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"The MCC Challenge" – 1st Place Winner

The *Community Guide's* Cancer Prevention and Control Increasing breast, cervical, and colorectal cancer screening recommended strategies were promoted and implemented in the MCC Challenge. Organizations in the MCC were challenged to "practice what they preach" and increase screening rates among their own employee populations. To do this, organizations who committed to the MCC Challenge completed an initial assessment to identify gaps in coverage, access and knowledge regarding cancer screening within their organizations. Organization's then reported their HEDIS screening rates for breast, cervical and colorectal cancer. Based on the initial assessment and HEDIS measures organizations then created an action plan to implement evidenced-based strategies to increase the employee screening rates. The organizations used The *Community Guide's* recommended strategies for increasing breast, cervical, and colorectal cancer screening as the menu of evidence-based strategies. The *Community Guide* was chosen because the strategies include policy, system, environmental, and educational strategies for organizations to implement.

The MCC Challenge was launched in March 2011. In the first year, eight organizations off the MCC participated and reported that approximately 7,000 employees and dependents were being impacted by the MCC Challenge. The MCC organizations participating in the MCC Challenge are currently implementing their action plans. There have been several successes celebrated by the MCC Challenge participants. Karmanos Cancer Institute instituted a new policy to use group education to inform employees of their insurance coverage for cancer screening and the benefits of being screened. Catherine's Health Center was able to obtain a group health plan for the first time, fully insuring covering all copayments and deductibles for breast, cervical, and colorectal cancer screenings. Northwest Health Department continued to enhance their wellness initiatives, which has a 98% participation rate, by including incentives for employees. The health department did not have to increase premiums for their employees this past year due to the success of their program. HealthPlus of Michigan also offers incentives for their employees to complete their cancer screenings and uses small media to educate their employees. All of the organizations reported that they provide paid time off for employees to attend doctor's visits, have extended coverage for family members and reduce out-of-pocket costs by assisting with or covering the entire cost of the copayment. Some organizations first found it a challenge to work with their insurance providers, but once they were able to open the door of communication the insurers and employers were able to collaborate on implementing interventions.

The MCC's experience with using The *Community Guide* can serve as a model for other organizations looking to create a comprehensive worksite wellness program which

includes cancer screening. As a statewide cancer coalition, made up of organizations dedicated to cancer prevention and control, the MCC found the recommendations of The *Community Guide* extremely beneficial in reinforcing the importance of cancer screening for the population that makes up our own organizations.

After the success of the first year the MCC has decided to continue to encourage our organizations to take the MCC Challenge and implement strategies from The *Community Guide*. Organizations who are currently participating stated that the strategies from The *Community Guide* have encouraged a positive culture around cancer screening at their workplaces. Organizations have also reported stronger relationships with their insurance providers and therefore a more routine analysis of their HEDIS measures.

The MCC was able to work with C-Change to further promote evidence-based strategies to increase cancer screening, including access to free small media. The American Cancer Society (ACS) is a MCC member and took the MCC Challenge. ACS was able to offer their free worksite wellness initiatives to the other participating organizations. A new partnership with a National Cancer Institute Research to Reality (NCI R2R) Mentorship Program has formed with MCC Challenge participants. Organizations who are interested will work with the NCI R2R mentor to send client reminders for colorectal cancer screening. The mentor will assist with implementing The *Community Guide* recommended strategy of client reminders for the organization and follow-up at three and six months to assess the success of the intervention.

There are several technical assistance calls held throughout the MCC Challenge process. During the calls organizations share what barriers they have encountered and how they have succeeded in overcoming the challenges. Organizations measured their HEDIS screening rates for breast, cervical, and colorectal cancer when committing to the MCC Challenge. In August 2012, after one year of participating in the MCC Challenge, the organizations will again measure their HEDIS screening rates to see if the policies implemented were successful in increasing employee cancer screenings. The organizations who have had the greatest success in implementing The *Community Guide's* interventions will be used as a model for future organizations. The organizations participating in the MCC Challenge are very diverse, at the completion of the Challenge there will be a wide variety of successful implementation methods for future organizations to replicate.

