Three Steps to a Healthy Heart Community: A Toolkit for Change through Collective Action

A Project to Implement the CDC 6|18 Initiative Hypertension Control Strategies

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POPULATION HEALTH INNOVATION LAB

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INTRODUCTION

Heart disease is the leading cause of death in the United States and stroke is the fifth.[1] All cardiovascular diseases contribute to about 800,000 deaths each year.[1] **A key risk factor for heart disease and stroke is hypertension, or high blood pressure.**[2] Hypertension is common, however, hypertension control is not.[3] Nearly half of all American adults, 108 million people, have hypertension, but only about 1 in 4 have their condition under control.[4] In 2018, hypertension was a primary or contributing factor in close to half a million deaths.[5]

Hypertension costs $131 billion each year – for individuals, employers, and communities – making it the "costliest of all cardiovascular diseases."[6] Annual health care costs for people with hypertension are roughly $2,500 more than for those who do not have the condition.[6] Hypertension-related absenteeism costs employers more than $10 billion annually;[7] and hypertension is projected to reduce productivity for paid and unpaid work by over $35 billion by 2025, impacting employers, families, and communities.[8]

Hypertension is a preventable or treatable condition. The Centers for Disease Control and Prevention's (CDC) 6|18 Initiative provides a set of evidence-based strategies to improve hypertension control. Achieving widespread community implementation of these strategies would likely take many partners working together and new tools may accelerate this implementation as the world shifts from individual actions to collective action.

This *Toolkit for Change* is designed for change agents in businesses, public health, healthcare, and community organizations who are committed to working together toward common goals. It is a starting place for those interested in making an impact on their community's heart health.

INTRODUCTION

This Toolkit for Change will 'step' you through three phases that can be used in developing an effective community action collaborative. It provides resources and guidance on selecting "best practices" for hypertension control and making the "business case" for their adoption. We share experiences from successful community collaboratives who are also tackling heart health strategies and provide further resources to also help you as you get started. The information is offered to launch you on the path to success in working collectively to improve the health and well-being of your community.

- Step UP covers foundational steps of establishing a community action collaborative and includes tools and resources, as well as case study examples.
- As the collaborative shifts to 'doing the work,' Step IN covers topics including data collection, establishing your vision and purpose, developing goals and outcomes, and choosing interventions.
- Once a heart health-focused collaborative is ready to Step OUT, we cover plans for evaluation and implementation, financing and doing the work to main strategies over time, as well as revisiting core collaborative practices.
- We have also included a separate section on Understanding the Economics & Value of Hypertension Control. This section focuses on the language of economic evaluation of community health investments.

INTRODUCTION

Approach: Before we developed this Toolkit, we interviewed key informants from businesses, health plans, providers, and nonprofit organizations. Quotes and thoughts from the interviewees frame many of the content sections. The broader approach to this work is informed by theories proven successful for implementing collective community action. This Toolkit provides change agents with the practical tools, resources, and information they can use to improve population-level health and well-being.

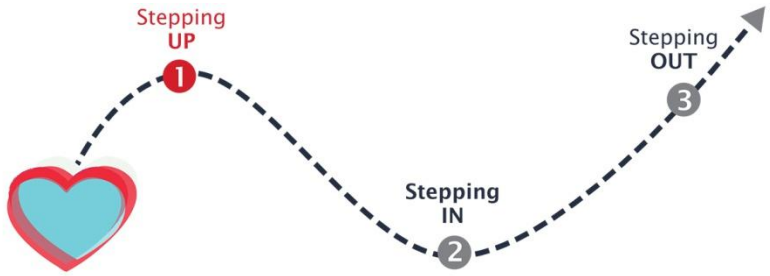
Why do collaborative efforts in public health sometimes fail?

This Toolkit was created with the two of the most common collaborative pitfalls in mind:

- It is difficult to work beyond different sector, organization, and department silos; and
- The collaborative does not fully tap into what its stakeholders have to offer (in terms of experience and wisdom).[9]

We try to help you avoid these pitfalls by demonstrating how you can take a 'systems approach' to your work, with many partners working together to develop, agree and support a set of mutually reinforcing interventions. We hope you will find this Toolkit for Change useful as your community collaborative tackles heart health.

Let's get started!



1 STEP UP

So, you're ready to **Step UP** to community action to improve heart health? Let's start with foundational steps and some real-world examples. We will also give you tips and resources to get started along the way.

Our goal is to enable you to create an environment that encourages everyone's participation.

This step can help you define, adapt, and evolve your collective by covering the following topics:

- Backbone Organization
- Operating Principles
- Mental Models
- Communication
- Identifying Partnerships

1 STEP UP: Backbone Organization

To me, once we have that backbone [organization], I think then we can lead to more positive change. I think that's one of those key steps regarding any collaboration that involves more than one organization or organizations of different motivations and/or missions, is understanding what that common charter is.

—Key Informant from the Health Care Sector

AT-A-GLANCE

A backbone organization facilitates and creates collective community action by managing its day-to-day operations. We show you two backbone organizations for heart health collaboratives and offer suggestions on how you can create a backbone organization, establish roles and responsibilities, and set up an infrastructure to support operations.[9]

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1 STEP UP: Backbone Organization

DEFINE

The backbone organization facilitates collaboration among partners. Their role is to coordinate and manage the day-to-day operations and implement collective community action. The backbone works in partnership with all members.[9]

APPLY

> ***Heart of New Ulm:*** *The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project.[10] The Project Manager was interviewed for this case study.*

Initially, the Minneapolis Heart Institute® provided the Heart of New Ulm coalition with funding for staff to serve in a backbone capacity. The Heart of New Ulm Project Manager described the importance of having a backbone organization to support their coalition.

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As she put it:

> *…"you absolutely need a full-time facilitator that works on the project to keep the agenda moving forward, to provide the updated science on what's happening, to help frame up some of the issues, to help train and build capacity of community members and help with some of the communications – so you need a full time staff person."*

The coalition and backbone staff began planning to look ahead for how the coalition would change over time. In 2012, the Project Manager began to focus on transitioning a 36-person coalition Steering Committee into a 12-person Leadership Team – with a stronger focus on "doing the work." The Project Manager and the Steering Committee members developed clear roles and responsibilities for the Leadership Team and selected new committed team members. Eight years later this backbone structure is still in place because members of the Leadership Team all have the "skillset to lead at the table," and are willing to do the work to maintain the project over time.

***Blood Pressure Collaborative**: In 2009 the Rochester Business Alliance (RBA) with an interest in health care partnered with Finger Lakes Health System Agency (FLHSA) to form the Blood Pressure Collaborative – a multi-stakeholder coalition – to address hypertension control in Monroe County, New York. Additional details about this case study can be found here.*[10]

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1 STEP UP: Backbone Organization

The Rochester Business Alliance (RBA) created the RBA Health Care Team (RBAHCT) in 2006. Over the span of three years, the RBAHCT consulted with the community and others before deciding to focus on high blood pressure. In 2009, the RBAHCT identified the Finger Lakes Health System Agency (FLHSA) as its backbone organization and formed a collaborative. This multi-stakeholder coalition included "employers, providers, insurers, labor, community organizations, the United Way, and minority consumer coalitions affiliated with the FLHSA."[11] The RBAHCT's decision to identify a strong convener – the FLHSA – to serve as the backbone organization laid the foundation for their collaborative work on hypertension control.

EVOLVE

The Heart of New Ulm and the Blood Pressure Collaborative of Monroe County both enlisted backbone organizations as their first step on the path to improve heart health. Here are a few suggestions on how you can get started:

Identify a backbone organization: Collaboratives have found that backbone organizations emerge in several different ways.[9] For example:

- The backbone organization may be one of the initial organizers and serves as the "caller" to the community asking them to operate in this new collaborative way.
- The collaborative chooses a community organization to serve as the backbone through a transparent selection process.

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1 STEP UP: Backbone Organization

- Collaboratives that begin with two organizations pairing together choose one to serve as the backbone. This model sometimes is employed when a funding organization partners with an implementing organization to begin a collaborative project.

TIPS

During your initial exploration of community heart health projects – **whether you are a business or a community organization** – one point of practice to consider is learning about existing efforts. To start, you may want to contact your state or local public health department, the American Heart Association, your local chamber of commerce, and any business group or economic development council with health as an interest.[12] It may be that there is a local group or collaborative who has already come together to work on heart health.

Roles and responsibilities:

Once you have decided upon a collaborative project and identified a backbone organization, identifying and agreeing upon roles, responsibilities, and expectations is a useful next step to foster unity and create operational governance. Here are seven key functions of backbone organizations – you can choose from this list or generate your own.[9]

Key functions of a backbone organization often include:

- Support Facilitation of Partnership & Leadership
- Support Vision & Strategy
- Support Aligned Activities
- Establish Shared Measurement Practices
- Advance Policy
- Build Public Will
- Mobilize Funding & Resources

Infrastructure:

A successful collaborative requires strong organizational support for its overall operations. The backbone organization provides the operations and communication support for the work throughout the various phases of the project. This guide to Operations and Communications Tools offers a variety of tools, platforms, and services that are useful in supporting the operations of the backbone organization.[9]

Form a Design Team:

Forming a Design Team to support the collaborative's launch can provide context, perspective and experience that the backbone staff may not have. Creating a design team early on can help with a successful collaborative launch. You can use this tool to help form your design team.[9]

Engage with the business community:

Engaging with the business community early in the design of your collaborative can create useful opportunities. You will be better able to understand their interests, take advantage of their financial expertise, and recruit business sector partners.[13]

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1 STEP UP: Operating Principles

Like any public health collaboration, there needs to be mutual respect; building up of trust so that we don't step into something where we say one thing but what we give to the public is very different. I think that there is a need for transparency, continued dialogue as well as a set understanding of what the expectations are from the different organizations and how they are going to contribute.

—Key Informant from the Health Care Sector

AT-A-GLANCE

Operating principles are shared agreements on how collaborative members want to function and interact with each other.[9] This section provides an example of operating principles, practices for forming your own, and several tips to keep in mind.

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1 STEP UP: Operating Principles

DEFINE

Operating principles are agreements the group creates together on how they want to interact with each other. This is an important practice to complete as you begin your work.[9] Operating principles may need to be revisited during the partnership to reflect changes in the agreements along the way.

