Myra Pinckney, RN
Case Manager/Outreach Coordinator, St. James-Santee Family Health Center, Inc.
Email pinckneymd@tds.net
Phone 843.887.3274

"*Black Corals:* A Breast & Cervical Cancer Screening Promotion Project for African American Women in SC" – 1st Place Winner

St. James-Santee Family Health Center is a community health center which provides primary and preventive health care services to medically underserved residents of three counties in SC. In September 2008 we applied for and received Legacy grant funding through the Southeastern U.S. Collaborative Center in the Elimination of Health Disparities to implement a breast and cervical cancer screening promotion project in African American communities. The project was implemented by the outreach department of our health center. The department consists of a registered nurse case manager, patient navigator, and three community health workers. Morehouse School of Medicine led us to the *Community Guide* which was a new resource for our organization. The *Community Guide* was extremely useful in helping us select empirically-based interventions for an effective program without wasting time and resources on strategies that would not produce desired outcomes for the target population.

We selected a combination of client-oriented, provider-oriented, and community-wide interventions for the project: client reminders, client incentives, group education, provider prompts, and social marketing strategies. At the conclusion of the 2-year project, Pap smear and mammogram rates at the health center increased by 10% and women in local churches continue to maintain screening behaviors. The interventions were so effective that we began utilizing the same strategies to address the missed appointment rates at four locations of our health center. We demonstrated a 30% decrease in missed appointment in 6 months by using client reminders and incentives. Compliance with regular follow-up appointments translates into better management of chronic diseases in vulnerable populations.

We have conducted numerous cancer education workshops at community-based organizations since the inception of *Black Corals* in 2008. As a result of our model, two new community projects are underway and using the same user-friendly interventions from the *Community Guide*. One of our partners for *Black Corals*, a local African Methodist Episcopal church, applied for grant funds to implement their own cancer screening promotion project using reminders, incentives, social marketing, and group education. A grassroots group of African American women formed the *Oatland Community Outreach Group* which conducted their first breast cancer survivors' charity walk and cookout in October 2010. The founder of the group attended a *Black Corals* workshop before starting her own project. These community-wide events expand the reach of *Black Corals* to improve health and prevent diseases in African American communities.

Since we discovered the *Community Guide* the health center has adopted two new policies for our primary care program: nurse visits and case management services. To shorten wait times for patients with chronic diseases, the medical providers have chosen to have patients scheduled for "quick visits" with the nursing staff. These visits are free of charge and serve as an incentive for patients with diabetes and/or hypertension to adhere to medical regimens and thereby prevent complications of their diseases. The other new component to our health center services is the addition of a nurse case manager to not only assist women with mammograms and Pap smears but also self-management of chronic diseases. The nurse case manager is currently implementing a community garden with staff, patients, and community residents to promote consumption of fresh fruits and vegetables, physical activity, and wellness in the community. The project is in collaboration with the SC Department of Health and Environmental Control.

The *Black Corals Project* was a collaborative effort between St. James-Santee Family Health Center and multiple partners: Medical University of SC Hollings Cancer Center, Georgetown Memorial Hospital, American Cancer Society, SC Department of Health and Environmental Control, BG's Beauty Salon, Buckshot's Restaurant, Lincoln High School, and churches across three counties. Our involvement with cancer screening promotion resulted in an invitation to join the Coastal Cancer Collaborative, a group which was formed a year ago to improve educational efforts, increase awareness, and build advocacy to reduce cancer mortality in the coastal region of SC. Last year the *Black Corals* staff organized our first cancer disparities conference with the Coastal Cancer Collaborative group with plans to implement another community-wide event later this year. Furthermore, the Buckshot's Restaurant has modified the menu to include entrées with less saturated fat as a result of *Black Corals'* cancer prevention efforts.

Lucy Wells
Immunization Service Line Manager, Duval County Health Department (Florida)
Email Lucy_Wells@doh.state.fl.us
Phone (904) 253-1244

"Increasing Immunization Rates for Two Year Old Children in the Duval County Health Department Clinics" – 2nd Place Winner

The Duval County Health Department (DCHD) recognized there was a problem with children being vaccinated as recommended by ACIP standards. The county overall immunization rates have been unfavorable and ranked among the lowest in Florida. DCHD is a major health care provider for Medicaid eligible children in the county, this provides an opportunity for us to reach our children, improve the department's immunization levels, and ultimately contribute to improving the overall county immunization levels. DCHD desired to identify evidence based strategy to improve the consistently low immunization levels of its two year old patient population. In 2009, Leadership gave priority to the low immunization levels hence initiating a quality improvement project to address the issue. In 2010, an Immunization Service Line was implemented to further enhance public health outcomes. The service line chose to incorporate the evidence based practices documented in the Community Guide. The Department's strategic goal was to increase the 4:3:1:3:3:1 series of two year old children in the Duval County Health Department clinics from 75% to 90% by 06/30/2011.

The Quality Improvement team used the PDSA model as a tool to systematically research, identify, modify, and implement solutions. During the planning and discovery stage, we identified challenges such as; most clinics were not utilizing Florida Shots (the immunization registry) to identify children who should be provided reminders when they were due for immunizations, staff who had an opportunity to administer vaccines were not trained and authorized to administer, some physicians preferred to delay some vaccines, educational materials was confusing to parents, and missed opportunities were not being identified properly. The Community Guide provided several evidence based strategies for the department to consider in addressing these barriers.