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"The Community Guide and Personalized Educational and Experiential Modules for Diabetes Management" – 2nd Place Winner

In recognition of the increasing prevalence of diabetes in the Akron Metropolitan area, the GAR Foundation (Akron, OH) funded the development, implementation, and evaluation of an educational and experiential diabetes management program, by the Austen BioInnovation Institute in Akron, Center for Community Health Improvement. The program, led by a multidisciplinary team, was offered to 26 participants at three diverse clinical sites and included education on diabetes, techniques for self-management, and information on and experience with nutrition and exercise and stress reduction for emotional wellness. In addition to educating individuals in the community with diabetes, the other goal of the project was to improve system level practices at each site in adherence to national standards of care. The innovation of this successful program focused along implementing best practices for a multidisciplinary team with impact on both the individuals living with diabetes and the transformation of the practices in which those individuals received their primary care. This was a prospective, pre- and post-test study of the effects of the program on both the patients and the practices, using practices outlined in The *Community Guide.*

We revised national programs using The *Community Guide* to assist us in tailoring the intervention to the needs of our population. There were 12 two-hour sessions at each of three sites held between July and December 2011. We met at the site from which the participants were recruited, which made it convenient and comfortable for participants and their healthcare providers. Because The *Community Guide* Task Force Finding indicated that "interventions were rarely coordinated with the patient's clinical care provider," we coordinated the care and helped increase the communication between the practitioners and their patients. We were patient-oriented, provider-oriented, and included family and friends in the program.

Participants were recruited from three sites, which functioned as community meeting places: The University of Akron Nursing Center for people without health insurance, Summa Health System Family Medicine Center, and Akron General Medical Center for Family Medicine. Therefore, private pay, public insurance, and no insurance participants were included. Each site identified patients who might be interested in participating and shared information about potential participation. The sites were two family medicine sites and one advanced practice nursing site, another example of the multi-disciplinary aspects of this program. The family medicine sites were led by a DO and a MD. The Nursing Center site lead was a MSN RN CNS. A practitioner from each site led one of the sessions, "Getting the Best Care for Your Diabetes," at that site. Information on tests and

frequency of testing, foot care, eye care, and skin care was presented. The practitioners from each site also discussed how to partner with the participants' healthcare providers and included site-specific information.

Each session was 120 minutes and based on the *Road to Health* and *Diabetes Prevention Project* [1-3]. Topics covered included diabetes, making changes in behavior (e.g., exercise and food choices), goal setting, body mass index (BMI), stress and mood management, self-monitoring, medication adherence, recognizing and managing symptoms, mindfulness, and preventing complications. Each session included a "Fit Minute" designed and led by an exercise physiologist, a "Nutrition Bite" designed and led by a dietitian, a healthy small meal as designed by a dietitian, and educational components designed and led by a sociologist. Three sessions had "guest" speakers: "Getting the Best Care for Your Diabetes" was led by a practitioner from each site; "Strategies for Healthy Eating" was led by a dietitian; and "Complications," which focused on avoiding complications by stress and mood management through mindfulness, was led by a mindfulness expert.

In addition to the diversity of the sites, the participants served at each site differed. The University of Akron site serves those without health insurance; some of the Summa participants had some form of health insurance (both public and private) and some did not, while seven Akron General participants had group health insurance, and one was covered by Medicare.

The program was received well by participants, and participant results were encouraging.

- Pre- and post-chart review included
  - decrease in Hemoglobin A1c (n = 14) -.386 + .994 (range -5.4 to 0.6)
  - decrease in LDL cholesterol (n = 16) -11.60 + 37.53 (range -68 to 49)
- Personal outcomes collected information included
  - 14 participants lost a total of 115.1 pounds and 22.8 points BMI
  - 16 participants lost 25.26 inches from their waists
- Participant attendance
  - 20 of the 26 participants (76.8%) attended 8 or more sessions
  - 9 (34.6%) had perfect attendance
- Self-reported findings involved
  - Increase in exercise
  - Increase in healthy eating and 5-6 small meals per day
- Pre- and post-program survey results included
  - Increase in knowledge about diabetes

At the site practice level, results included participants' assessments of the practice and suggestions for practice improvement as a Quality Improvement tool. Evaluation of practice adherence to The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures defined for diabetes care was based on the percentage of adults 18–75 years of age with diabetes (type 1 and type 2). Across all three practice sites, compliance to these measures was

high with practices exceeding recommendations for Hemoglobin A1c testing and control, LDL cholesterol testing and control, and blood pressure control.