APPLY

Hearts of Sonoma County: is an initiative of Sonoma Health Action, a multisector collaborative working together to improve health and equity in Sonoma County, CA. The goal of Hearts of Sonoma County is to reduce heart disease by focusing on clinical and community prevention of cardiovascular disease. Here are some additional details about this case study.[14]

As Hearts of Sonoma County is an initiative of Sonoma Health Action, a multisector collaborative working together to improve health and equity in the county, the Sonoma County Department Health Services provides the backbone staff and its director co-chairs the collaborative. The collaborative has developed well defined roles and responsibilities, which are described here.[14]

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Backbone staff members are developing a plan to maintain the project over time and have formed a Wellness Fund Development Team to assess options for financial stability.[15] Although the initiative has since evolved, at the first team meeting, members created a set of "Team Operating Principles" to spell out what contributes to a strong team and their aspirations. Operating principles from this meeting are noted:[16]

- Sense of urgency
- Clear purpose and desired outcome
- Backbone support, i.e., someone who tracks and prompts the work
- Clear structure for how decisions are made
- Accountability and follow through
- Relationship building, i.e., happens through travel, 1-1 coffee, non-meeting dialogue, food, and drink
- Diverse group, i.e., roles of visionary, bean counter, safety, and space to share
- Trust
- Homework with no more than 2-hour meetings

EVOLVE

The Hearts of Sonoma County case study demonstrates that operating principles do not have to take a specific form. As a starting point, you may want to consider using this tool to ***create operating principles*** for your community collaborative.[9]

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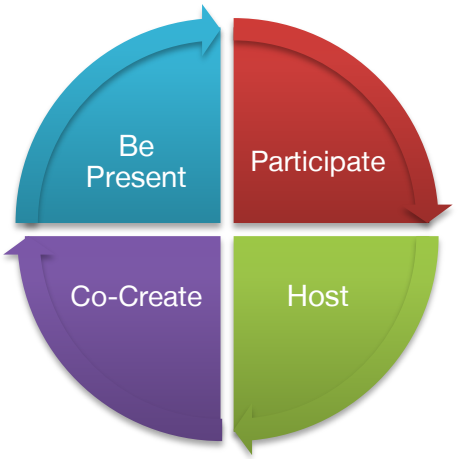
1 STEP UP: Operating Principles

Four Fold Practice:

The Four Fold Practice can help create operating principles for working with collaborative partners.[17] This video explains it in more detail.[18] The practice is grounded in the idea that quality conversations lead to close teamwork and wise action arises when four conditions are met:



TIPS

Simplicity: Sometimes operating principles can be made more complicated than necessary. Keep sight of what you are doing and recognize that people are learning and absorbing information along the way. This may take time.[9]

Three concepts that can foster simplicity:

1) Let go of trying to be perfect - by doing so it may make things more complicated.
2) Create deadlines for tasks to increase likelihood of getting it done.
3) Accept that you do not have to have it all figured out.

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Transparency: Establishing operating principles may also help your collaboration operate with transparency. This builds trust among with partners. Here are some transparency tips to consider:[9]

- Share information regularly and quickly with partners.
- Provide the full information and background. Tell the whole story – even if it is not good news.
- Post meeting minutes, decision making processes, decisions, and budgets online, or in an accessible format.
- Craft communications for different audiences as each may perceive information differently – understanding that all partner perceptions are important.
- Employ a team to plan transparent meetings and practice distributed leadership.

Listening: Change work requires participants to **deeply listen** to fully hear **diverse perspectives**, even when seemingly opposing viewpoints are present.[19] You may also want to watch this video on Four Levels of Listening and Talking, or refer to this one-page framework.[9,20]

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1 STEP UP: Mental Models

Your beliefs become your thoughts, your thoughts become your words, Your words become your actions, your actions become your habits, Your habits become your values, your values become your destiny.

—Gandhi

AT-A-GLANCE

"Mental models" are the assumptions and beliefs that people develop over time and bring into the collaborative. If identified early, they have the potential to improve collaboration and better impact change.[9] This section shows how one Heart of New Ulm staff member identified mental models of Steering Committee members, and offers tips on how you can become more aware of your own thinking and reasoning, and how you can inquire into that of others.

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DEFINE

Mental models are the assumptions and beliefs people develop from their experience. Our own mental models influence the ways we interpret the world. A diverse group of people who come together for a specific purpose will bring different perspectives and viewpoints. This can provide both opportunities for growth and challenges for cooperation. Differences in assumptions and beliefs are important to identify to improve collaboration and avoid problems.[21]

APPLY

Heart of New Ulm: The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project. We interviewed the Project Manager for this case study. [10]

A few years into the Heart of New Ulm project, a backbone staff member interviewed every Steering Committee member to assess their 'mental models.' This staff member discovered that about half of them supported the project because it was a hospital-based program and they wanted to support the local hospital. The other half believed that they had a responsibility to help with the health of the community.

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This insight prompted a shift from a 36-member Steering Committee format to a much smaller Leadership Team based on a shared understanding that Heart of New Ulm benefited the entire community.[11]

EVOLVE

The experience of the Heart of New Ulm backbone staff's assessment demonstrates the importance of assessing assumptions and beliefs over time, but it is particularly useful in the beginning phases of the collaborative. When multiple individuals come together, there are likely to be different viewpoints on the problem.

As a starting place, some suggestions can be found here and include:[22]

1) Become more aware of your own thinking and reasoning.
2) Share your thinking and reasoning with others.
3) Ask about other's thinking and reasoning.

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TIPS

Examining Biases: You can use this tool to examine existing biases. The more aligned partners are in language and understanding, the easier it will be to move forward.[23]

Pivot: It is not uncommon for groups to come together around one issue and as they learn more, the scope of their project may change. For example, the group may not have considered exploring the root cause of heart health in the community, but once they dig into the root causes, their understanding changes and may be different than what they originally thought. Learn how to discuss this in a group and to pivot when necessary. For more information watch this video on Learning to Pivot and read this article on How and When to Pivot, which includes the following 5 rules for executing a successful pivot. [24,25]

5 Rules for Executing a Successful Pivot				
Have an idea compost pile.	Know your customers, not just their statistics.	Fail earlier, more cheaply, and more often.	Build a customer focused culture, not a product focused one.	Don't survive mediocrity.

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1 STEP UP: Communication

Just having a conversation with my partners, my counterparts at different organizations is difficult because there is so much intricacy in terms of bureaucracy for 'this is my'… The firewalls we put at our organizations that keep us from having simple conversations … I'm looking for the ability for conveners or organizations that can help bring these groups together so we can have a conversation in a safe space, and then work together. Even though outside of that, that wall or the Zoom we're involved in, we may have competing areas. That is what I'm seeing right now as a challenge.

—Key Informant from the Health Care Sector

AT-A-GLANCE

This section provides tools and guidance for identifying your audience and creating a communications plan for your collaborative.

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DEFINE

As you form your collaborative, spending time identifying audience and understanding each audience's perspective on the issues you are addressing can help you more effectively communicate the work of the collaborative.[21]

You may need to identify **several key factors** before you begin to design your strategy.

These include:[9]

- Goal, or the reason you are sharing this information with others
- Audience
- Message
- Audience's reaction to this communication

APPLY

***Heart of New Ulm**: The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project. We interviewed the Project Manager for this case study.*[10]

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1 STEP UP: Communication

The Heart of New Ulm collaborative identified communication between public health and local businesses as an initial challenge. After recognizing and addressing the issue, the coalition was successful at identifying strong business partners within the local community. As their Project Manager told it:

> *That's one of the challenges, and also in the literature, you have to view health as a shared value, but how you get there… I think it's learning how to speak your partner's language. So when I go talk to a business, I don't throw health out there as a top priority and say, 'You ought to care about it.' But [instead] 'What is it that you care about within your business?' I take that information, find out what motivates them and try and wrap health around that. So, how does health support your motivation? How will health help you get to your ultimate goal? That's how I talk about health, and how we talk about health when we meet with our partners. I think that's what helped bring them to the table.*

The next step addresses, in detail, communication between public health organizations and businesses.

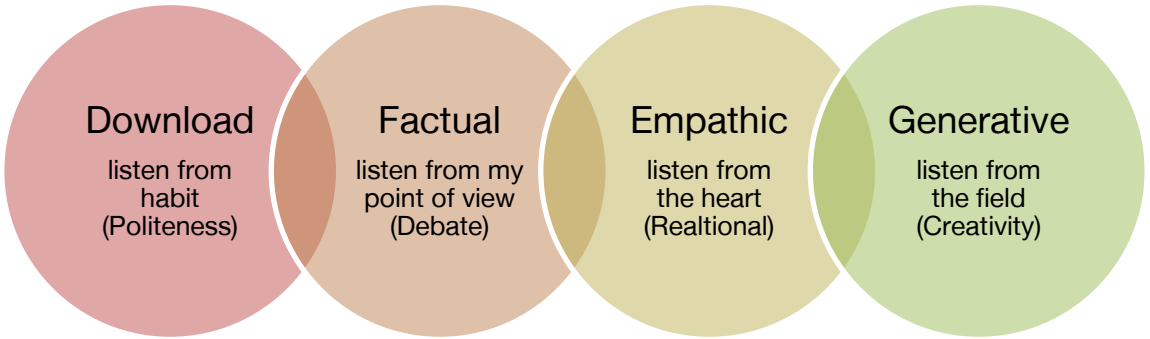
EVOLVE

Communications Plan: Common steps to creating a communications plan include identifying your target audience(s), talking points and channels to distribute your messages and methods to evaluate the effectiveness of your communications plan.

TIPS

You can use this Strategic Communication Tool for starting to create your communications plan.[9]

Regularly returning to the Four Levels of Listening facilitates understanding of different perspectives.[9]



Business and public health often speak different languages. You may want to work with your business partners to craft communications that will make sense to the business sector. The separate section on Understanding the Economics & Value of Hypertension Control can help with communicating economic information about your collaborative's projects.[13]

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1 STEP UP: Communication

Diverse partners may have different languages and ways of operating. This diversity may cause confusion and misunderstandings. Taking a minute can ensure that everyone means the same thing when talking about certain terms or issues. Consider the following steps to facilitate these efforts.[9]

- Develop a common language for the group to keep dialogues clear and comprehensible.
- Create a space during team meetings to discuss and define terms and come to agreement on shared definitions.
- Use simplified language throughout processes to ensure they are inclusive.
- Capture the defined words and keep them in a space, like a created shared glossary where others may refer to them when needed.
- Share assumptions made when defining shared terms and language.

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1 STEP UP: Identifying Partnerships

The voice of those impacted by the problems are often not included when evaluating challenges and creating solutions.

—Key Informant from the Health Care Sector

AT-A-GLANCE

A collaborative, by definition, brings together two or more partners to work toward the same goal. This section offers tools to help you identify potential partners.