The first intervention addressed reminder and recall procedures. The Community Guide recommends reminder and recall interventions based on strong evidence of effectiveness in improving vaccination coverage. The updated review performed by the Task Force on Community Preventive Services documented client reminder and recall combined with additional components yielded a 10 percentage increase in vaccination coverage. The DCHD clinic incorporated the use of the Florida Shots registry to extract data indicating which children needed reminders and recall on a monthly basis. The department also discovered by using this tool many errors in data was identified including many children who were no longer in the area or were no longer clients.

The second intervention addressed education and policy. The Community Guide recommends health care system-based interventions implemented in combination such as provider education and standing orders. The department had staff available to administer

vaccines however they were not trained or authorized to do so. In another instance Physicians were accessible but decided not to give the necessary immunizations also creating a missed opportunity. DCHD instituted a large scale training for all clinics to train Health Technicians and LPNs to administer the vaccines which were formerly only administered by RNs. Policies which clearly referenced the Advisory Committee on Immunization Practices (ACIP) recommendation for vaccination were communicated to providers and combination vaccines were made readily available.

The third intervention addressed educational media for parents and caregivers. The Community Guide recommends community-based interventions implemented in combination. The Task Force identified media and educational activities as contributing to reducing missed opportunities. The Duval County Health Department's printed educational materials on immunizations showed the full range of time when a child could still receive vaccines and be up to date rather than when the child should receive shots. Following clarification of policy for children to obtain immunization at earliest eligible opportunity, education posters were revised and distributed to reflect recommendations for parents that would maximize immunization rates.

In March 2011, the DCHD achieved a level of 90% up-to-date overall immunization rate for the 4:3:1:3:3:1 series from a 75% rate in 2009, a 15% increase. The department is currently documenting and sharing best practices with private community providers. Community providers and partners also will be given the link to the Community Guide website. The task has not been easy but having a tool such as the Community Guide has truly decreased the time spent in trial in error.

Katherine Riddle, RRT, CTTS, Whidbey General Hospital (Washington State)
Email riddlk@whidbeygen.org
Phone 360-678-7656, ext. 2130

"Tobacco Free for Good" – 3rd Place Winner

Since 2004, Whidbey General Hospital (WGH), in partnership with the Island County Health Department has been offering free tobacco cessation classes. We have been offering vouchers at the end of the classes for 2 weeks free Nicotine Replacement Therapy (NRT) patches during this time in partnership with the WGH Cancer Care Committee and the WGH Foundation. In 2010 we included NRT gum as an alternative for those who cannot use the NRT patches.

- In February of 2006 we developed an in-patient system for identifying those who have used tobacco in the last year, providing short interventions, and performing follow-up phone calls for those who expressed interest in resources for quitting.
- In 2008 we developed a similar system for the Emergency Department patients.
- In October of 2010 WGH became a tobacco free campus. This was preceded by one year of planning, which entailed a multidisciplinary committee developing the policy, training, publicity and implementation.

We have been doing community outreach since 2006, presenting tobacco prevention/cessation messages to school groups, nursing students, return to work classes, health fairs, juvenile detention groups, jail inmates, and drug rehabilitation groups. We offer information/support sessions to the community 7 months out of the year. The free resources offered are Washington State Quitline, the National Quitnet, the American Lung Association, the American Cancer Society, The American Heart Association, local tobacco cessation classes and information/support sessions.

The outcomes of implementing the *Community Guide* include: Increasing Tobacco Use Cessation: Reducing Client Out-of-Pocket Costs for Cessation Therapies:

1. Increasing use of the effective therapy
2. Increasing the total number of tobacco-using clients who quit

The collaboration of the WGH, Island County Health Department, WGH's Cancer Care Committee and WGH Foundation has allowed us to increase the community outreach and allowed us to positively impact the health of our community.

The free classes and vouchers for free NRT patches/gum have reduced out-of-pocket costs to the participants, but have also ensured that the appropriate psychosocial tools are offered, which improve outcomes with the therapy. This is reflected in the follow-up phone calls which show a 35-40% quit rate at one year for the participants.

Increasing Tobacco Use Cessation: Multi-component Interventions that Include Telephone Support.

1. Increased patient tobacco cessation

2. Was effective in both clinical settings and when implemented community-wide

The development and implementation of the in-patient and Emergency Department system for identifying tobacco users, doing interventions, and follow-up by telephone have also increased our community outreach and was effective in both clinical settings.

Decreasing Tobacco Use Among Workers: Smoke-Free Policies to Reduce Tobacco Use

1. Implementation of regulations that prohibit smoking in indoor and enclosed work setting and public areas
2. Adopted by companies and organization with multiple worksites
3. Implemented by individual worksites

When WGH became a tobacco free campus, this included our outlying clinics and offices. The same resources that had been offered to the community at large were also available to the employees, patients and visitors. This was aimed at creating a single consistent health care message re: the importance of tobacco cessation on overall health in our community. These resources were:

1. Tobacco cessation groups
2. Client educational materials or activities
3. Telephone-based cessation support
4. Counseling and assistance from healthcare providers
5. Access to effective pharmacologic therapies

How will your experience serve as a model for assisting other organizations using the *Community Guide*? Because we are a rural population with varied needs, the challenge was to reach as many people as possible. By using a collaborative approach and having the local hospital as the hub, we have been able to reach a larger group. Anyone who wishes to widen their outreach to include hospital patient populations, workplace populations, community outreach, or attain improved success with tobacco cessation outcomes could implement similar processes specific to their population needs.