This was a promising evidence-based intervention that was well received by participants because it used recommendations from The *Community Guide* and involved a multidisciplinary team to present and implement the educational and experiential components. This was a high impact solution to the increasing prevalence of diabetes that contributed to the participants' improved disease self-management and increased self-efficacy.

References

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3. Diabetes Prevention Program, *DPP Lifestyle Materials*. 1996, University of Pittsburgh.

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"Together We Can! Create a Healthier Community" – 3rd Place Winner

In early 2010, the Central Michigan District Health Department (CMDHD or the health department) embarked upon the Together We Can! initiative, an effort to improve the overall health of the more than 196,000 people within its health district, which includes the central Michigan counties of Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon. This action was in part motivated by the results of the University of Wisconsin's Population Health Institute's *County Health Rankings*, which showed the counties in CMDHD's district to be among the unhealthiest in Michigan. This evaluation clearly indicated an urgent need for health improvement in the region. The first step in addressing the health issues in our community was to form a multi-jurisdictional health improvement council, made up of representatives from across the health district from health care organizations, educational institutions, human service agencies, and government agencies. The council first established formal operating agreements and a unifying mission statement. Additional data was gathered by survey and through focus groups, and eight areas were identified as health priorities in the region. These eight areas are Access to Health Services, Nutrition/Weight Status/Physical Activity, Maternal/Infant Health, Reproductive/Sexual Health, Abusive/Violent/Controlling Behavior, Substance Abuse, Environmental Health, and Transportation. Health Improvement Planning Working Groups were also formed in each county in the central Michigan health district.

Armed with data and community input, CMDHD lead the Together We Can Health Improvement Council in creating a strategic plan to address the eight health priority areas. One challenge CMDHD faced was selecting interventions to address the health priority areas that would be effective in improving the health of the community. The *Community Guide* was an invaluable tool in this process. For each health priority area, measurable objectives were identified, and then specific interventions were researched and selected for implementation. The *Community Guide* was used to identify evidence-based initiatives to apply in the region. The *Community Guide* was also very helpful in communicating this process among the Together We Can network of partners because it gave all members a common source of reference. Members were able to get a clear understanding of the criteria that were used in selecting interventions for the strategic plan. Another useful aspect of The *Community Guide* has been the ease of use. It clearly details effectiveness, community-specific recommendations, and cost/ROI information.

With the help of The *Community Guide* as valuable reference, the Central Michigan District Health Department and the Together We Can Health Improvement Council successfully completed and approved the 2012 Together We Can Community Health Assessment and Health Improvement Plan- the group's strategic plan. Finalizing such an important step in the community health improvement process is a great accomplishment.

One challenge that CMDHD faced was the length of time it took to finalize the document. The longer-than-expected timeframe was due to the need for additional data collection and resource gathering. But, because The *Community Guide* provided such a concise template for interventions, the action plan portion of the document was developed relatively quickly.

Now, the Together We Can Health Improvement Council and CMDHD look forward to the implementation phase of the Together We Can initiative, where information from The *Community Guide* will be put into action. One of the first initiatives being introduced is the development of a worksite wellness program within the health department itself. A weight management program, delivered by Central Michigan University, is now in place in the Isabella County branch office of the health department. Indoor walking "maps" are currently being created and point-of-decision signage is being developed for all branch offices that will encourage employees to walk during breaks, and before or after the workday. Additional wellness initiatives will be implemented pending a survey of employee interests. These initiatives have benefited the organization by providing our employees education and access to weight control resources, right at work. Participation in the weight control program remains high, and more employees are using break-time for physical activity. CMDHD's over 120 employees recognize that as members of the community, we need to set a great example of healthy lifestyle. By being healthier, we can improve the quality of our life and the quality of our time spent at work as well.

Other strategies set forth in the strategic plan (as directed by The *Community Guide*) beginning implementation are community-wide physical activity campaigns and activities related to monitoring of Michigan's smoking ban in public places.