DEFINE

Collaborative partnerships often involve diverse stakeholders with multiple perspectives. Partners work together to find holistic solutions.[26]

Their influence encourages:

- Listening with intention to perspectives;
- Being willing to have one's point of view challenged;
- Seeing, together, solutions that nobody could have seen on their own.[9]

APPLY

> ***Blood Pressure Collaborative**: In 2009 the Rochester Business Alliance (RBA) with an interest in health care partnered with Finger Lakes Health System Agency (FLHSA to form the Blood Pressure Collaborative – a multi-stakeholder coalition – in order to address hypertension control in Monroe County, New York. Additional details about this case study can be found here.*[11]

The Rochester Business Alliance (RBA) in forming the Blood Pressure Collaborative in Monroe County, looked outside of the 'usual' partnerships.[11] They took the initial and important step of bringing in a backbone organization with a history of community work. This facilitated the inclusion of other change agents – partners who strengthened and diversified the group – all while remaining focused on their collective commitment to the community. As Bisognano et al. (2012: 178) note:

> *This project is unique in that the stimulus and funding for community-wide action came from the business community through the Rochester Business Alliance. They saw beyond the often unsuccessful short-term cost reduction programs and joined with a community-focused organization, the Finger Lakes Health Systems Agency to construct a multi-year, multifaceted intervention designed to encourage practice redesign and an invigorated community commitment to partnership and accountability.*[11]

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In the case of the Blood Pressure Collaborative in Monroe County, the collaborative demonstrated the importance of creating partnerships with multiple perspectives and diverse stakeholders.

EVOLVE

As you look for **change agents** as potential partners, change agents may emerge from community groups, local businesses, public health organizations, health care providers, health plans, and other groups.

Partner Identification: This tool and this tool can help you identify potential partners for your collaborative.[9,27] As you are looking for partners with diverse viewpoints and stakeholders who are willing to work toward the same goal, this process may necessitate the application of different strategies to identify, convene and support these partnerships – including community engagement and outreach to both traditional and non-traditional partners.

Partner Mapping: Partner mapping exercises can help identify potential partners, and assess the strength of potential relationships between actors, organizations, and institutions within a network. You may want to consider the role of your collaborative in your community, just as the Blood Pressure Collaborative did. A good starting point is to list all of the key influencers in your community.[21] Check out this article on Guide to Actor Mapping for more information; and you can use this tool to map stakeholders.[9,28]

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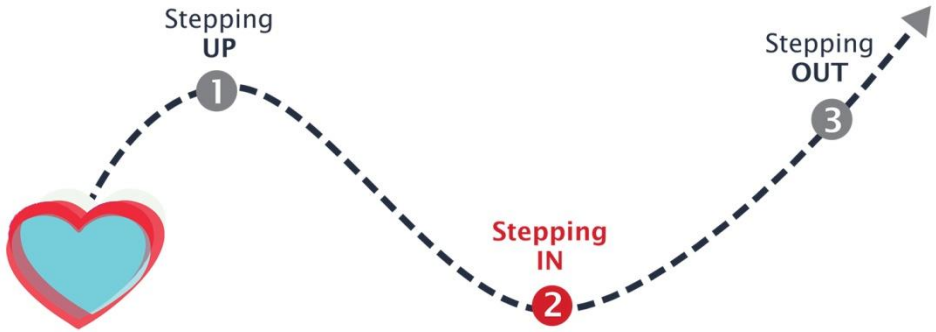
TIPS

Examining Biases: This tool can be used to examine existing biases.[29] The more aligned partners are in language and understanding, the easier it will be to navigate forward.

Now you are ready to move to the next step!



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2 STEP IN

So far, we have covered foundational steps to Step UP.
Now it is time to **Step IN** to the work itself.

ARE YOU READY TO STEP IN? If you are coming to this Toolkit for Change already having formed a collective project, this step is your likely starting point. Take a moment to reflect on three key elements of a collaborative before you begin:

- Is my collaborative working beyond the different silos of sectors, organizations, and departments?
- Does my collaborative fully tap into what stakeholders have to offer in terms of experience and wisdom?
- Are we setting the space for a participatory environment?

These are hard questions, and the process of forming a collaborative is never really done. Revisit the first step if you need additional support while you continuously work to improve the heart health of your community.

This next step will cover the following topics:

- **Know Your Community**
- **Establish Your Vision and Purpose**
- **Develop Goals & Outcomes**
- **Choosing Interventions**

2 STEP IN: Know Your Community

…let's partner and stakeholder with the community around this whole notion of metrics. Community is totally there in terms of wanting measurement and so forth. That's not the issue. The issue is, to have a voice in choosing their metrics, they need to understand and make clear what's relevant to them, what they need to see improved and have a dialogue around that and then agree on the metrics. I just think it's so important to have focus, work a group of metrics rather than trying to be wildly broad based.

—Key Informant from the Health Care Sector

AT-A-GLANCE

Data are the collection of various facts, and include numbers, words, measurements, and observations, or just descriptions of things. This section provides definitions for two types of data – quantitative and qualitative – and provides tools and tips that can assist in measuring your collaborative's progress and impact.

DEFINE

This section provides an overview of different types of and approaches to data collection.

Data are the collection of various facts, and includes numbers, words, measurements, observations or just descriptions of things.[30] There are two types of data: quantitative data and qualitative data.

- **Quantitative Data**: Usually numeric data or information that can be converted into numbers. For example, the number of people who have cardiovascular disease in a county.
- **Qualitative Data**: Usually descriptive and conceptual information, which may be categorized by properties, themes, and other identifiers. For example, survey feedback from community health workers about their training experiences.

Data collection is integrated as part of the collaborative's operations and it involves tracking and monitoring current and emerging trends in your disease focus area (in this case, cardiovascular disease) and its related risk factors.[27] Collecting these data allows a collaborative to assess the incidence, prevalence, and risk factors of hypertension, and to identify effective approaches for detection, prevention, control of the disease. Data allow you to monitor and assess progress toward key program goals.

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A data collection and management plan is often included in the evaluation plan. Data collection and management plans are often required by government funders and are used to assure privacy and confidentiality of information.[30]

Health system partners can be helpful in developing the collaborative's data collection and management plans and have Institutional Review Boards (IRB) to assure that plans protect the rights and welfare of any individuals from whom data are collected.

APPLY

***Blood Pressure Collaborative**: In 2009 the Rochester Business Alliance (RBA) with an interest in health care partnered with Finger Lakes Health System Agency (FLHSA) to form the Blood Pressure Collaborative – a multi-stakeholder coalition – in order to address hypertension control in Monroe County, New York. Additional details about this case study can be found here.*[11]

From the beginning, the Blood Pressure Collaborative of Monroe County adopted a data-driven approach to their project. The backbone organization, FLHSA, developed and managed the data process. The team began by collecting baseline information on community demographics, paying special attention those that affect hypertension.

They captured specific heart health indicators including:

- Rates and numbers of hospital admissions for heart attacks, heart failure, and stroke.
- Proportion of residents with high blood pressure.
- Costs of healthcare per person with high blood pressure per year.

The collaborative used these data to generate a community report and a community-wide survey. They over sampled certain populations that appeared to be the most at risk. The information generated by these data activities helped shape the focus of the collaborative's implementation plan. This case study demonstrates 'knowing your community' through the use of strategic data collection to target next steps for greatest impact.

EVOLVE

Two key questions to consider as your collaborative 'steps in' to data collection:[30]

- What data sources are available to assess your community's current status and its needs?
- How will your collaborative measure progress? What metrics should you use?

Here are some data collection approaches to consider:

Use the Asset-Based Community Development (ABCD) approach: This approach considers local assets to be the primary building blocks for developing strong, sustainable communities. Communities have the ability and power to drive change themselves by identifying and mobilizing existing, but often unrecognized assets. This tool can be used by collaboratives to identify community assets.[31] This video explains more about the ABCD approach.[32]

Engage with Community Health Needs Assessments (CHNA): The Patient Protection and Affordable Care Act of 2010 requires non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years.[33] Community input is gathered as part of the CHNA to help determine local needs. Your collaborative could explore the opportunity to engage in the process and help shape the CHNA. This presents a valuable opportunity to collect the data the collaborative needs before identifying goals.

- A starting point is learning when the community health needs assessment is set to be redone or has been completed in your community using the Community Benefit Insight Tool – also a resource to learn more about your local non-profit hospital CHNA.[34]
- If the local non-profit hospital is not part of your collaborative, consider setting up a time to meet with the Community Benefit Coordinator to review the CHNA and how investments are being directed. You can use this tool in your meeting to help assess alignment between the hospital and collaborative.[35]

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Consider recruiting your local nonprofit hospital as a partner in your collaborative. For example, Healthy Savannah, a health coalition in Savannah, Georgia, managed the community input process for their local hospital's CHNA.[36] The local hospital was also a member of Healthy Savannah.

Form a data subcommittee: Another strategy is to form a data subcommittee within your collaborative to track and monitor data. This group would also be responsible for reporting progress to the larger collaborative.[9] For example, the Blood Pressure Collaborative of Monroe County formed the metrics and measures work group to track the progress of their hypertension initiative.

Establish a shared metrics system: It can be useful to obtain community input in the selection of metrics for the collaborative's interventions. Your measures should ideally reflect both interventions and infrastructure and process and outcome, and should also be relevant and understandable, measurable, and operational.[30]

Measures extend beyond those for tracking interventions and can also be used to assess the effectiveness of the collaborative. Regular review of these indicators can demonstrate the value of the collaborative.

As such:

- The **backbone organization may want to consider effectiveness measures** or key performance indicators that demonstrate the collaborative's value and operational effectiveness. This can contribute to the organization maintaining the effects over time.[9]
- Collaboratives may **wish to track the backbone organization's performance**. They can set certain targets and the indicators based on operational objectives.

Other Ways to Get to Know Your Community and What Matters to Them:

Understand your community's health system:

- **What health insurance options are in your community?** This knowledge may help inform the role that health insurance will play in your hypertension initiatives or whether types of insurance coverage may present a barrier to action. Around half of Americans receive health benefits from their employer.[37] Does this apply to your community?
- **Understand where the community seeks health care.** This includes identifying healthcare providers and where are they located. Are there nonprofit hospitals in your community? Which providers are part of larger health systems? Who are the decision makers for clinical care practices?
- **What does the clinical community look like?** This includes pharmacists, community health workers, nonprofit organizations, schools, employers with on-site health activities, and the faith community. Many hypertension interventions involve these partners.

- **Locate and map the assets of the community that impact health.** These might include the transportation systems, parks, grocery stores, and other elements of the community environment.
    - Community Commons is a potential resource for community asset mapping.[38] Tools like the Build Environment Assessment Tool may help you measure things that impact health in your community.[39] The Food Environment Atlas may help map community-level statistics on where residents obtain their food.[40]

Understanding and mapping your local health care system can help your collaborative identify key decision makers and influencers.[9] You may wish to consider recruiting these partners for your collaborative.