Did you make any changes in practice as a result of using the *Community Guide*? Please explain. We developed our own in-patient identification/intervention/follow-up system and implemented it into our computer system. The Emergency Department system was developed with the help of the Tobacco Cessation Resource Center (TCRC) Tobacco Cessation Systems Change Project in partnership with the Washington State Department of Health.

Did you use any partnerships or collaborations while implementing the *Community Guide's* strategies? Please explain. Everything that we have done has been collaborative and involved a teamwork approach. This includes the Washington State Department of Health, Island County Health Department, The TCRC, WGH, WGH Foundation, and the WGH Cancer Care Committee.

Mary Singler
Health Promotion Manager, Northern Kentucky Health Department
Email mary.singler@nkyhealth.org
Phone 859-363-2083

"Using the Community Guide in Grant County Kentucky"

I learned about the Community Guide through the 2003 Physical Activity Public Health Practitioner's Course. At the time our Health Department had issued health report cards to the Boards of Heath in the 4 county regions we serve. One county Health Board had taken the Health report card very seriously and asked staff to give them a suggested plan of action on how to address the major health issues in their county. After we completed some health assessments we used the community guide to facilitate discussion among community members. It helped us help these community members focused on what works, and what had insufficient evidence. In the early days of using the Community Guide what we liked about it was its usefulness in shaping discussion and in focusing community effort. What we like about it now, is that it is a dynamic document that provides a quick check on interventions we are considering using.

Our use of the Community Guide resulted in the fledging coalition implementing a community wide campaign. This coalition is located in a rural county with high unemployment. The group initially wanted to work on "awareness and education." The activities they identified were health fairs and articles in the newspaper about the importance of physical activity. Through the use of the Community Guide we were able to help this coalition to add essential elements such as involving many different community sectors and inclusion of highly visible, broad-based, multi-component strategies. The intervention that this coalition created was called "Get Up, Get Out, Get Fit." It involved media, social support, a physical activity program and evaluation. The evaluation data helped to shape future interventions. The coalition felt successful. They saw the intervention worked to change attitudes and behaviors. This first effort spurred them on to future efforts. The coalition is now a strong 501(c)3 that is using many strategies outlined in the guide. Environmental and policy change interventions are included in most programming efforts

After our introduction in 2003 to the Community Guide we changed many practices related to physical activity and worksite wellness. In the past we had followed the lead of the tobacco prevention team. The Community Guide helped us to understand and communicate to our stakeholders why a "one size fits all" approach does not work. It helped us to assist community stakeholders in designing effective interventions. We continue to use the community guide for work with any community group for whom we provide significant health promotion services. It is also used by staff when interventions are being planned. We have also contacted researchers that had been involved in studies cited in the Community Guide to help shape our interventions and evaluation strategies.

Sonja Engle, RN, Itinerant Public Health Nurse III
State of Alaska, Department of Health & Social Services, Public Health Nursing
Email Sonja.engle@alaska.gov
Phone ___907-465-1241_______

"Engaging A Rural Village, and Motivating Change"

I personally learned about the guide after doing a search on CDC's website about a year ago. I was looking for tools to help guide communities on the topic of obesity. I am an itinerant PHN who travels to rural villages in Southeast Alaska. After an informal community assessment for Hoonah, Alaska, it was determined that there was a need to focus efforts on this issue. Hoonah is an Alaska Tlingit community located on the northeast shore of Chichagof Island, with a population of about 850 full time residents, and it has a very unique set of circumstances. Like many rural Alaskan communities it has a high poverty rate, very few local employment opportunities, a culture that struggles with historical trauma, and geographic/environmental challenges.

One of the strategies mentioned in the guide, was to start community coalitions or partnerships to address obesity. In September of 2010, key players were invited to discuss the issue and to start a work group. This group is like a Coalition; bringing together stakeholders and locals from the entire community to work on the issue of obesity. Goals of this group include increasing recreational activities within the community, promoting better nutrition in the school & community, and public awareness of issues related to obesity.

We started this group less than a year ago and have had four meetings. Current planning around category 1: include working with the school district food authority in promoting better nutrition in the school; working with two local grocery stores, both have agreed to partner with the Fun & Fit group around a project that promotes education on better nutrition; researching information on how to get locally caught fish into the school lunch menu; and encouraging community members to apply for community school based vegetable garden and bloom garden grants which they have received and began work on.

Category 2: includes working with the school district administrative offices and supporting them in their choice to not have vending machines.

Category 3: includes supporting and working with the local Parents as Teachers staff, Lamaze class instructor, the Hoonah Clinic and those involved in the Universal Postpartum outreach program on breastfeeding issues & concerns.