Using The *Community Guide* has been an important part of the health improvement planning process for CMDHD. Health improvement planning can be very challenging, and creating a concise action plan is a critical step in any community health improvement activity. The initial step taken by CMDHD and the Together We Can Health Improvement Council in creating a community health improvement plan, including using The *Community Guide* to select appropriate interventions, should be used as a model by other organizations undertaking community health improvement. The planning phase must come first, in order to have a good understanding of community needs and selecting appropriate interventions.

With the help of The *Community Guide*, CMDHD and the Together We Can Health Improvement Council have finalized a strategic health improvement plan. The Together We Can Health Improvement Council has now changed its practice from planning to implementation. Additionally, after learning more about policy and legislation in The *Community Guide*, the Together We Can Health Improvement Council has began developing an Advocacy Plan that will create the tools necessary for partner organizations and individuals to properly advocate for health-promoting legislation and policies. CMDHD has changed by implementing an employee wellness program and dedicating staff time and financial resources to creating healthier employees. In March

2012, the Central Michigan District Board of Health passed a board policy stating it will "use the Guide to Community Preventive Services as a resource to help choose evidence-based programs, practices, and policies to better improve health and prevent disease, injury and disability in our communities. This resource will enable the board to better advise, support advocacy, and justify decisions when developing evidence-based policies for the Central Michigan District Health Department. This guide should help our public health team as we strive to maximize the benefit of our core functions of assessment, assurance and policy development."

Whereas participation in the needs assessment and planning stages has been great, participation from Together We Can network members in the implementation stage is expected to continue to be strong as we move from plan to action. The collaborative nature of this endeavor helps to maintain and sustain efforts. The Together We Can Health Improvement Council members as well as the Health Improvement Planning Working Group members have been meeting since May, 2010, during which time the members have offered their resources such as staff and conference rooms. Network members are continually actively recruiting other community members to the Together We Can Health Improvement Council and the Health Improvement Working Groups to join the health improvement initiative. Although the numbers are fairly fluid, the Together We Can Health Improvement Council has representation from 38 individuals and organizations and the combined totals for the Health Improvement Planning Working groups averages over 100.

CMDHD is an advocate and leader in Michigan with quality improvement initiatives and activities. The community health assessment and improvement plan development is considered by health department leadership and staff as a QI initiative and incorporates the elements of Plan-Do-Study-Act. The assessment process was the "Plan" where we assembled our base-line data. The community health improvement plan outlines the "Do" and, as previously stated, the plan does contain evidence-based strategies that were found in The *Community Guide*. Since the health improvement plan was just launched in April 2012, we are just beginning to "Do", but as part of our on-going process we will need to "Study" the effectiveness of the strategies employed and then "Act" to revise and modify the plan as necessary.

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"Continuous Quality Improvement for School Health Policy and Environmental Change"

The Northern Kentucky Health Department (NKHD) utilized The *Community Guide (CG)* while developing an intervention to improve the process for incentivizing schools for health-related policy and environmental change. Our AIM Statement is: "By December 31, 2012, develop a process that enables more than 50% of participating NKY schools to implement health-related policy and environmental change." The Health Department was not obtaining desired results from the former incentive funds process. Operating under the constructs of Continuous Quality Improvement (CQI), our CQI team has developed and is facilitating an intensive, two-year project with four pilot schools. We are currently in Phase 2 of the four-phase project, and are reviewing and providing feedback on their drafted action plan strategies for implementation in fall 2012. The pilot intervention is as follows: Phase 1) school health teams were trained and comprehensively assessed their school health environments, practices, and policies via the School Health Index (SHI); 2) school teams were trained and established action plans for two health topic areas of established need, which includes one or more policy and environmental changes;3) pilot schools will implement the newly-developed action plans; and 4) school teams will re-assess their school health environments at the end of the project using the SHI. Last year, the CQI team reviewed and utilized the *CG's* "Recommendations & Findings" as well as additional information provided on the following topics to inform our work: Adolescent Health, Nutrition, Obesity, Physical Activity, Tobacco, Violence, and Worksite. NKHD personnel are familiar with the *CG* and have used it to guide planning and implementation projects as well as campaigns developed by our Community Health Promotion unit. Examples of challenges we are working to solve via the school health incentive funds project include the following *CG* strategies: "increasing tobacco use cessation" and "reducing exposure to environmental tobacco smoke"; supporting school-based interventions to reduce violence; promoting good nutrition and physical activity at schools (includes worksite wellness); supporting school-based interventions for obesity prevention and control; and supporting adolescent health through injury and violence prevention. The CQI team regards the systematic reviews, results from systematic review, statistics, and recommendations and findings as quite beneficial to informing our discussions and providing guidelines for specific health interventions.