Understand You Community's Business Environment: Business leaders in your community may become some of your strongest partners. Many feel a strong civic responsibility and a healthy workforce improves their bottom line. The community are the consumers for their products and services, their future workforce, and a draw for recruitment. The community is their home and businesses often want to help improve its health and well-being. For example:

- Some businesses are members of coalitions aimed at improving employee health and well-being such as a "business groups on health." For example, the Memphis Business Group on Health (MBGH) is a coalition comprised of local business owners that work together to better manage both the cost and quality of employee health benefits.[41]

- "How to Build a Successful Employee Health Program" is another example, and resource, that gathers lessons learned from top Nashville area companies interested in the interaction between health and business.[42]
- For more on this topic, also see the separate section on **Understanding the Economics & Value of Hypertension Control**.

Businesses directly impact the health of their employees, and they have a role in selecting and shaping insurance policies. Community health can have a direct impact on business's health care costs and premiums.[43] To **assess the business environment in your community**, here is one place you can start:[13]

- Reach out to business leaders with whom you already have connections. Which have supported local causes?
- Talk to the local Chamber of Commerce. Who are the large employers? What type of employment predominates in your community? Manufacturing, services, farming?
- Find out who does the local business forecasts for your county's governing body. We use the term 'governing body' here as they are termed differently in each county. It could be a board of supervisors, for example. Regardless of what they are titled, these governing bodies look at possible economic conditions at the county-level for the upcoming year on an annual basis. To do so, they look at things such as economic growth rate, unemployment, and other indicators.

- Talk to your local Economic Development Agency about actions they are taking to attract new businesses to your community. You may want to get their thoughts on how improving the health of your community would make it a more attractive place for businesses to locate.

Identify key business leaders and explore their interest in health and their community. You may want an opportunity to meet with organizations where you can get to know them better such as the local Rotary Club. You can meet with them or invite them to a "meet and greet" with your collaborative. Such an event may present an opportunity to ask about their involvement in and support of local health initiatives.

TIPS

You can also get information from online governmental resources including U.S. Census data, information from the U.S. Bureau of Labor Statistics, the U.S. Department of Agriculture, and the U.S. Department of Commerce.[44]

Businesses and community health success go hand-in-hand. Read more about this topic in two reports:

"Good Health is Good Business," released by the de Beaumont Foundation and learn strategies for businesses and community organizations to work together.[13]

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2 STEP IN: Know Your Community

"Community Health and Economic Prosperity: Engaging Businesses as Stewards and Stakeholders,"— a report of the Surgeon General released by U.S. Department of Health and Human Services with *recommendations for how businesses can address the U.S. health disadvantage by engaging with and investing in communities, while creating value, lowering business costs, and improving the health of employees and other stakeholders.*[45]

Business leaders and public health officials often use different languages. This is never more apparent when discussing financing and productivity.[13] We have provided a separate section on **Understanding the Economics & Value of Hypertension Control** in this Toolkit for Change to help bridge this gap.

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2 STEP IN: Establish Your Vision and Purpose

What is the world we are trying to create for local businesses, our children, and the community we live in?

—Key Informant from the Health Care Sector

AT-A-GLANCE

A clear vision can inspire action and draw potential collaborative members to contribute their time, passion, and resources. A clear purpose is developed through a shared understanding of 'WHY' collaborative members are coming together to address heart health. In this way, a clear vision and purpose can be unifying elements of a collaborative.[9]

DEFINE

A vision statement clearly articulates the collective aspiration of your collaborative, and its intended impact on the community.[9] Using the vision to guide decision making, actions and resource allocations follow – helping to keep these intentions at the center.

APPLY

Hearts of Sonoma County is an initiative of Sonoma Health Action, a multisector collaborative working together to improve health and equity in Sonoma County, CA. The goal of Hearts of Sonoma County is to reduce heart disease by focusing on clinical and community prevention of cardiovascular disease. Here are some additional details about this case study.[14]

Sonoma Health Action, the broader health coalition under which Hearts of Sonoma County sits, has taken heart health to be one of their key initiatives. To this end, the goals and outcomes of Hearts of Sonoma County help fulfill the vision and purpose of Sonoma Health Action, as do many of their other initiatives. Sonoma Health Action's vision and purpose is that "Sonoma County aspires to achieve equity and improve health and well-being for all."[46] Sonoma Health Action then coordinates across partners to ensure this is a shared vision and purpose. More on the ways in which the goals and outcomes of Hearts of Sonoma County feeds into Sonoma Health Action's broader vision is described in the following subsection.

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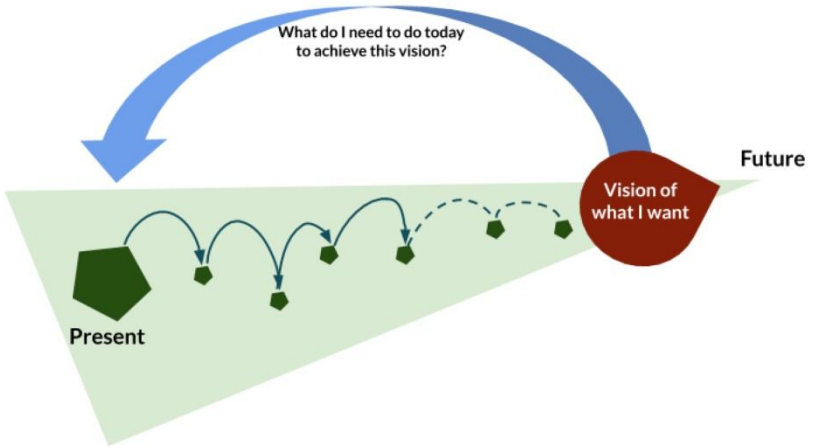
All partners in your community collaborative will likely have different organizational drivers and goals. As you foster relationships across a diverse set of community and professional partners, you can focus on the development of a shared vision and purpose. Formally adopting these statements may be one way to help in identifying goals and outcomes (detailed in the next subsection). Resources below may help guide you in hosting work sessions with your team to co-create your shared vision and purpose.

- Backcasting: This resource describes a technique called 'backcasting' that can be used to articulate a vision and purpose.[9]
- Shared Vision & Mission: See this resource for definitions and examples of vision and mission statements.[9]



Source: Population Health Innovation Lab, Backcasting https://pophealthinnovationlab.org/wp-content/uploads/2020/10/Backcasting.pdf

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2 STEP IN: Develop Goals and Outcomes

The most important step in developing the portfolio of interventions (POI) is having a clear set of goals and knowing what outcomes you want to achieve.

—*Portfolio of Interventions Tool Kit* [47]
Desert Vista Consulting

AT-A-GLANCE

Developing clearly articulated goals, objectives, and outcomes help set the direction of a collaborative. But there are several ways to develop these, and this section can help you select the approach that works best for you.

DEFINE

Clearly articulated goals, objectives and outcomes are the *North Star* for a collaborative's performance, setting the direction for the collaborative's work.

2 STEP IN: Develop Goals and Outcomes

APPLY

Hearts of Sonoma County is an initiative of Sonoma Health Action, a multisector collaborative working together to improve health and equity in Sonoma County, CA. The goal of Hearts of Sonoma County is to reduce heart disease by focusing on clinical and community prevention of cardiovascular disease. Here are some additional details about this case study.[14]

Hearts of Sonoma County was formed as part of Sonoma Health Action's interest in improving heart health in Sonoma County. In Step UP, an early iteration of a set of operating principles for members of Hearts of Sonoma County were detailed, but Hearts of Sonoma County partners later launched the 'It's Up to Us' campaign that spells out three primary initiative goals:[14]

1) Educate the community about cardiovascular disease risk factors.
2) Conduct community-based blood pressure screenings.
3) Link high-risk individuals to primary care to reduce risk of heart attacks and strokes.

These three campaign goals also feed into the vision and purpose of Sonoma Health Action.

Heart of New Ulm: The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project. We interviewed the Project Manager for this case study.[10]

A second example of goals and objectives comes from Heart of New Ulm. Recently, the collective published a Community Health Action Plan for 2020-2022. Based upon a CHNA, they identified three "significant and widespread health issues" and for each listed a series of objectives and outcomes. A sample of this process is to the right.

Source: Heart of New Ulm. A Community Health Action Plan for 2020-2022. https://www.newulm.com/wp-content/uploads/2020/01/HONU-3-Year-Action-Plan-2020-2022.pdf.

1. Healthy lifestyles across the lifespan

Our goal is to support educational programs, activities and policies that help individuals increase access to physical activity and healthful foods, as well as support eating well and active living.

OBJECTIVE #1: Maintain and support the Worksite Wellness Action Team to provide quarterly networking and training opportunities.
• Provide quarterly workplace wellness trainings • Partner with Mental Health and Wellness Action Team to provide resiliency program to local worksites
OBJECTIVE #2: Maintain a team that addresses the safety for walking and biking by making improvements to the built environment in New Ulm.
Continue to prioritize and implement the recommendations contained in the Walkable Livable Communities Report.
Continue to prioritize and implement the objectives contained in the Safe Routes to School Plan.
Work with the city to incorporate a health chapter in the newest edition of the city comprehensive plan.
Work with the city to make Minnesota Street a two-way or pedestrian plaza.
OBJECTIVE #3: Maintain and support the Food Environment Action Team to continue improving access, availability and affordability of healthier food choices in a variety of different venues throughout New Ulm.
Work with local civic and religious organizations to improve nutritional offerings at their potlucks and events.
Research and implement a Food RX program.
Work with schools, city and county to adopt and implement healthy concession policies.
Continue to expand the restaurant recognition program.
Continue to promote and support the community garden and expand gardening communitywide.
Work with the food shelf to offer self-selection by their clientele and redesign their food storage and display areas promote healthier options.
Work with the farmers market to create events during open times.

EVOLVE

There are several ways to develop your goals, objectives, and outcomes. One approach is offered so, select the approach that works best for your collaborative. Then you can use your data, community input, and the insights and perspectives of collaborative partners to create a plan.

Identifying root causes of poor health: One first step to consider in goal development is the identification of root causes of poor health in your community; in this case root causes specific to heart health.[48] The danger of not fully understanding the root causes of poor health is that your collaborative may spend more time and resources applying solutions that either work as a temporary fix, or do not do anything to address the problem. Neither is cost or time effective. These tools allow teams to move beyond obvious answers and identify the right set of interventions for the situation.