Category 4: includes working with the school district on their PEP grant by supplying BMI data from research the group helped obtain; supporting the school in having regular open gym hours; encouraging a community member to step forward and coach the "Girls on the Run" program; being supportive of and promoting the benefits of a PE and health curricula (in 2010 the school district hired a full time PE/health teacher which had been lacking for the previous 3 years); encouraging community members to apply for grants

that encourage youth to be active by forwarding opportunities to the group and larger community; assisting with the promotion of and helping increase opportunities for families and community members to be active outside school/work hours by asking a local woman to offer free dance/exercise classes, by organizing a fun run/walk, by planning a grand opening Hawaiian themed "pool party", by planning a bike rodeo, by planning a walking challenge, and by working with the local community to compile a list of "Fun" physical activities to do while living in Hoonah.

Category 5: include encouraging the city to promote better walking and biking trails and helping promote their use; supporting the city and the school district in their efforts to reopen the pool which has been closed for 3 years and will finally open in mid June; investigating opportunities to increase ice skating and cross country skiing in the area; writing a grant for a Safe Routes to School award that should promote walking and biking to school; starting the conversation with local law enforcement and the Fish & Game department on the safety issues around bears in the community.

Category 6: includes starting the workgroup/coalition with a diverse group of members and organizations to achieve a shared goal of increasing recreational activities within the community, promoting better nutrition in the school & community, and public awareness of issues related to obesity.

There have been many challenges this past year, but the largest one has been getting consistent members to the table and having a shared vision. We meet this challenge by having patience, continuing to invite a large group of partners (sometimes with personal phone calls), revisiting the goals and mission of the group on a regular basis, and sharing our agendas and meeting notes with the larger community through email forwarding.

The most useful thing about the Community Guide is that it has evidence based strategies that can be pointed out to the group. The guide allows structure, and helps remind the group of strategies that are most likely to work (it gives hope). We discuss them, consider which ones can be implemented for a small rural community, and make plans accordingly. The timeliness of the Guide and the reference sections are very beneficial. The guide is "user friendly" and has practical advice that can be adapted or used to spark discussion and brainstorming.

Our experience will show that the Community Guide is flexible and simple enough to be used in small rural villages to promote change. As intended it can assist work groups and coalitions in reaching their goals. It will show that this can be a starting point and that any small step helps the group gain confidence and assist with the group's productivity. It makes sense to look to the advice of experts and to utilize the knowledge that is out there. Why would you want to reinvent it?

We made a large change as a result of using the Community Guide. Initially, when the group convened the group census was to focus on the obesity issue by focusing primarily on adding fun physical activities that would promote those who are already active to stay active. The group felt like this would have a "domino" effect. What the guide did was

show us that we could attack the problem from multiple areas using strategies that enhance behavioral change by looking at policies and our environments. The group has widened its view about how to approach and tackle this issue. We are now focusing energy on getting traditional foods into the school lunch program, partnering with local grocers, and beginning the process of working with the city on changes that could help prevent obesity.

But, we haven't forgotten that in Hoonah community engagement and strong partnerships are strengthen by planning fun events together that help promote the issue we are working on. So we will be hosting a Hawaiian themed grand opening pool party next month, in hopes that this will encourage families to use the pool more often.

The Hoonah Fun & Fit workgroup is a collaboration of Hoonah agencies and community members which have included (but not limited to): the Hoonah School District, Parents as Teachers, Big Brothers Big Sisters, Hoonah Indian Association, Hoonah Organizers for Peace and Equality, Hoonah Youth Center, Hoonah Police Department, Hoonah EMS and volunteer Fire Department, Hoonah Clinic, the City of Hoonah, and the State of Alaska Department of Public Health.

Stephanie Vogel, Health Education Manager
Northern Kentucky Health Department
Email stephanie.vogel@nkyhealth.org
Phone 859.363.2087

"You Think We Should Do What?"

I first learned about the *Community Guide*, through my work as a health educator in tobacco control and by attending CDC Conferences on tobacco control strategies. We received training about the guide and the definitions of the recommendations. We immediately began looking at our current tobacco programs and having the hard discussions about whether or not we should be spending the amount of time we had been, on a strategy that was deemed to have insufficient evidence. The *Community Guide* was the motivation behind the discussion and analysis of the amount of staff time I spent implementing direct school based prevention and intervention curriculum in a classroom. We had several staff meetings to discuss what we were currently doing and how it could change. We met with state program managers, who also provided insight, expertise and support for a change in direction. We made the decision to move towards a process of offering incentive funds to schools to implement programs and our role as a trainer of trainers, with the school providing the direct facilitation for programs. The incentive funds process has evolved since that time, to include additional topic areas and coupling policy change with programs.

As our health department's health promotion efforts in physical activity and nutrition expanded, I was able to attend the CDC Physical Activity Practitioners Course, where we received in depth training about the *Community Guide* and the physical activity and nutrition recommendations. It was at this training, I realized the *Community Guide* covers others areas our staff were currently working in. Myself and another coworker came back from the training, delved deeper into the guide, and prepared and delivered a training for our staff about the *Community Guide*. We began referring to guide during our annual program planning process where we develop five year plans and yearly strategies.

The most useful aspect of the guide is that it is quick reference for strategies, with a recommendation for implementation. The studies reviewed are credible and cited so that you can locate the full article and read more when needed. We have used this to follow up on ideas and strategies we are considering for implementation.

The outcomes of using the *Community Guide* in our organization has been that it provides the basis to have the tough discussions about whether or not we should spend our resources on strategies that are not recommended or have insufficient evidence. When we have made the decision to implement a strategy with insufficient evidence, we have committed more resources to the evaluation of the strategy.