At the end of the first phase, all members from pilot schools demonstrated an increase in knowledge of and increased confidence in their skills to implement policy and environmental changes pertaining to nutrition, physical activity, tobacco, and unintentional injury/violence. We noted other positive results from this initiative. For instance, due in part to the participation of one pilot high school, the entire school district

has drafted a 24/7 100% tobacco-free schools policy, which will be approved in June 2012 and go into effect for implementation on July 1, 2012. There have been a few unexpected occurrences, which we are tracking and responding to; for example, the setup of the online SHI tool changed during the process and there was a learning curve with our staff and school teams. In addition, there were a few logistical modifications made in order to refine the process. The *CG* is an invaluable, informative tool for which allows cost-savings by enabling us to examine and employ the most effective strategies.

Our experience with this CQI project can prove useful to other organizations that are moving toward working with schools in an engaged method, for facilitating more sustainable policy and environmental change at the school or district level. We can share our successes, challenges, and how to overcome unexpected occurrences or barriers. It is our aim to contribute to the best practices pertaining to school health-related policy and environmental changes.

We were able to develop the pilot and trainings, and to modify our procedures and practices by using the *CG's* nutrition, physical activity, adolescent health, tobacco, unintentional injury and violence, and obesity-related strategies.

We are partnering with four local schools to complete the pilot and implement policy and environmental changes. We collaborated with the Centers for Disease Control and Prevention, HealthMPowers, the Kentucky Department for Public Health, and the Kentucky Department of Education to provide the School Health Index training.

Our CQI team developed the school health incentive funds pilot process by following the "Plan-Do-Check-Act" (PDCA) cycle and utilized the following: cause & effect fishbone diagrams to group causes according to the three causes in the Problem Statement.; interrelationship digraphs to determine relationships between root issues; brainstorming and the nominal group technique to identify and prioritize potential solutions. We developed the project phases with the following planning tools: affinity diagrams, flow charts, in addition to a logic model and a Gantt chart. Prior to beginning the PDCA cycle, our CQI team solicited consumer feedback in order to further develop the solution, so we created a school survey for our target audience (142 survey responses), which provided us with feedback on their leading health issues (obesity, poor eating habits/nutrition, substance abuse, and physical activity); what school representatives are most likely to have the greatest influence on policy and environmental change; that most saw benefits to implement policy and program/curriculum changes, and that their largest barrier was lack of funding.

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"Tobacco use and exposure reduction initiative at Atlanta VA Medical Center"

It did not take long, working at the Atlanta VA Medical Center (VAMC) to determine that tobacco use and exposure to second hand tobacco were a significant issue. As a preventive medicine resident I set out to tackle those issues head on. I was previously boarded in family medicine and was familiar with the USPSTF recommendations, but not with The *Community Guide*. My site-supervisor, also trained in preventive medicine recommended The *Community Guide* to me as a starting place. That is where I found not only what could be done (eg reduce tobacco use), I also found effective strategies for achieving those ends (eg tobacco use bans). The evidence-based recommendations help me cut through all guesswork and gave me forthright recommendations on community level health interventions and the evidence that supports them. Since that time, The *Community Guide* is my starting place for any and all community level health interventions.

The *Community Guide* provided me guidance to craft the intervention at the VAMC, from suggesting what goals were achievable to exactly how to achieve them. For this project, I selected the goals of decreasing tobacco use, decreasing second-hand tobacco exposure and increasing participation in tobacco cessation programs. Then, directly from the guidelines, I knew which interventions to use. I set out to establish a workplace tobacco use ban, use a mass media campaign and enhance the current tobacco cessation program.

So far in this project, I have implemented an enhancement of the tobacco cessation program, to improve participation, I have conducted a mass media campaign to incite tobacco users to ask for referrals or even self-refer to the tobacco cessation program and I have worked with the executive staff to develop a tobacco-free campus (which is still a work in progress). If this latter initiative goes through, this will have a huge impact on personnel who work at the campus, 47% of whom at the beginning of the project, reported they were exposed to second hand tobacco smoke on at least a daily basis.