- **5 Whys** tool is a helpful practice to better understand the root causes of issues present in your community.[9] It can help you assess current partners and explore other organizations that are also working on the root cause issues you identify.
- **Visual metaphor** is a tool that you can use to communicate a goal. Using visual thinking metaphors is much like building a story. It helps you visualize the journey towards the goal. You are effectively taking thoughts, different scenarios, choices, and options and making them concrete and real. This helps you to clarify thoughts, to identify patterns, and make better and more effective decisions.[9]

- **Results-Based Accountability (RBA)** is a decision-making tool that builds collaboration and consensus by following an approach that works backward from the goal to define the means of getting there.[49] Read more about RBA here and here.[50,51]

Developing SMART Objectives: A useful step to consider is developing goals and objectives.[52] Now that you understand the issues contributing to heart health in your community, it is time to think about developing goals and objectives for your collaborative. A goal is a statement that makes clear what the collaborative wants to accomplish and serves as a beacon for implementing the vision of the collaborative partners. Objectives break the goal down into smaller parts.[52,53]

SMART objectives are Specific, Measurable, Achievable, Realistic and Timebound actions by which the goal can be accomplished. The SMART Objectives define for stakeholders and partners the results the collaborative expects to achieve in the selected interventions. Before setting "SMART" objectives, you may want to refer to five initial questions in the CDC Resource Kit and reference the CDC Evaluation Guide: Writing Smart Objectives.[52] Another tool to help you develop clear goals and objectives is the CDC SMART Objectives Template.[54]

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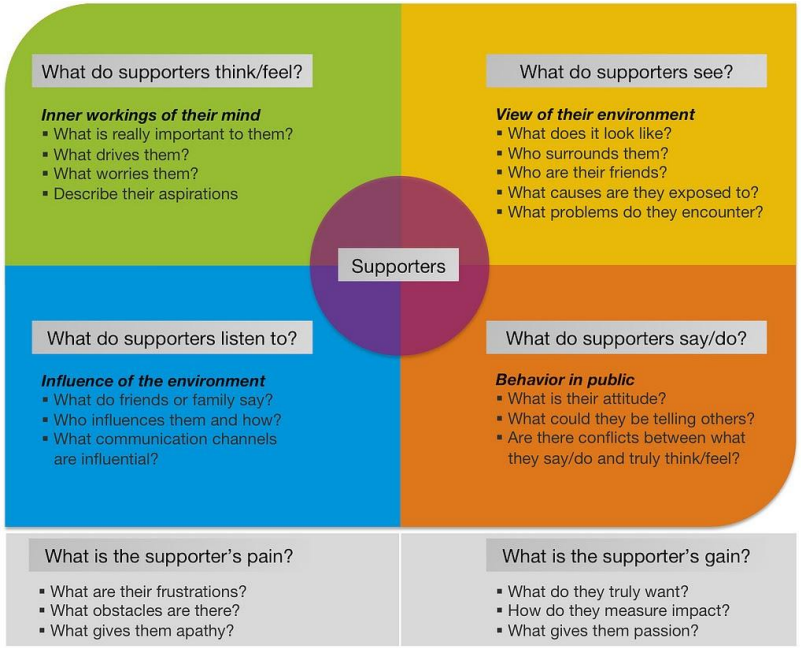
Empathy Mapping: Empathy mapping is a collaborative visualization tool showing what is known about stakeholders and those impacted by your work.[55] The process helps create a shared understanding of their needs, which can help with setting your goals and objectives. This template can be used to help your team build an empathy map.[9]

Listening Sessions: Similar to a focus group, a listening session is a facilitated discussion aiming to collect information and understanding from an individual or group. This approach can be helpful in diving deeper in to understanding those impacted by the work of your collaborative. This tool can help you prepare to host a meaningful dialogue.[9]

Consider actively engaging your **business partners** in the goal setting process.



Source: Adapted from Elliott K, Grinnell S, Pearlman D. 2019. Accountable Communities for Health: Start Up Guide. Population Health Innovation Lab.

AT-A-GLANCE

There are many resources available to help you choose evidence-based heart health interventions for your community. Deciding which interventions to invest in is usually more effective when a collaborative process is used that weighs opportunity, resources, and information about community health, access to and quality of clinical services.[9] You may also look for opportunities to bundle mutually reinforcing interventions for greater impact. For example, a set of clinical, community and linkage practices can be put together for a single implementation campaign. The entire set of interventions you select for your collaborative is sometimes referred to as a *portfolio of interventions*.

TIPS

As you assess the specific interests of your partners you may want to consider the **business sector**. They may be especially interested in interventions that impact their workforce, or that they can actively support through benefits plans or workplace wellness programs. The business sector can also be a powerful force in achieving policy initiatives and in gaining funder support.[13]

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DEFINE

Interventions are methods used to influence, facilitate, or promote clinical, behavioral, and community-level change to improve the health and wellbeing of individuals, organizations, and communities.[56]

The following sources describe evidence-based heart healthy interventions you may want to consider:

Centers for Disease Control and Prevention (CDC):

The Centers for Disease Control and Prevention (CDC) has described a number of evidence-based interventions to help communities improve heart health. These interventions include those that can be implemented in the clinical setting, behavioral change interventions for individuals, and community interventions. Below are CDC initiatives and programs where you can find information on heart healthy interventions, the science behind them, and in some cases information about their economic value.

6|18 Initiative:

In the 6|18 Initiative, CDC and partners are targeting six common and costly health conditions. CDC is collaborating with partners – like healthcare providers, public health workers, insurers, and employers who purchase insurance – to improve health and control healthcare costs by:[1]

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- Giving partners evidence about high-burden health conditions and related interventions.
- Highlighting disease-prevention interventions to increase their coverage, use, and quality.
- Aligning proven preventive practices with value-based ways of paying for healthcare.

With this information, partners can make decisions that improve people's health and help control costs.

HI-5 Initiative:

The Health Impact in 5 Years (HI-5) Initiative highlights non-clinical, community-wide approaches that have evidence reporting: 1) positive health impacts; 2) results within five years; and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier.[57] The HI-5 Initiative includes several recommendations for interventions that target cardiovascular disease.

CDC's DHDSP:

CDC's Division for Heart Disease and Stroke Prevention (DHDSP) works to improve cardiovascular health through public health strategies and by identifying evidence-based policies that promote: [58]

- Healthy lifestyles and behaviors.
- Healthy environments and communities.
- Access to early and affordable detection and treatment.

With $165 million for heart disease and stroke programs (including WISEWOMAN) in Fiscal Year 2018, CDC supports all 50 states and the District of Columbia to conduct heart disease and stroke prevention efforts.

Million Hearts®:

Million Hearts® 2022 is a national initiative co-led by the CDC and the Centers for Medicare & Medicaid Services (CMS) to prevent 1 million heart attacks and strokes within 5 years.[59,60] It focuses on a small set of priorities selected for their ability to reduce heart disease, stroke, and related conditions.

Other resources from DHDSP:

Released in 2020, The Surgeon General's Call to Action to Control Hypertension (Call to Action), identifies evidence-based interventions that can be implemented across the country to improve hypertension rates.[3] The Call to Action strategies are in support of the following three goals:

- Goal 1. Make hypertension control a national priority.
- Goal 2. Ensure that the places where people live, learn, work, and play support hypertension control.
- Goal 3. Optimize patient care for hypertension.

If you are interested in aligning with the Call to Action, you can search by Sector and Strategy on DHDSP's website – with a customized list of actions and resources for each group.[61]

In 2017, the CDC/DHDSP published "Best Practices for Cardiovascular Disease Prevention Programs: A Guide to Effective Health Care System Interventions and Community Programs Linked to Clinical Services."[62] The best practices include community programs linked to clinical services.

The Guide to Community Preventive Services:

The Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF).[63] It is a resource that can help you select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school. The Guide includes a number of heart healthy recommendations and also has cost considerations.

Association of State and Territorial Health Officers (ASTHO):

The CDC/ASTHO Heart Disease and Stroke Prevention Learning Collaborative is a collaborative project and partnership between ASTHO and CDC, funded through the Division for Heart Disease and Stroke Prevention (DHDSP).[64] Since 2013, ASTHO has partnered with CDC's DHDSP to support state and territorial health agencies through a learning collaborative to address hypertension. To date, the Learning Collaborative has engaged 32 state and territorial health agencies in implementing innovative models to prevent hypertension through system changes and quality improvement processes.

American Heart Association:

Before the American Heart Association (AHA) was founded, people with heart disease faced a life of poor health or death.[65] In 1924, a group of committed physicians and social workers decided to change that course. They formed the AHA, whose cornerstone was based in the scientific research of cardiovascular disease and stroke. The AHA offers a wide range of resources useful for community collaboratives working to prevent and control cardiovascular disease. The In Your Community tab on AHA's homepage allows you to search for relevant activities in your community.[12] Three other relevant efforts by AHA that may be useful as you consider interventions for your community collaborative include: Target: BP™, the Workplace Health Playbook, and My Life Check.[66,67,68] Target: BP™ is a joint effort from AHA and the American Medical Association (AMA) that tailors to health care organizations looking to implement programs aimed at hypertension control. For workplace health programs, refer to AHA's Workplace Health Playbook. In compliment to the Workplace Health Playbook, you may access the Workplace Health Achievement Index – an online organizational assessment or score card that measures an organization's culture of health using science-based best practices. Individuals, can refer to My Life Check which offers an interactive online tool that helps individuals better understand heart disease and stroke risk.

National Forum for Heart Disease & Stroke Prevention:

The National Forum for Heart Disease and Stroke Prevention (NFHDSP) is an innovative, multi-sector collaborative working at the international, national, and local

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levels to support initiatives and provide resources for the prevention and control of heart disease and stroke.[69] They are an example of a successful multi-sector collaborative with strong business sector engagement. The NFHDSP is source for resources for researching and choosing your strategies and interventions, including joining in ongoing initiatives across other communities.[70]

APPLY

Hearts of Sonoma County is an initiative of Sonoma Health Action, a multisector collaborative working together to improve health and equity in Sonoma County, CA. The goal of Hearts of Sonoma County is to reduce heart disease by focusing on clinical and community prevention of cardiovascular disease. Here are some additional details about this case study.[14]

The Hearts of Sonoma County focused on standardizing the delivery and quality of clinical care for hypertension. The initiative was modeled on Kaiser Permanente's Preventing Heart Attacks and Strokes Everyday (PHASE) initiative.[71] Hearts of Sonoma County implemented "PHASE strategies" to implementing the initiative in all clinical settings in the county. The collaborative also began a community-wide initiative to raise awareness of hypertension. You can read about their campaign here.[72]

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Health Action's Hearts of Sonoma developed a portfolio of clinical and community interventions based on sound science. Although they began their campaign slowly with the implementation of the PHASE+ project, they laid out a solid path for future action. This approach allows them to build upon their initial successes and demonstrates to funders the vision for health in the community.[14,73]