Successes in using the guide have been that the *Community Guide* motivates us to use our resources more effectively, and towards population based public health. With limited

financial and nonmonetary resources, the *Community Guide* provides reassurance in strategies when the money for evaluation may not be available.

One challenge in using the *Community Guide* is that it can be hard for staff to move from a strategy you've always been doing. The conversations around the current strategy can be difficult and emotional. The decisions can be tough; you have to weigh public impression and stakeholder input. It can also be hard for the community on the receiving end to experience the change of a well recognized and liked strategy. With the example of our incentive fund process, some schools were upset that they would have to do the direct teaching; it was a change from what we had been doing and it was hard for them to see the benefit, despite the money they received.

My experience with the *Community Guide* has been able to serve as a basis for strategies I recommend when working with other groups through coalitions and collaborations. I have also trained others on recommendations from the *Community Guide* and reference strategies in presentations.

The incentive funds process discussed has been a model for other health departments and state agencies. The process has been presented at state conferences as well.

One of the greatest changes in practice has been that we have the tough discussions about whether or not we should spend our resources on strategies that are not recommended, or have insufficient evidence. The *Community Guide* is also used by all of our staff when planning programs. The *Community Guide* is a constant, credible source for our health educators; we always come back to it when assessing and looking to improve our programs.

The *Community Guide* was the motivation behind the discussion and analysis of the amount of staff time a health educator spent implementing direct school based prevention and intervention curriculum in a classroom. We had several staff meetings to discuss what we were currently doing and how it could change. We met with state program managers, who also provided insight, expertise and support for a change in direction. We made the decision to move towards a process of offering incentive funds to schools to implement programs and our role as a trainer of trainers, with the school providing the direct facilitation for programs. The incentive funds process has evolved since that time, to include additional topic areas and coupling policy change with programs.

Partnerships are used in the implementation of the *Community Guide*'s strategies.

During the incentive fund process with schools, we collaborated with state officials and a coalition of individuals interested in school health, the REACH team. The REACH team assisted with promotion and the planning of the logistics for a conference that kicked off the initiative. State officials, school representative presented, along with the health department, at the conference.

Karen Cameron
Executive Director, Central Virginia Health Planning
Email _karenleecameron@gmail.com
Phone __804-932-5055________

"A Place to Start"

In the city of Richmond, Virginia, we used evidence-based best practices to improve our community's mental and behavioral health programs. We identified the need to research evidence-based programs in 2004 when the Central Virginia Health Planning Task Force found that there was a lack of community-based support services for behavioral health in the Richmond area. We turned to evidence-based strategies to reduce readmissions for inpatient hospital visits for the homeless and other at-risk populations in our city. We found it useful to learn from other cities that have experienced similar issues in their community. The process involved bringing together many partners and intensive research to follow the program participants.

Through research and working closely with the homeless population, we found that the homeless in our city actually wanted to be helped. The program dropped our arrest rates of the homeless population, and the associated costs with the law enforcement, which we estimated at a savings of over $300,000. By reducing emergency room visits from those studied by 61.5%, we were able to save program participants $83,000 in health care costs, which would have been picked up by the state. With the monitored mental health care, we saw a drop in inpatient hospital stays for mental health reasons as the population became more mentally stable. We attribute the increase in mental stability to the Virginia Supportive Housing program, which placed homeless individuals in scattered housing locations across the city, rather than confining them to a single neighborhood.

Other state agencies that followed our model saw similar reductions in arrest rates across the state of Virginia. We also were fortunate to learn from other cities that used these evidence-based programs including Washington, DC and San Francisco. We learned that with a lack of stable housing, the homeless population was putting a strain on the public health system in our cities. Understanding the model, we found that there are non-negotiable pieces in the program and also flexible parts that can be manipulated based on the community. We can share with others the many things that we learned throughout the process of implementing this program, including the value of having evidence-based strategies, studies, and the people who have working knowledge of how the programs were conducted to improve public health. We learned to establish a long planning process to make sure things are done correctly, and to be adaptable to changes along the way.

We have become more reliant upon evidence-based best practices as a result of our success with this program. We also learned that similar programs could be replicated across the state if successful in Richmond.

Partnerships included the Virginia Department of Mental Health, Behavioral Health and Developmental Services, Virginia Supportive Housing, Richmond Redevelopment and Housing Authority, Virginia Coalition to End Homelessness, Homeward, VA Community Services Board, and the Public Broadcasting Service (PBS), which produced a documentary based on the "A Place to Start" program.

Mary Kushion
Health Officer Central Michigan District Health Department
Email mkushion@cmdhd.org
Phone 989-773-5921 ext. 8421

"Together We Can Use the Community Guide!"