If this project is fully successful, these interventions could be adopted nationwide at all VAMCs, thus impacting tobacco use and exposure at all of these facilities.

Anytime I begin a community based health intervention, I will always start with The *Community Guide* as it is the ultimate resource in evidence-based interventions.

Yes, I did use partnerships and collaborations. Specifically, I partnered with personnel within the facility who had a similar vision, the employee health clinic and the medical centers' health promotion and disease prevention program manager. In addition, I

reached out to the state of Georgia's Department of Public Health Tobacco Use Reduction Program manager who also put me in contact with other individuals and resources that aided my endeavor. They included the Georgia Hospital Association, Americans for Non-Smoker's Rights and a document from The Joint Commission entitled "Keeping Your Hospital Property Smoke-free. Successful Strategies for Effective Policy Enforcement and Maintenance"

Yes, as part of the project, I examined the current tobacco cessation program that was in place in the facility and found there were two large areas of attrition. First, not all providers used the US Public Health Service's recommended Clinical Practice Guidelines for referrals to tobacco cessation programs. Secondly, nearly 67% of those who accepted a referral did not show up for the intervention. We examined the reasons behind that rate for making recommendations on how to improve the program and participation.

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"Activate Fox Cities"

We had a team of professionals representing healthcare, schools, local health department, businesses and YMCA participate in a year-long training supported by The Healthy Wisconsin Leadership Institute. During the skills training portion of the Institute we learned how to use research to help identify best practice community interventions. Our team was interested in community interventions which improved physical activity. Our research led to "The *Community Guide*" which we found a great benefit in choosing a "Point of Decision Prompts" to Encourage use of Stairs in all of our downtown Appleton locations which have four or more levels, including all of our parking ramps.

The *Community Guide* placed the Point of Decision Prompts as a recommended strategy based that evidence demonstrated that they increase the number of people using stairs rather than escalators or elevators. This intervention has been shown to be effective in a range of settings and with a variety of population subgroups. No harm was reported which was also important to our efforts planners. Our program evaluation led to these same conclusions.

We have shared our outcome measures of the project with other worksite locations and many have since implemented the "Point of Decision Prompts" in their own settings as a result. This has lead to more opportunities for awareness in our community.

We did an awareness campaign and incentive program within one worksite location. Our evaluation indicated improved greater use of the stairs. Random participants reported changing behavior as a result and continued the practice of taking the stairs long after the campaigns completion.

Yes, our community planning team maintains strong relationships and continue to collaborate on new community interventions as a result of our work and look to The *Community Guide* as a best practice guidebook.

Yes, and as a result we decided to invest in durable, consistent sign holders for our "Point of Decision Prompts" messages. These attractive sign holders have a consistent look throughout the community and are flame resistant exterior plastic which has held up to community traffic for more than three years.

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"Using Social Network Strategies to increase HIV & STI testing and break down barriers among the MSM population"

In Kent County, MI there are an estimated 260 HIV infected individuals unaware of their HIV status. More than half of these undiagnosed HIV-positive persons are men who have sex with men (MSM). Those individuals who remain unaware of their HIV status have the potential to unknowingly transmit HIV to others, do not benefit from early diagnosis, care, and treatment, and may face increased health risks including earlier mortality.

The Kent County Health Department (KCHD) implemented Social Network Strategies (SNS) to increase the rate of HIV testing among MSM at the KCHD Personal Health Services clinic (PHS). The primary goal of KCHD's SNS program is to identify persons, called ambassadors, to reach persons with undiagnosed HIV infection within their various social networks and link them to medical care and prevention services. SNS is a peer-driven initiative. It identifies individuals that are HIV-infected or have high-risk behaviors for HIV to serve as ambassadors who will recruit (Individual-level interventions) their social, sexual, and drug-using network associates to participate in counseling, testing and referral (CTR) services utilizing the Rapid HIV-1/2 Antibody Test.

KCHD employs an ambassador coach as the point of contact for any interested ambassador. Potential ambassadors are identified and recruited by reviewing client records, upon nomination by HIV/AIDS case managers or care providers, by utilizing participants at PHS HIV outreach sites or persons responding to SNS fliers and posters distributed through strategic venues in the community. Ambassadors are HIV-positive MSM with a favorable impression of PHS and SNS services or HIV-negative individuals previously tested through SNS with social network associates at high risk of HIV infection.