Hearts of Sonoma County Portfolio of Interventions

INTERVENTION	DESCRIPTION	DOMAIN	STATUS
PHASE+	Hearts of Sonoma County clinical partners are working together to implement the following strategies across their organizations: • Widespread adoption of proven guidelines to identify and treat cardiovascular disease, high blood pressure, high cholesterol, diabetes, and tobacco use. • Adopting highly effective teams to provide comprehensive care. • Use of data to inform and drive effective clinical decisions. • Sharing best practices across healthcare organizations to accelerate improvement and provide a consistently high level of care for all.	Clinical	In progress
Standardized community blood pressure screening tool and follow-up procedures	Clinical and community partners prioritized this tool as their top strategy for clinical-community linkages. Hearts of Sonoma County partners already developed the tool in conjunction with the *It's Up to Us* campaign and are currently using it to screen community members for high blood pressure and connect them to primary care.	Clinical-Community Linkages	In progress
Standardized workforce of community health workers (CHWs)/promotoras	Clinical and community partners prioritized the development and deployment of a standardized workforce of CHWs/promotoras to support clinical-community linkages for cardiovascular health. Partners will reconvene to further plan and implement this strategy.	Clinical-Community Linkages	TBD
Bidirectional electronic referral system	Clinical and community partners prioritized the use of a bidirectional electronic referral system that could be used to support clinical-community linkages. Partners agreed to wait to further explore this strategy until Redwood Community Health Coalition completed an analysis of the best platform to use locally.	Clinical-Community Linkages	In progress
Standardized social determinants of health screening	Clinical and community partners prioritized the use of a standardized social determinants of health screening tool that would be used consistently in both clinical and community settings.	Clinical-Community Linkages	TBD
Clinical-based Tobacco/Nicotine Use Cessation Intervention	Partner with the Sonoma County Department of Health Services Tobacco Prevention Team to coordinate and activate primary care provider organizations to: • Identify and implement selected standardized/shared approaches to improve shared systems and address barriers related to tobacco/nicotine use prevention and cessation intervention strategies.	Clinical	In progress
Community-based Tobacco/Nicotine Use Prevention and Cessation Intervention	Partner with the Sonoma County Department of Health Services Tobacco Prevention Team to coordinate and activate community health stakeholders to: • Develop a coordinated media campaign, using both paid and earned media as well as selected educational materials, around tobacco/nicotine use prevention and approaches that destigmatize and improve access to cessation resources and services.	Clinical-Community Linkages	In progress

Source: Adapted from Hearts of Sonoma County: Approved Portfolio of Interventions, May 2018 and Health Action: Hearts of Sonoma County

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EVOLVE

Just as Hearts of Sonoma County included both clinical and based-community interventions, your collaborative can take a comprehensive approach to the selection of interventions to address your vision, goals, and objectives. Here are some resources to help you develop your implementation strategy.

Which level of prevention will your strategy address? The Community Health Assessment Toolkit starts by asking your collaborative this question and offering the following three options:[74]

- *Primary*: Focusing at the population-level on prevention. Thinking about the root of the problem (such as food security, housing quality, educational opportunities, among others) and prioritizing interventions that promote health and well-being.
- *Secondary*: Identifying at-risk or high-risk populations to prevent the problem from getting worse.
- *Tertiary*: Focusing on individualized treatment or interventions.

Like the Hearts of Sonoma County Initiative, described above, you may consider starting with one program and then with additional funding, partners, and community support, expand your activities.

3 Buckets: Utilizing the 3 buckets of prevention framework may be useful as a way to gain support from providers, insurers, and public health for both improvement of traditional office-based services and adoption of innovative clinical approaches.[75] Clinical activities can be paired with projects that address community factors to accelerate health impact.

FIGURE

Three Buckets of Prevention

Source: J Public Health Manag Pract. 2016 May-Jun; 22(3): 215–218.

Convening to Select Interventions: Once possible interventions have been identified, partners can convene to review and consider possible interventions. The backbone organization, or design team can help plan the agenda and process to select the interventions. Focusing the convening on a review of background and contextual factors, along with possible outcomes, can help the decision-making process stay focused on the collaborative's goals.[9] During the meeting here are possible tools for prioritizing interventions:

- Affinity Clusters: A process by which data or ideas can be gathered and then categorized for easier analysis by a group.[76]
- Prioritization Grid: a group-based process that helps prioritize ideas.[77]
- **Four Category Voting**: Choose one or two ideas from the following four categories: (1) the rational, (2) the most likely to delight the user, (3) the long shot, and (4) the darling (most likable to the team).[78]
- **Sticky Note Voting**: Each team member gets three sticky notes to place next to the ideas that are most appealing to them. Using tools such as Google's Jamboard or Mural, among others, can be useful if it needs to be done virtually.[78,79,80]

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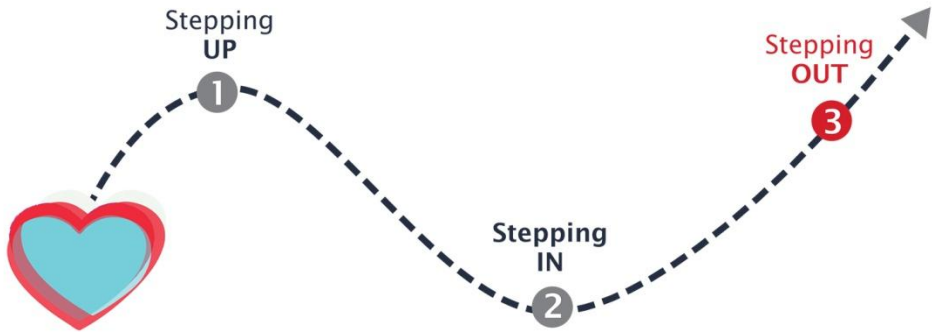
2 STEP IN: Choosing Interventions

TIPS

The peer influencers in your local health system may be key to a successful initiative. Working with them can help to identify evidence-based interventions and get other partners on board.[72] In Hearts of Sonoma, Kaiser Permanente was the peer influencer who helped encourage other healthcare providers to adopt improved standards of care for hypertension control.

If your partners include the business community, you may want to address how interventions impact the workplace or working population. Selecting interventions that can be implement in the workplace may encourage employer involvement or support of the collaborative. We have added a separate section on **Understanding the Economics & Value of Hypertension Control** to help you do this.

Now you are ready to move to the next step!



3 STEP OUT

Now that we have covered foundational steps needed to Step UP and form collective community action and learned about how to Step IN to the work itself, it is time for your collaborative to **Step OUT**.

ARE YOU READY TO **STEP OUT**? Do you already have a collaborative and have started its work? Then this step may be your starting point. Take a moment to reflect on three key elements of your collaborative before you begin:

- Is my collaborative working beyond the different silos of sectors, organizations, and departments?
- Does my collaborative fully tap into what all stakeholders have to offer in terms of experience and wisdom?
- Are we setting clear, data-driven goals and outcomes?

These are hard questions. The process of forming a collaborative is never really done so return to the first two sections of this Toolkit for Change for additional support when you need it.

Step OUT can help you continue to define, adapt, and evolve your collective by covering the following topics:

- **Implementation Plans**
- **Evaluation Plan**
- **Financing and Sustainability Planning**
- **Core Practices**

3 STEP OUT: Implementation Plans

We really worked to change our narrative and the way we function ... If you have community ownership, you are willing to devote time and resources to projects and so we talk about ownership rather than buy in and we've really worked hard to make sure there was that community ownership piece.

—Key Informant from the Public Health Sector

AT-A-GLANCE

Once you have identified a backbone organization, created partnerships, explored data, heard community perspectives on community health and well-being, and set your project's goals, it is time to implement your heart health interventions!

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3 STEP OUT: Implementation Plans

DEFINE

Implementation is the action you take to carry out your plan.[81]

APPLY

Heart of New Ulm: The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project. We interviewed the Project Manager for this case study.[10]

Heart of New Ulm aligned with "AHA guidelines for improving cardiovascular health at the community level"[82] and worked with partners accordingly for implementation. Some of the interventions implemented within Heart of New Ulm include:

- Free health screenings in community and workplace settings.
- Run/walk events.
- A community-wide weight loss challenge.
- Social marketing.
- Weight management phone coaching program.

Other interventions were more collaborative with initiative members, including partnering with local restaurants, grocery stores and the farmer's market to improve the "food environment."[82] The restaurant program in particular partnered with Heart of New Ulm to make healthy eating more accessible.[83] Local businesses also partnered with Heart of New Ulm around "worksite behavior change programs"[82] as well as "built environment initiatives to improve the ability of residents to bike and walk in the community."[82] The Project Manager interviewed for this Toolkit spoke toward wanting residents to think about walking and biking not just as exercise, but as a form of transportation. Finally, a more "primary prevention intervention" was aimed at high-risk residents.[82]

EVOLVE

This section can help your collaborative create an implementation plan (this tool can get you started).[9] Here are some steps recommended by the interviewees to consider:

- **Create an implementation subcommittee**: Meet regularly to steward implementation activities and monitor progress.
- **Create a dashboard or data tracking mechanism**: Regularly track implementation status.
- **Identify champions**: Solicit champions who are passionate about your projects. Give them a voice and encourage them to bring each other along.

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- **Awards**: Offer awards or designations for particular aspects of the implementation plan. For example, Heart of New Ulm implemented an awards-based restaurant program with bronze, silver, and gold designations for participating restaurants willing to change their menu to offer non-fried foods, fruits, whole grains, and smaller portions. This was part of a broader community effort to address root causes of poor heart health. Refer to this journal article for more on Heart of New Ulm's approach providing awards to restaurants offering heart healthy options.[84]

TIPS

Regularly reflecting on your progress can help you adjust when needed. The experiences of other collaboratives show us that this phase is not always a linear or sequential process. The Pro Action Cafe is a methodology to guide conversations about projects and work toward collective action.[85]

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3 STEP OUT: Evaluation Plan

Knowing is not enough; we must apply. Willing is not enough; we must do.

– Johann Wolfgang von Goethe

AT-A-GLANCE

Evaluation of an initiative and its chosen intervention is an important component in building a successful community collaborative. This section provides key resources for developing an evaluation framework.

DEFINE

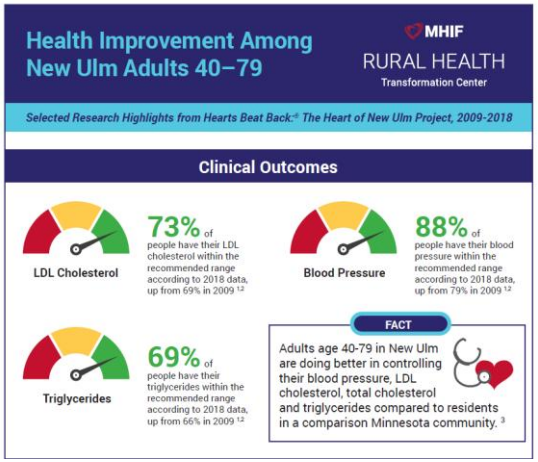
The CDC's defines evaluation as "a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate".[86] This section will give you suggestions to help you develop your evaluation framework in the context of your collaborative. The framework can guide the evaluation plans for the projects your collaborative undertakes.[86]

APPLY

Heart of New Ulm: The Heart of New Ulm project is a collaboration of the Minneapolis Heart Institute Foundation®, Allina Health, the New Ulm Medical Center, and the New Ulm community to address heart health in the community. See here for more information on the project. We interviewed the Project Manager for this case study.[10]

Within Heart of New Ulm, data collection remained ongoing over the course of the ten-year project, ending in 2018. Collection approaches included electronic health records, survey responses, and other sources within the target population of 40-79-year-old residents. In 2018 the project released a dashboard-type summary using baseline data collected in 2009 to highlight change over time.