In the spring of 2010, the Central Michigan District Health District Health Department established the Together We Can!(TWC) initiative as a result of a poor showing in the *County Health Rankings* released by the University of Wisconsin's Population Health Institute. The initiative which is a six-county community health assessment and community health improvement planning project received much attention from the University of Wisconsin's Population Health Institute as it was seen as a pro-active approach to using the Rankings information to improve health status. As a result, agency director Mary Kushion was asked to be on a National Health Policy Forum panel to discuss the initiative. It was there, that she heard of the CDC's Guide to Community Preventive Services (*Community Guide*) from CDC presenter Shawna Mercer. It was an AHA! Moment for Ms. Kushion and she shared the information regarding the *Community Guide* back to the TWC Health Improvement Council and the individual county HIP (health improvement planning) Working Groups because she recognized it as a valuable tool/resource to use when developing strategies for the 8 identified health priority areas they would be addressing during the health improvement planning process. The Council and the working groups were very agreeable and appreciative that such a resource exists given the limited resources available within the communities; they want to be effective both in the efforts to improve health status, but also recognize the need to be cost effective as well.

The *Community Guide* was also used for two related internship studies. In the first internship, the student compared the County Health Rankings results and other data sources to where the agency's counties were in meeting the Healthy People 2020 targets. In the areas where the targets were not met, the student referenced the programs and policies contained within the *Community Guide* as potential solutions to meet the targets. The written report provided as a requirement of the internship was shared with the TWC group. The second intern project consisted of a review and crosswalk of the topic areas in the *Community Guide* and the 8 identified TWC topic areas in order to direct and facilitate discussion for the TWC members as they seek and develop potential solutions to address the identified priority health areas.

The *Community Guide*, as stated previously is currently being used to develop the community health improvement plans for the six individual counties associated with the Central Michigan District Health Department as well as for the overall district-wide plan. The success and benefit we have seen in using the *Community Guide* is that it is an easy to use resource that is available on-line for stakeholders/participants to utilize not only in the TWC process, but also within their organizations. The link to the *Community Guide* has been widely shared through the monthly publication "HIP (Health Improvement Planning) News to Know" to the 144 individuals associated with the TWC initiative, the

county collaborative council members in the six counties, health department staff and board of health members. It is also available on-line at the health department's (www.cmdhd.org) and Central Michigan University's Bridges Center (http://www.cmich.edu/chp/x3049.xml) websites.

The TWC and health department hosted its second public health summit on April 14, 2011. One of the primary goals from the summit was to gather stakeholder input on potential programs and policies. Samples of programs and policies drawn from the *Community Guide* were distributed to all of the 120 participants in order to focus their efforts on evidence-based/focused options.

The TWC initiative and the County Health Rankings have also generated interest from the legislators representing the central Michigan area. Ms. Kushion has met with several of the them and utilized examples from the *Community Guide* in discussing how to improve the health status by maintaining effective evidence-based programs such as Michigan's motorcycle helmet law, the public smoking ban and by reversing the law which passed in late 2010 which increases the hours that alcohol can be sold.

The one challenge identified with the *Community Guide* is the fact that it does not contain evidence-based programs and policies related to environmental health. This is a challenge as one of the 8 identified priority areas is Environmental Health. As a result, the goals and strategy development process has been more difficult for the topic area.

The work products cited previously (internship reports, summit results, community health improvement plans) which utilized the *Community Guide* are available for broader distribution and will serve as examples to other communities and organizations who are involved in community health assessment, community health improvement planning and/or strategic planning efforts all of which are pre-requisites for the national voluntary public health accreditation. The experience and continued use of the *Community Guide* both within the organization and with the TWC initiative will serve as a model and testament to the value and utility of the guide.

The TWC Community Health Improvement Plan is still under production. While it is too soon to know if **changes** will occur as a result of using the *Community Guide,* it is anticipated that a much more effective plan will be implemented and that improvements in health status will realized in a more efficient and credible manner because of its use.

The TWC initiative is a major health improvement planning process within the health department's jurisdiction. Its members include, but are not limited to representation from local county government, hospital systems, K-12 schools, community colleges, universities, substance abuse agencies, services to the aging, community mental health, the media and transportation. The members, totally 144 and expanding on a monthly basis, who are associated with either/both the county health improvement planning working groups and the TWC Health Improvement Council have become aware of the *Community Guide* and the necessity to look to programs and policies that are the most effective in addressing the health concerns within the communities.

Jackie Sergent
Granville-Vance District Health Department (GVDHD) (North Carolina)
Email __jsergent@gvdhd.org_____
Phone _919-693-2141___________

"GVDHD's Use of Community Guide"

GVDHD is a low resource health department that covers two counties. GVDHD has used the Community Guide since 2002 to identify strategies that will achieve a positive change in the community. These strategies become the focus of health promotion efforts and justification for funding. The following programs have been implemented by GVDHD based on Community Guide recommendations:

