San Diego Accountable Community For Health

Collective Action Workgroup Meeting Summary

September 6, 2018
2:00-4:00 pm
211 San Diego (3860 Calle Fortunada, San Diego, CA 92123)

Accountable Communities for Health

Members Present:
Jim Dudl, Kaiser Permanente
Alana Kalinowski, 211
Cherolyn Jackson, MHF
Tina Emmerick, HHSA
Dan Fesperman, CHIP
Jeff Dziedzic, Healthy San Diego
Shelley Tregembo, LWSD
Rosa Ana Lozada, Harmonium
Carey Riccitelli, HHSA
Darrin Brant, NCHS

Staff & Consultants Present:
Kitty Bailey, BTSD
Elizabeth Bustos, BTSD
Alaina Dall, Consultant
Cheryl Moder, Consultant

Welcome and Introductions
Cheryl welcomed the group and went over the agenda for today's meeting. Introductions were made around the room.

Review Agenda and previous meeting summary
Cheryl reviewed the meeting summary from the August meeting. The meeting summary was approved to be posted to the website.

Updates: ACH Workgroups

- Data & Metrics Workgroup: Alaina Dall reported that the workgroup has been developing secondary indicators for each of the protective factors. After identifying secondary indicators for wellbeing and nutrition, the group is now considering secondary indicators for physical activity and healthy weight.
- Community Resident Engagement Workgroup (CREW): Elizabeth Bustos reported that the workgroup meets monthly on the second Thursday of each month and that all Collective Action Workgroup members have an open invitation to attend. The CREW workgroup's draft charter was presented to the SD ACH Stewardship Group, where a robust discussion about equity led to a request for further consideration and clarification by the workgroup.
- Sustainability and Wellness Fund: Kitty Bailey reported that the workgroup last met in July, at which time they discussed a budget for the backbone organization and using the POI to create a value case for potential funders.
- Stewardship Group: Kitty Bailey reported that at the August meeting, the group reviewed and adopted partnership guidelines for the Stewardship Group. This document will eventually be expanded to include partnership guidelines for all workgroups. The group also reviewed the CREW draft charter (see above).

Presentation: "Ideal" Portfolio of Interventions

Cheryl presented for discussion an example of an "ideal" portfolio of interventions (POI), which included possible interventions for all eight protective factors by ACH domain (see below). Questions/comments included:

- Are all interventions evidence-based?
- For clarification, include "Examples of" in the heading
- Include behavioral health services, which incorporate mental health *and* substance use disorder
- How will we visualize this document for the greatest impact?
- Consider programs that focus on prevention vs. intervention
- Focus on the need to provide resources to community residents, quality of life, and wellbeing
- Consider the relationship between the interventions and identified primary and secondary indicators as one way to prioritize interventions

"Ideal" Portfolio of Interventions

Accountable Communities for Health

Cardiovascular Protective Factors

SD ACH Domains		Blood Pressure	Blood sugar	Cholesterol	Smoking	Physical Activity	Nutrition	Healthy Weight	Wellbeing
	Clinical	Blood pressure management in clinical settings (e.g., PCPs, FQHCs, hospitals)	Blood sugar management in clinical settings	Cholesterol management in clinical settings	Smoking cessation programs	Prescriptions for physical activity	Screening for food insecurity in clinical settings	Weight management programs for children and adults in clinical settings	Mental health services in clinical settings
	Community	Blood pressure screenings in community settings (e.g., faith centers, workplaces)	Blood sugar testing in community settings	Cholesterol testing in community settings	Tobacco education in community settings (e.g., schools, faith centers)	Physical activity programs in community settings (e.g., walking clubs, Zumba)	Food assistance enrollment and nutrition education classes in community settings	Cooking classes and physical activity programs for children and adults in community settings	Stress management programs in community settings
	Clinical-Community Linkages	Referrals for blood pressure management from community to clinical settings (e.g., community health workers, 2-1-1)	Referrals for blood sugar management from community to clinical settings	Referrals for cholesterol management from community to clinical settings	Referrals for smoking cessation from community to clinical settings	Connections between clinical providers and community-based physical activity providers	Referral for food assistance and/or nutrition education from clinical to community settings	Referral for weight management from community to clinical settings	Depression screening and referrals from community to clinical settings
	Policy, systems or environmental	Enhanced opportunities for physical activity (e.g., walking paths, sidewalks)	Policies that limit access to sugar sweetened beverages	Enhanced financing for full-service grocery stores in underserved neighborhoods	Policies that prohibit smoking in public settings	Joint use of physical activity settings (e.g., parks, school playgrounds, walking tracks)	Healthy nutrition standards for foods served in government and institutional settings	Adoption of farm to institution programs (e.g., schools, preschools, hospitals)	Policies and adequate financing that support parity between physical and mental health

Note: This table presents examples of components of a portfolio of interventions that, when balanced by the lenses of health equity and implemented in alignment, can lead to greater impact on cardiovascular disease, population health, and wellness.

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Presentation: SD ACH survey results

Cheryl reviewed the results of the community survey. Highlights include:

- After focused outreach by workgroup partners, 79 organizations reported on 109 programs, most from non-profit, community-based organizations.
- All regions are represented.
- Nearly all programs serve all races/ethnicities and genders; nearly half serve populations of low socio-economic status.
- Over half of programs serve all age groups; of those programs that serve a specific age group, most serve adults.
- Most programs utilize one or more evidence-based factor in program design.
- In terms of data collected to demonstrate program impact, most programs collect process data (e.g., numbers of participants) or survey/evaluation data (e.g., pre- or post-tests, satisfaction surveys) vs. outcomes data (e.g., demonstrated changes in clinical measures or health behaviors).
- The majority of respondents indicated an interest in aligning their programs with others, both within and outside of their sectors, and adopting new shared measurement systems; nearly half are interested in sharing program outcomes data with SD ACH.
- Respondents indicated wanting to develop new partnerships with community-based and clinical organizations.
- Identified areas of support needed by respondents include new opportunities to build relationships with other organizations; resources about collective impact; and assistance with data collection, reporting, and sharing.

Presentation: POI Framework:

Cheryl and Kitty reviewed the framework and four dimensions of the portfolio of interventions for input:

- **Balance** across all domains, protective factors, regions, ages, populations, time to impact, etc.
- **Mutual reinforcement** including data sharing and progress toward identified indicators
- **Strong, high quality** programs that are strengthened by support, training, and technical assistance
- **Accountable** to the community

Discussion: Next Steps in developing the POI

Kitty reminded the group of the SD ACH's dual approach, which includes both countywide and more focused regional approaches. She mentioned that three of the four dimensions (mutual reinforcement, strength of programs/capacity building, and community accountability) are focused at the county level, while balance may initially require a more focused approach. Cheryl proposed testing a model of achieving balance on a smaller scale by prioritizing one geographic region and protective factor, identifying gaps, and convening partners to develop and implement strategies. The group agreed to revisit and further discuss this concept at the October meeting.

Next Meeting

The next meeting will be on October 4, 2:00-4:00 p.m.