To incentivize individuals to participate as ambassadors they receive a $10.00 gift card per network associate that they identify, contact, and who subsequently presents for HIV testing. Network associates that receive their HIV test and result also receive a $10.00 gift card.

In program development and when seeking grant funding, KCHD staff utilizes various sources for evidence-based practice to guide their selection of program activities. One source that is often consulted is The *Community Guide*. Since there are health indicators for which research is still being analyzed for future *Community Guide* recommendations, programs also rely on literature reviews of research in the areas of health education and prevention.

Evidence of the efficacy of SNS for yielding previously undiagnosed HIV positive individuals is provided in a report of a two-year SNS demonstration project among nine community based organizations in seven U.S. cities (*Morbidity and Mortality Weekly Review, V.54(24);601-605, June 24, 2005*). SNS is also supported through the Individual-level interventions (strong evidence) and Community-level interventions (sufficient evidence) of The *Community Guide's* Interventions to Reduce Sexual Risk Behaviors or Increase Protective Behaviors to Prevent Acquisition of HIV in Men Who Have Sex with Men. The SNS Individual-level intervention consists of ambassadors making personal contacts with their social network contacts and encouraging them to seek HIV testing, and the CTR sessions that take place between PHS HIV counselors and MSM seeking HIV testing. The ambassadors also function as Community-level models by disseminating prevention messages as they act as leaders to the larger MSM community.

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"Integration of Community Guides into Healthy Communities Institute's web based Healthy Communities Network (HCN) System"

Healthy Communities Institute (HCI) offers a web-based information system called the Healthy Communities Network (HCN). The HCN system provides a dashboard of indicators that includes community health and quality of life measures customized for communities across the nation. To accompany the data in the dashboard, the HCN system provides a *Promising Practices* database that contains roughly 2,000 community-level interventions and policy models to support community health improvement planning and strategy. Each practice is classified as good idea, effective practice or evidence-based practice. The system is designed to empower hospitals, health departments, community coalitions and others to make a real difference by identifying community needs, tracking health and quality of life indicators for their communities, and making evidence-based program planning and strategy decisions. In May 2012, HCI integrated nearly 100 systematic reviews from The *Community Guide* into the *Promising Practices* database under the "evidence-based" category. A special blue "CDC" tag was added to the reviews so that individuals could easily find this featured content.

By integrating The *Community Guide's* into the HCN system, Healthy Communities Institute is promoting best practice sharing with hospitals, health departments, community coalitions and others across the nation who are working on improving the health and quality of life in their communities. Visitors to any HCN system will have access to The *Community Guide* reviews. Here is an example of an HCN system in Texas: http://www.healthyntexas.org/ Visitors to this site can access the *Promising Practice* database, containing The *Community Guide* reviews, here: http://www.healthyntexas.org/modules.php?op=modload&name=PromisePractice&file=index
The reviews also appear as related content as a visitor is browsing the site. For example, if a visitor is viewing mortality data on diabetes, (http://www.healthyntexas.org/modules.php?op=modload&name=NSIndicator&file=indicator&iid=36738), the "Diabetes Prevention and Control" reviews will show up on the right hand side. Once the visitor clicks on the review (http://www.healthyntexas.org/modules.php?op=modload&name=PromisePractice&file=promis
ePractice&pid=4051), they will find a review summary, the Community Preventative Services Task Force recommendation, a results section, and links directing the visitor to The *Community Guide* site for more information.

Healthy Communities Institute does not implement programs/initiatives. Hospitals, health departments, government agencies, and community health coalitions utilize the HCN

web-based system to identify community needs, track health and quality of life indicators, and make evidence-based program planning and strategy decisions.