1. Teen PEP (Prevention Education Program)- GVDHD was awarded funds by the NC Department of Health and Human Services Teen Pregnancy Prevention Branch to implement this program from the Princeton Center for Leadership Learning in January 2011 in Northern Vance High School. The program recruits 15-20 juniors and seniors to enroll in a 4-credit course, co-taught by a faculty advisor team using a structured curriculum. Advisor teams train the students to be effective sexual health advocates and role models to their peers. They conduct outreach workshops with peers, parents, and educators focusing on postponing sexual involvement, unintended pregnancy (Vance County's teen pregnancy rate is the third highest in North Carolina), HIV/AIDS, other STDs, sexual harassment, date rape, dating violence, homophobia reduction, and other teen health concerns.
2. Greenway Master Plan- GVDHD has is addressing the design and land-use barriers to physical activity with a county-wide Greenway Master Plan.
3. Mini-grant funding- For 2 years, GVDHD provided 10 mini-grants a year ($1,500 each) to district organizations to implement policy or environmental changes, many of which involved increasing access to or creating social support for physical activity.
4. Annual Eat Smart Move More Weight Loss Challenge- GVDHD strives to meet the Community Guide's recommended practices for physical activity (social support, individually adapted behavior change in a group setting, and community-wide campaigns) and obesity (multi-component coaching) with this program, which is modeled after "Scale-Back Alabama." In addition to challenge goals and prizes, GVDHD sends weekly educational e-mails and support material, holds free classes, and offers a variety of free or reduced price exercise options throughout 2 counties during the course of the challenge. The Challenge is also part of an effort to increase recognition of North Carolina's state-wide campaign, Eat Smart Move More (ESMM) North Carolina, as consistent messaging is important in addressing health disparities. GVDHD has worked to increase awareness of the campaign, its resources, and the need to alter lifestyle behaviors through an annual county-supported ESMM Award to organizations that implement policy or environmental changes that support eating smart and moving

more. ESMM partner signs are posted in health provider waiting rooms and there are rotating ESMM NC message signs to encourage healthy behaviors.

Teen PEP is finishing its first semester with 18 juniors and seniors completing the course. Interviews were just completed for next year and it appears that classes will be full, which we take to be a sign that the course is making an impact. It is currently undergoing more structured evaluation, including pre- and post-testing at multiple grade levels in a control versus the intervention high school.

The Greenway Master Plan has spawned numerous initiatives, grant awards, and municipal planning efforts since it was published in February 2006. One municipality has developed a pedestrian master plan and one is in the process of doing so. A third municipality has applied for funding to develop one, and two others are planning to develop. There is now a 9-member, county-appointed Greenway Advisory Board, which is made up of individuals from the local school system, counties, and municipalities. There is also a county-appointed working group.

Among the outcomes of GVDHD's mini-grant initiative were: 1 large and 1 small stairwell initiative, a DT walking path with signage, 1 church and 2 school walking paths with signage, 3 exercise facilities (small) at worksites (1 also giving free access to their low-income clients), as well as several policies to implement programs that support physical activity or healthy eating.

The Annual Eat Smart Move More Weight Loss Challenge had 1,000 participants the first two years. This year, over 850 participants lost 3,600 pounds in 10 weeks. In addition, 20 medical providers have posted ESMM signs.

Before passing on public health strategies to others, you want to make sure that they are recommended. The programs above illustrate that the Community Guide recommendations do work to improve health – they're shown to make a difference. Therefore, these activities can be implemented by, and would be successful in achieving intended results for other organizations, as long as they closely follow the same process used to implement GVDHD's activities.

GVDHD's Board of Health was the first in North Carolina to be trained on the Community Guide (by NALBOH in January). Although GVDHD had already been using it, a policy was passed on April 5 that the Community Guide should be used and referenced as much as possible in future efforts. For example, the Community Guide is consulted when deciding what community activities the health department should partake in (i.e.: the recommendations indicate whether participating will lead to sustained change).GVDHD works with Vance County Schools to implement the Teen PEP program. There are also representatives from the school system on the Greenway Advisory Board, in addition to representatives from counties and municipalities. GVDHD works with various organizations to implement policy and environmental changes that support Eating Smart and Moving More, as well as with medical providers to promote ESMM by posting signs in their offices.

Cathy Cedillo
Program Coordinator, Diabetes Prevention and Kidney Care (Maryland)
Email m.belledonne@verizon.net
Phone (301) 881-7511

"Diabetes Prevention and Kidney Care Program in Community Clinics"

Diabetes Prevention and Kidney Care is committed on fighting against the diabetes epidemic and its complications namely renal and cardiovascular disease affecting mostly uninsured minority populations attending Community Clinics. Based in the *Community Guide* recommendations, we implemented a kidney disease case management within a multicomponent treatment plans including self-management support. The challenges we had to solve were active participation of primary care, care coordination among all other providers and follow up for continuity of care. We used Community Health Workers for Care Coordination, self-management support at home and at the community, and to assist to navigate the clients through community resources. We found most useful that the clinics also agreed that Disease and Case management are the most effective means to prevent progression of diabetic renal and cardiovascular disease and also to prevent diabetes in the populations at risk.

The outcomes are earlier detection, management and treatment of individuals at high risk for progression of cardio-renal disease, and improvement of care coordination and follow up. The benefit were improvement in glucose control, blood pressure, decreased provider inertia, medication adherence, weight loss and increased exercise, delaying progression of renal and heart disease, and ultimately significant savings in health care costs. Because of the of CHW in the community, they are able to extend self-management programs to the community and assist the client at home and interact with families.

Because we are in the process of implementing "Medical Homes" and associated specialty "Neighborhoods" with focus on improving quality of care, prevention, care coordination, and to apply evidence-based guidelines, the Community Guide will provide those organizations with information to support programs that have evidence of being effective so they could adapt them to the particulars of each organization.

We had to refocus prioritizing programs proven more effective and to link them with others that did not have as much proven evidence to be recommended. We implemented Disease Case Management as our core service, and integrated with a self-management education program based in a clinic setting but with follow up at the community and at home. We used especially trained CHW because of the lack of funds to pay for higher degrees of providers such as diabetes educators.