Heart of New Ulm demonstrates the importance of collecting baseline data before starting implementation, as well as the ways in which data can be collected over a period of many years to evaluate specific projects and other outcomes the project has selected.



Source: Minneapolis Heart Institute Foundation®. Health Improvement Among New Ulm Adults 40-79. https://mplsheart.org/wp-content/uploads/2020/05/MHIF-Heart-of-New-Ulm-Project-Outcomes-2020.pdf.

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EVOLVE

Developing an evaluation plan: Once you have identified the outcomes you want to achieve and selected your interventions, you may want to develop an evaluation plan.

The Community Health Assessment Toolkit helps design evaluations that have short and long-term outcomes and process metrics.[87] Tracking intermediate goals and benchmark metrics provides partners, funders, and the community with an indication of the impact of the project.[87]

Short-term measures focus on "process measures and intermediate health outcomes."[87]

Long-term measures "monitor changes in health status."[87]

Evaluations can be used at many levels.[87] For example, an evaluation can be used to determine the impact of the interventions implemented by the collaborative, and evaluation also can be used to monitor the effectiveness of the collaborative and its backbone organization.

Center for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48 (No. RR-11)

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TIPS

Design your evaluation and data management plans and collect your baseline data before starting implementation.[53] Unfortunately, if a project delays this step, it could result in not having adequate baseline information and progress measures to conduct the evaluation.

Ask your partners what is important to them – evaluations can be used to generate further support. Be sure to consider obtaining input from your business partners in the development of your evaluation plans.

Community engagement can be critical to a successful evaluation.[87] See the CDC evaluation framework for ideas.[88]

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3 STEP OUT: Financing & Sustainability Planning

But there's a common denominator [of what influences employers, health plans, and providers] in terms of savings across the board, and/or revenue. To me, they are all influenced slightly differently but there are key elements, as part of that, that they are all influenced by and often times that's time and money.

—Key Informant from the Business Sector

AT-A-GLANCE

This section describes how to develop financing and sustainability plans. It offers several applied examples and shows you how to get started writing a business plan.

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DEFINE

Financing and sustainability plans to maintain the project over time are key elements to the success of any long-term community coalition or collaborative. Sustainability planning encourages thinking beyond merely establishing a collaborative and moves toward how the program will continue over the long term. The elements the program will need to continue long term include a permanent governing structure and stable financing. Planning long term, even in early project phases, supports a strong organizational backbone and a diversified portfolio of health and wellness investments.[89,90,91,92,93,94] According to the ACH Strategies for Financial Sustainability (JSI 2015), **planning for a financing and sustainability strategy begins at the very first stages of the formation of the collaborative and extends into the implementation and reinvestment phases.**[89] Such a plan is built upon key principles of leadership, collaboration, measures, and investment.

Figure 2. Key principles and phases

Accountable Communities for Health: Strategies for Financial Sustainability
JSI, 2015, Page 5[1]

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3 STEP OUT: Financing & Sustainability Planning

Solid sustainability and financing planning serve as the basis for the coalition's case statement and business plan. This indicates or identifies the value proposition and the organization's mission statement, goals, landscape, partnerships, backbone, short and long-term activities, key financial information, and fundraising strategy. It also includes plans for establishing brand identity and visibility.[89, 90, 91, 92, 93, 94, 95]

TIPS

Much of the information you collected in **Step IN** can be used in your value proposition and business plan.

Creating a financing plan for the workgroup or committee as early as possible can help to maintain the collaborative's work. [89, 90, 91, 92, 93, 94, 95]

Successful coalitions often depend on multiple funding sources to support their organizational backbone and range of interrelated projects.[96] This approach recognizes that a portfolio of related activities may be more effective at producing desired outcomes than individually funded isolated projects. The portfolio approach frequently requires the "*blending, braiding, and aligning*" of multiple funding sources targeting a common set of outcomes.[96]

Funding sources have also diversified. Where once community organizations relied on government and private grants, community coalitions now have extended their reach into an extensive list of funders and sophisticated funding mechanisms.[89, 90, 96, 97] Terms for new types of funding mechanisms such as community benefit, social impact investing and "pay for success" contracting have entered the community organization's lexicon.[87, 89, 90, 96, 97, 98]

Funding Sources for Collaboratives and Their Portfolios

Funding Source	Type of Funding
Philanthropy	Foundation funding Impact and program-related investment
Federal and State Government	Federal and state grants Section 1115 waiver Inter-governmental transfers Dedicated tax revenues
Local Government	General revenues Dedicated tax revenues Bonds
Payers and providers	Cost-saving investments "Pay for success" initiatives
Employers	Grants Other program investments
Non-profit hospitals	Community benefit Impact and program-related investment

Source: Adapted from Accountable Communities for Health: Strategies for Sustainability | JSI [89]

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Community coalitions are becoming more entrepreneurial. Many are establishing free standing wellness funds. This concept has now been implemented by several states and is being used more frequently as a sustainable funding strategy for local coalitions.[99] A wellness fund is a dedicated funding source, supported by multiple funding sources, to support the activities of the coalition.

Wellness funds are often operated as independent nonprofit organizations or as components of a coalition. Funding can be used to support both the backbone organization and the portfolio of interventions. Funds held in a single entity improves the coalition's ability to blend, braid, and align funds for greater coalition impact. More information on wellness funds can be found here.[96,100,101,102]

APPLY

Some strategies that community collaboratives have used to expand their funding beyond their initial grants are noted below. Many of these examples are California Accountable Community for Health (ACH) communities and their mechanisms may be specific to their state or locale. Collaboratives in other states can investigate their own state and local opportunities.

Diversifying your portfolio and expanding your funding opportunities. Healthy Savannah, for example, has expanded their potential grant opportunities by taking a "health in all policies" approach. They have integrated urban planning, housing, education, the food system, transportation, and justice into their portfolio of interventions. As a result, Healthy Savannah has received grants from planning,

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agriculture, public health, and other funders resulting in a diversified coalition that represents all major segments of the community.[103]

Looking to leadership first. Funders sometimes ask if the coalition's leaders are providing financial support. This may increase the chances of getting funding from local foundations and funding sources. Both Sonoma County's Health Action and Fresno County's Health Improvement Partnership have leadership committees comprised of key members of the business and health care sectors.[46,104] These partners have made substantial multiyear pledges and this provides a stable source of unrestricted funds to support the backbone organization.[46,105]

Champions make a difference. Key champions who are visionary and have the power to bring others together make a difference. The San Diego Accountable Community for Health has a ten-year strategy to improve the health of county residents that was developed by San Diego's County Administrative Officer and the Health and Human Services director. This strong leadership has resulted in creating a large and diverse set of leaders and funding sources including governmental and nonprofit grants and programs, matching funds, hospital community benefit funds and other sources.[106,107]

Being entrepreneurial. Looking beyond grants and considering creating a wellness fund to support your collaboration's work.[89,90] The Imperial County Accountable Community for Health, for example, has an established Wellness Fund through contributions from the county's Medi-Cal (state Medicaid program) managed care vendor to support county-wide investments in population health. The amount of the contributions is established in a contract and is a percent of shareable revenue.[108]

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EVOLVE

Is your coalition ready for a financing and sustainability strategy? Are you ready to write your business plan? Once you have completed your first formative steps, it is time to jump in. There are numerous resources available to take you through each step.

TIPS

Take advantage of all of the information you collected in your community assessment in **Step In** and economic information described in the separate section on **Understanding the Economics & Value of Hypertension Control** address key segments of your value proposition and your business plan.

Consider reaching out to the **business community** to identify individuals with expertise in creating a business plan.

Fortunately, there are many resources to assist collaboratives with financing and sustainability planning and many offer a wealth of creative suggestions for diversifying funding sources. The resources outlined below provides four “hands on” guides, toolkits, frameworks, and other resources for accomplishing these tasks.

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Consider your local Small Business Development Center (SBDC), if available in your community, as a potential resource for writing a business plan.[109] The SBDC is part of the Federal G Small Business Administration. Many centers provide one-to-one counseling, offer courses, and assign SCORE volunteers to businesses seeking help.[110] SCORE is a non-profit organization of volunteer business mentors dedicated to helping small businesses achieve their goals and is partner of the Small Business Administration. One resource offered by many SBDCs is the NxLevel course for business plan development.[111] Information on the course can often be obtained from your local SBDC. There are also numerous books and online resources available for assistance with developing business plans. Many metropolitan areas also have a nonprofit resource center that can provide assistance.

Other Examples of Resources:

Beyond the Grant: A Sustainable Financing Workbook. ReThink Health, Dec 2018. https://www.rethinkhealth.org/our-work/financing-workbook/

Financial Sustainability Mini Toolkit: Domestic Violence Collaboratives and Others. JSI, July 2020. https://www.jsi.com/financial-sustainability-mini-toolkit/

Sustainability Framework. A service of the Georgia Health Policy Center. Download the Sustainability Framework fact sheet at https://ghpc.gsu.edu/tools-frameworks/sustainability-framework/

Establishing a Wellness Fund: Early Lessons from the California Accountable Communities for Health Initiative. CACHI, 2019. https://cachi.org/uploads/resources/Establishing-a-Local-Wellness-Fund_Issue-Brief_FINAL_7-10-19.pdf

Business Plan Basics, 3rd Edition. NxLevel. https://www.nxlevelorder.com/wp/shop/micro-entrepreneurs-student-guide-workbook-3rd-ed-digital/

3 STEP OUT: Core Practice

There is much that we have learned, and even more still unknown, about the formation and functioning of multi-sector partnerships for health. One thing is certain: they sit at the epicenter of some of the most ambitious endeavors to reimagine and transform health across the country.

—A Pulse Check on Multi-Sector Partnerships,
ReThink Health

AT-A-GLANCE

Core practices are those most central to a particular culture of a collaborative. These practices relate to many components addressed in the first two sections **Step UP** and **Step IN** – for example, operating principles, and develop goals and outcomes. This Toolkit describes two primary practices you can consider incorporating into your collaborative, and there are others you can explore as well.