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"HYPE!: Implementing School Programs to Help Youth Prepare and Engage"

Community Advocates for Family and Youth, Inc. (CAFY) is a nonprofit community organization based out of Prince Georges County, Maryland. CAFY's services, education, and outreach programs provide information, tools and resources to raise awareness about the impact of crime, increase public safety and health, and facilitate violence prevention. Through culturally and socially competent programs that address and serve the diverse needs of our community, we increase the ability of all individuals to live violence and crime-free lives. We learned about The *Community Guide* through our Annual Conference in April 2011. The Public Health Foundation was one of our sponsors, and they provided informational materials discussing what The *Community Guide* is and how it could benefit organizations. I found The *Community Guide* has violence interventions relevant to our mission. In particular, the school-based violence prevention programs and reducing psychological harm from traumatic events interested me the most. As a part of our Helping Youth Prepare and Engage (HYPE) Program, we go to area schools to help at risk students grades K-12 improve social skills and problem solve, to foster team work, and build self-esteem. Consistent with The *Community Guide* recommendations, we serve all youth who are in need of our services. Our programs in elementary schools target disruptive behaviors, while our programs for middle and high school focus on preventing dating abuse and violence, bullying, and changing behaviors.

Many people in the community are not aware of these targeted programs – which benefit individuals, families, and the community as a whole. We have consciously tried to create more visibility for our programs, because we know the evidence-based interventions do make a significant impact. If we are able to change the mindset of just one youth in our school outreach, we know this change is positively rippling through the community. We estimate a 30% increase in program awareness and a 5% increase in our group discussion participation over the past year.

CAFY serves as a model in our community, because we are proactively implementing needed violence prevention interventions that are **proven** to have an impact. We touch the lives of hundreds of youth a year, and we intend to expand our programs such as HYPE. We also intend to share our experience in using The *Community Guide* recommendations with our community partners.

A significant change is that we are really looking to partner with more schools within the county and doing more outreach training. We will be conducting a Career Day Workshop in June 2012 to assist at risk youth with developing social and emotional skills as well as set short and long-term career goals.

Because CAFY is a community based organization, we rely heavily on our partnerships. Prince Georges County leaders urged community based organizations, faith-based organizations, law enforcement, justice system, and schools to take a coordinated approach to reduce violence. There are identified "hot zones" in the County that we look to, but we also rely on our partnerships with the Prince Georges County Board of Education and the Prince Georges County Police Department to identify and target at risk youth for our HYPE program.

We continuously try to improve ourselves, our programs, and our policies every day. Using survey for students, teachers and counselors, we look at our processes and see what has been effective, what can be more effective, and what has not been ineffective. We make adjustments where needed to better serve those in our community.

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"Worksite Wellness for Small Businesses"

We engaged the Business & Industry Association to identify small businesses (6-49 employees) who were interested in worksite wellness. It is challenging for small employers to engage in worksite wellness efforts because they usually lack human resources staff to identify and manage an employee wellness vendor and they often lack the economics of scale of larger employers. The *Community Guide* was used to make clear the efficiency of certain worksite wellness efforts (Assessment with feedback, Obesity prevention interventions in worksite programs). This was helpful to business owners who wanted some assurance about the value of participating.

We succeeded in surveying 105 employees in six businesses (response rate 72%-100%) to assess health risks and interest in worksite wellness interventions. The assessment process worked well although it was a challenge to find time to meet with employers to follow up on survey findings and develop an intervention strategy for the worksite. The *Community Guide* is an excellent framework to use in identifying interventions for community settings such as a worksite. A sample of survey findings include:

- Most employees (78%) indicated an interest in some type of informal group for pursuing a wellness related activity and this interest was distributed over a variety of topics including walking (26%), hiking (26%), biking (17%), nutrition (17%) and fishing (17%). About 22% of employees are "not interested" in any type of informal group wellness activity.

- With respect to more formal programs or classes for wellness at the worksite, the highest levels of interest were indicated for back safety/managing back pain (44%), stress reduction (39%) and fitness classes (35%). Only 17% of employees indicated that they are "not interested" in any type of formal program for wellness at the worksite.

We will continue to refer to The *Community Guide* to engage employers and community organizations in helping them to develop.

We advised employers on "recommended" findings when asking them how they might respond to the employee assessments and guided them away from random ideas that had no relation to The *Community Guide*.

We partnered with a local business association in outreach and we partnered with community health organizations to respond to what employees in small business say

would be helpful for on-site worksite wellness (e.g., education by a physical therapist from local hospital to prevent back injuries at a small engineering and construction firm).

No, we did not use any Quality Improvement (QI) methods while implementing The *Community Guide's* strategies.