and the same people are on all of them; state could provide leadership to strategize on that
- Importance of data analysis—small community doesn't have capacity, needs help from state level (ex \$5,000 allowed them to get some helpful data)
- Database: enter info and create reports
- Have group/body to educate on new policy; help with implementation; if new policy is ignored, no one is there to enforce; include local and industry reps to help.

- Evaluation based on best practices, the value of evaluation, link the data to implementation
- At state, partnering at that level. Ex, like working with planning guidelines to connect to health; robust input opportunities
- State needs to hear from local where state can be helpful
- Nice to integrate what's happening at state level down to local level
- Ex: Dept. of Education, promotes health in facilities decisions
- Federal realignment money, like to see official bodies take position that money stays with counties, legislator may have different idea than governor, governor thinks public health may no longer be needed
- Talk to legislators on your own to explain this; not just there to provide direct care but preventive care
- Need uniform statewide message
- Question: will your small organization pay for these technical and infrastructure recommendation? State won't have more money
- Possible to write that into grant?
- Need enterprising aspects to market, generate fund for health departments and community organizations
- Look at potential funding streams, unify funding

Summary Recommendations

- State create a 10-year chronic disease plan
 - Increase stability
 - Increase capacity
- Streamline and unify funding requirements in all state branches
- Develop a T.A. hub to help with local implementation
- Create a unified message
 - Realignment money → locals
 - Continuing role of LHD
- Mechanism to integrate state and local cross-sectorial actions

Measuring Impact and Progress toward Health Equity: Group 4

Tools/Strategies

- Mendocino: health measures, standards, effectiveness, HMO, government mandated
- BARHII instrument - baseline measures
- BRFSS/YRBS: Disparity enumeration via oversamples. Built environment
- CA Convergence: info share collective measurement
- Difficulty with capturing full morbidity, mortality
- Payment systems» data
- Cx, Cx3 » expanding application, injury, environmental data
- Alameda: Inter-agency contact, collaboration, health equity is criteria in evaluation. Share inequity concepts
- PHI forum on collaboration
- CA Convergence tracking tools and cap building
- Transportation plans as source of data, e.g. transportation survey
- SB375 drinking data collection, coordination, geographic/health disparities
- Breaking out of silos yields new data
- Electronic med records (e.g. quit rates)

- Gallup Well-being index
- Survey monkey
- CDC MUH tool to non-profit partner
- SRTS federal by school/region (Easy): schools collect; CA Center for Rural Policy interprets
- CDC (using census blocks) door to door surveys- better representative-more outreach. Develop own questions, can use validated?, e.g. emergency preparedness; good for pop with special needs; tool kit online, help from CDC
- CASPER- will be implemented in West, TX, Kaiser Phase (smoking, asthma, diabetes, hear, immune
- Medical records-electronic; ++reimbursement
- Public Health Dept. accreditation-data from this
- "how to" manual with indicators-state has indicator database healthy community; lit review to identify socio-determinants indicators (N. Maizlish, CDPH, Rochelle from Marin); wish list

Challenges

- Changes in morbidity and mortality difficult to show
- Data "soup" varied sources , indicators
- Showing case and effect
- Longitudinal needs, short-term, given latency of cd
- Strategies can be abstract, which complicates metrics
- Need to show qualitative data as well
- Data turf and funds; competition; who gets credit
- Jurisdictional issues
- Rural challenges; tribal govts-data sharing, data dissemination
- Capacity building, training on use, interpretation
- Fear of how data will be used, PR issues, increase access
- Level of data » geography; needs to reflect level of intervention/community
- Physical environment new, need useful indicators
- Survey response- participation, distrust of govt MUH; community willingness to participate
- Selection bias
- What's in data within database-? Disparity (sample size)
- Resources- epidemiology capacity/funding from State
- Some indicators not available or not at census block level, etc.
- Generational outcomes (# years to achieve)
- Small counties are pooled with dissimilar counties
- Setting minimum level of improvement (standard)
- Timing of release of data-how can it be embargoed until counties can fold it into their daily activities-good process thru RWJ and county health rankings.
- Partners not readily available to all, how can state facilitate?
- CHIS unit of analysis/sample size

Opportunities

- Measuring impact: length of time to achieve, how can we communicate sooner; develop "canned statements using descriptive, short-term outcomes (e.g. potential years lost)
- Better pooling of county-to-county data, so like counties are together
- MCH model (FHOP) did basic data work to counties-educate/training and analyze-building capacity
- Provide cost data by county
- Data from Health Dept. strategic plan- use accreditation process

- County HI plan – best performing neighborhood as the standard-what is standard? What partners can help
- Give TCE’s Building Health Community site access to all TCE TA
- RWJF County Health Rankings- marketing tool, TA offered
- Invite Richard Jackson to speak
- CHIS by zip code will soon be available

How can the local work be supported?

- CA State fund
- Webinars/training
- Data
- Recognize intermediate outcomes
- Data Clearinghouse
- Measuring progress in small steps
- Disseminate data to community/partners; what are needs?
- Policy data, alerts

RECOMMENDATIONS

- Develop local data sources to help frame scope of problems/achievements. Really local, county or school district
- Help answering questions with causality re: healthy policies/resources. If we build a park, will “they” really play and exercise?
- Unified and sophisticated communications strategies capable of going toe-to-toe with SSB/tobacco marketing

Recommendations for Action from Breakout Sessions

Building local health dept. and community capacity:

1. Establish a collective chronic disease community:
 - Breakdown of how we can use categorical funding to work together
 - Develop shared language, integrated approaches across CD programs, including health equity
 - Centralized communication, linkages, info sharing, ongoing conversation
2. Create workgroup for rural/conservative communities to develop trainings for stakeholders to advance Framework in conservative context
3. Strategies on how to work with Covered CA to incorporate prevention into health care reform and preserve the role of LHDs

Telling Our Stories

1. Create central website for story and data collections to reflect statewide impact
2. Launch unified and sophisticated communications program, capable of going toe-to-toe with SSB and tobacco marketing programs
3. More assistance to communicate links between healthy resources/policy and healthy behaviors/outcomes

Measuring Impact

1. Build capacity of all health depts. To collect, analyze and interpret data

2. Develop local data sources to help frame scope of problem and achievements, using really local information. (county, school districts)
3. Help answer questions about causality re: health policies and resources, i.e., if we build the park, will people really play and exercise there?
4. Develop unified and sophisticated communication strategies capable of....
5. Provide TA on messaging, e.g. how to use RWJF county health rankings to promote cd prevention and health equity
6. Develop standardized tools, sub county level data sources

State/Regional/community partnerships

1. State CDPH to create a 10 year plan: will create stability and allow to increase capacity
2. State to streamline and unify funding streams and contract requirements in all state cd related branches and programs
3. Develop a TA hub to help locals with implementation
4. Create a unified statewide message:
 - Under ACA, realignment money needs to remain with Local jurisdictions and be dedicated to broad chronic disease prevention efforts
 - Strong message about the continued unique role of public health and LHDs in ACA
5. Create mechanism to integrate state and local cross-sectorial actions; e.g. connect HiAP work happening at the state level, to local efforts to work cross-sectorally. Provide t.a, support to locals