We develop partnerships with the Community Clinics. We negotiated coordination agreements and formed a task force to implement and evaluate the program at the Community Clinics. We organized a multicomponent case and self-management team.

Nancy Forlifer
Community Health Improvement Director, Western Maryland Health System
Email _nforlifer@wmhs.com
Phone _240-964-8422____________

"Use of the *Community Guide* in the Western Maryland Health System"

We look to the *Community Guide* for recommendations on what public health interventions are effective, which have insufficient evidence, and which are not recommended. We have used the *Community Guide* recommendations in our worksite wellness and obesity programs, which helped us to develop and identify funding opportunities with our community partner, CareFirst BlueCross BlueShield.

While our programs are still ongoing using evidence-based recommendations, we have been able to reduce emergency room use with the help of primary care physicians in our community. Surveys that we have done in the community also show progress in areas such as diabetes, asthma, depression, and maintaining blood pressure levels. We have been working on some of these programs for ten years now. Our challenges are convincing physicians and special interest groups to adopt evidence-based strategies because it is unfamiliar territory and uncomfortable for them to change their ways. Use of the *Community Guide* resulted in two funding grants for our community. We used the recommendations as support for earning $20,000 for our obesity programs through CareFirst BlueCross Blue Sheild and $105,000 for our maternal and child health programs through Maryland Physician Care. These programs are ongoing and results have not yet been released, however we have stabilized BMI rates in elementary schools over the past three years, which is perceived as a success in our community.

We use the *Community Guide* recommendations in conjunction with the *Guide to Clinical Preventive Services*. The *Community Guide* is user friendly, and easier to use than the *Clinical Guide*. It is a wonderful resource where we can research by topic, and find succinct recommendations for what works in public health, with specific examples. We also connect the findings in the *Community Guide* to CDC resources online.

The *Community Guide* helped us change policies which had a direct result in our ability to raise over $100,000 from different sources to address challenges in our community. It brought together managed care organizations, insurance companies, and our health system to form new programs.

In the Western Maryland Hospital System, we used the physical activity recommendation to put point-of-prompt visuals to remind staff to use the stairs in our buildings. We posted signs around the facility and rewarded staff using the stairs with a raffle, including stickers and prizes. The doctors love the promotion. We had full staff collaboration in implementing our evidence-based programs and also brought together several partners, including social service agencies, federally qualified health centers, neighborhood groups, faith-based organizations, local government, private fitness centers and area colleges.

Rita Miracle
Public Health Preparedness Coord./Health Educator, Knox County Health Department (Kentucky)
Email ritas.miracle@ky.gov
Phone 606-546-3486

"Best Practices for Better Health"

The Community Guide is recommended by NACCHO and Partnership for a Fit Kentucky as well as the Public Health Foundation. I am always researching was to better address public health problems or issues in our community. I read best practices from CDC, NACCHO, PHF, as well as other agencies that have science based evidence of what works and what doesn't. When I find something that has worked and there is data to provide evidence that it has worked, I share these studies and recommendations with other public health workers in our agencies that work with that demographic population. I also forward information to our local school districts, community agencies, faith-based communities, etc. that would deal with the same demographic populations that these studies involve.

I am truly a person that doesn't reinvent the wheel when it comes to a best practice that has proven to be effective. I am also one that is always trying to come up with an idea that would work in areas that there is little evidence of a best practice.

The biggest outcome of using the Community Guide is having staff that do not spend a lot their time and resources utilizing programs that traditionally have not worked to make a significant impact on health issues. I would hope that other local health departments use this logic in choosing how to spend the limited dollars that we have to benefits the most and make the greatest impact. As we look at grant writing and other avenues of being able to purchase program materials, we now research for best practice or science/research-based programs when choosing what to gear our resources to.

Shawn LaFrance
Executive Director, Foundation for Healthy Communities (New Hampshire)
Email _slafrance@healthyNH.com__
Phone _603-225-0900___________

"Using the *Community Guide* as a Planning Tool"

The Foundation for Healthy Communities is assisting the New Hampshire Planners Association with planning their Annual Conference to take place in June 2011. This year's conference theme is "Planning for Public Health." This theme presents a different way of thinking for state planners with regard to how their jobs relate to health. The *Community Guide* provides a great opportunity to create a bridge to health.

Therefore, we decided that the *Community Guide* should provide a framework for this year's conference. The keynote presentation will outline and discuss the *Community Guide*'s land use recommendations to promote physical activity, which will not only provide planners with recommended scientific approaches to future projects, but will also clearly illustrate how their profession has a bearing on public health. In addition, introducing the *Community Guide* at this event will get planners to understand the value of having an evidence basis for their work.

Penny Farris, R.N., Immunization Program Manager
Ector County Health Department
Email farripd@co.ector.tx.us
Phone 432-498-4141 Ext. 1010

I have not had the pleasure or privilege to view or read your Community Guide, but would consider myself fortunate to have the information to utilize in our facility. I certainly am welcome to information regarding how to capture the attention of our community residents of all race & age & interact with them to provide education on public health issues along with the services we provide in our facility. Our greatest challenge is finding ways to connect & engage with our community resident's. We participate in many community collaborations, but do not seem to be able engage participants so they would be more responsive to our booth for education, etc.