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3 STEP OUT: Core Practice

DEFINE

Core practices are those central to the culture of your collaborative and can be a way to demonstrate your core values.[9] This section speaks to two practices that you may want to continue to keep front of mind as they facilitate continuous reflection and innovation within the context of your collaborative. Other core practices can be found in the first two sections, Step UP and Step IN. Be sure to continuously reflect as the process of forming a collaborative is never really done. Return to this Toolkit for additional support whenever you need it.

APPLY

Blood Pressure Collaborative: In 2009 the Rochester Business Alliance (RBA) with an interest in health care partnered with Finger Lakes Health System Agency (FLHSA) to form the Blood Pressure Collaborative – a multi-stakeholder coalition – in order to address hypertension control in Monroe County, New York. Additional details about this case study can be found here.[11]

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The core values of the High Blood Pressure Collaborative of Monroe County are "transparency, honesty, and respect."[11] The collaborative intentionally established a multi-stakeholder project that was designed to identify and address the goals of each participating stakeholder. This process was not linear, and the ever-evolving work groups within this collaborative are evidence of that, but they continually returned to core practices. Because the collaborative did not want to implement another unsuccessful short-term cost reduction program and brought on a community-grounded organization as their backbone, their group was continually encouraged to practice redesign. They also maintained community commitment to the partnership as years progressed.

EVOLVE

Establishing relevant core practices for your collaborative can promote continuous program or project innovation and fuel community-wide engagement and impact.[9] Two such core practices are described below.

Incorporating Reflection: Active reflection and evolution of your approach is key to building an effective and sustainable collaborative.[9] Incorporating intentional times to reflect can help to ensure that what you are learning is ingrained into the ongoing work of your collaborative.

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One way to embed this practice in your work is to discuss the following questions with your team and revisit these questions regularly as your collaborative grows:

- What are you learning about systems, and specifically the systems in which you work?
- What is working well and where are there gaps in the systems?
- What do these learnings mean for the broader context of your work, and the work of your collaborative?

The Collaborative Reflection Form is a simple template that can be used efficiently in meetings to gather data on current perspectives and needs related to the work, the group, and mindset development.[9]

The What, So What, Now What learning cycle is useful for partners to reflect on a shared experience in a way that builds understanding and spurs coordinated action while avoiding unproductive conflict.[9]

Innovative Mindsets: Innovation in the context of your work also calls for the ability to accept experimentation in processes, relationships, and approaches.[21] Below are a few starter questions that may be helpful to investigate and discuss innovation with your team. You may also want to consider innovation you already have in place, your culture, and your business approach.[9]

- What is innovation for your organization?
- Is it just creative thinking or are creative ideas actually implemented?

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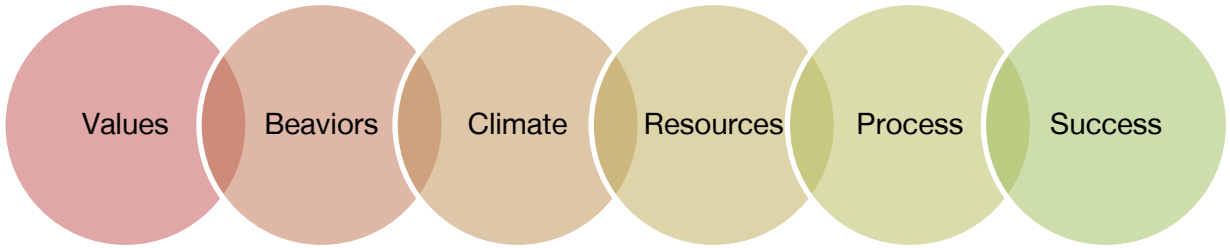
- Why do you think it is necessary in your context?
- What do they apply to? Products, services, methods, customer relations, operational processes, administrative processes, or something else?
- What about reconciling the idea of innovation with standards one is expected to follow in healthcare? What kind of business approach and culture would you need to be innovative (flexible, open, constantly learning, disciplined come to mind)?

The Building Blocks of Innovation Survey explores organizational culture and creating a culture of innovation.[112] The survey is structured around six building blocks: resources, processes, values, behavior, climate, and success. Often an organization may be stronger in some building blocks than in others, which can affect adoption of innovative practices. This is a potential resource for your partners to use in their own organizations.



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Understanding the Economics & Value of Hypertension Control

The business sector is often an overlooked component of community collaboratives. One possible reason is differences in understanding perspectives on the value of interventions. In addition to the intrinsic values placed on health outcomes, businesses also examine the economic and financial impact of interventions, which may be overlooked by public health organizations. A growing trend among organizations – business, public health, and health care entities – is multiple bottom lines, or ones that simultaneously address financial, social, and environmental goals.[13,105,106,107,108,112] The goal of this section is to provide information to bridge the gap in approaches to valuation of interventions. Is my collaborative working beyond the different silos of sectors, organizations, and departments?

This section includes: [13,113,114,115,116,117]

- Questions and answers on economic valuation such as cost effectiveness, return on investment, and value on investment.
- What we know about the economic case for hypertension control: the CDC fact sheet and how to approach the question.
- Two examples of community economic assessment of heart health and goals to improve heart health.
- Resources for conducting valuations of interventions.

There almost needs to be this bridge and this translation between business and public health. In a way, coalitions can kind of do that, can help facilitate that.

—Key Informant from the Public Health Sector

AT-A-GLANCE

Economic information can make a compelling case for investment in strategies for heart health.[118,119,120,121] But businesses and public health often use different language and methods for economic and financial analyses.[13,114,115,116] You may find that economic evaluations that bridge this barrier to be the most effective for your work as a community action collaborative. Businesses and community collaboratives can answer economic questions, even with limited expertise and resources. **Speaking a common economic language can help strengthen partnerships between businesses and public health.**[13]

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DEFINE

Economic information gives us a powerful tool for promoting science-based approaches to health.[13,113,114,115,116,117] It supports value-driven investment decisions in health initiatives. Frequently used measures of value include Cost Effectiveness Analysis (CEA), Return on investment (ROI), and, recently gaining in use, Value on Investment (VOI). There are also other measures and approaches and understanding each is critical to using them effectively.

ROI is one of the most commonly used measures when making the case for business investment in health initiatives, while CEA is most commonly used in public health and health care.[116,117,122] But ROI and CEA can mean different things to different people. How you calculate ROI and CEA can give different interpretations of what produces good value and what is profitable. This may lead to conflicts between business and public health approaches to prevention.

Below are some of the questions and answers that will help explain ROI and CEA and why there are differences in how it is calculated and used. We also introduce VOI methodology as an alternative or to augment other types of valuation determinations (known as valuations).

Economic information can be used for: [115]

- Education and promotion.
- Creating a value proposition.
- Selecting strategies and designing portfolios.
- Evaluation and quality improvement: improve the ROI of existing programs, benefits.
- Examining impact on budgets.
- Metrics for shareholders and stakeholders.

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TIPS

You may want to ask partners about what is important to them in an economic analysis. What are their goals? What questions do they want answered? How will they use the information? Which costs and benefits? What time frame? Identifying possible differences among partners can help you design an analysis that is relevant to everyone.[116]

QUESTION & ANSWERS

Q1 What is an economic evaluation of a health intervention?

Economic evaluations examine the size of health problems, from an economic perspective, as well as the costs and benefits associated with addressing them.[116,122] Benefits may be shown as financial costs saved, as improved health outcomes, or improvements in other desired social, environmental, and economic outcomes.

The type of economic evaluation depends on the question being asked, who is asking it, and the audience for the results.

Methods for economic evaluations:[116,122]

- Economic burden of disease.
- Return on investment.
- Cost-effectiveness analysis.
- Cost-utility analysis.
- Cost-benefit analysis.
- Budget impact analysis.
- Value on investment.

Q2 What is ROI and how is it different from CEA?[122,123]

- ROI answers the question: How many dollars do you get back for the amount you put in?
- Net Profit / Total Investment * 100 = ROI
- CEA is a way to examine both the costs and health outcomes of one or more interventions. CEA estimates what it costs to produce an additional unit of a health outcome, such as a life year gained, a quality adjusted life year (QALY), or a death prevented. CEA always compares one intervention to either other interventions or to no intervention, meaning the status quo.
- CEA answers the question: what does it cost to produce an additional unit of health (e.g., life year, QALY, death prevented) when compared to an alternative intervention or to the status quo (i.e., no intervention)?
- Net Cost / Additional Health Outcomes = CE Ratio
- ROI is more frequently used for business sector decision making. CEA is more frequently used in the health and public health sectors.

Q3 What is VOI?[124]

Value on investment, or VOI is a form of analysis that incorporates multiple difficult-to-measure outcomes of an investment and compares them to the cost of the investment. It is sometimes used to evaluate employee wellness programs and their effect on such benefits as employee well-being, organizational performance, morale, and retention. VOI methodology is still being developed and does not have a standard

summary measure but can be useful alongside traditional forms of analyses such as CEA and ROI.

Q4 Which costs and benefits are included in economic evaluations such as ROI and CEA?[116,122,123]

ROI and CEA include the costs associated with the investment – the initiative, program, or intervention – and the costs of health condition being addressed. A business may be interested in health care savings, worker productivity, employee turnover costs. Often, businesses may only consider costs they make or the benefits they receive. Public health and community groups might consider all of the costs and benefits, (categories of benefits include health, economic, psychological, social, environmental, and others), regardless of who pays or receives them. This broader perspective provides a more complete measure of societal value. For example, in addition to healthcare system costs, a community coalition may also want to consider costs to patients or employees as well as social and environmental costs associated with the initiative or the health issue.

Q5 Why does perspective matter? [116,122]

Perspective is the point of view from which an economic evaluation is conducted and determines which costs and benefits are included. The choice of perspective determines whose value is examined. Analyses done from different perspectives will produce different results. The societal perspective includes all of the costs and benefits regardless of who pays them or who receives them. Analyses done from the societal

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perspective provide the most comprehensive approach to value. Businesses, health plans, and healthcare providers may feel that the societal perspective is too broad and doesn't adequately represent them. Many of the benefits may accrue to others while the businesses, health plans, or providers pay the costs. This can make economic evaluation challenging and can lead to differences when interpreting the results.

For more information on perspective see the book, Prevention Effectiveness: A Guide to Decision Analysis and Economic Evaluation, and an article entitled, "What are the benefits and risks of using return on investment to defend public health programs?" [116,122]

Q6 How do business and public health view economic evaluation differently?[13,114,115,116,118,123]

There is not one standard answer for how an economic evaluation should be conducted. It depends on many factors – including the goals for the investment, the decisions being made, and the audience for the evaluation. Here are some differences that often occur in evaluations done from business and public health's approaches:

Which outcomes are included? These outcomes – often called benefits – can accrue to businesses, health plans, providers, patients, and the community. Depending on the perspective, certain benefits may or may not be included. For example, some of the community benefits of an employer-sponsored wellness program may not be included in the employer's ROI analysis. A CEA may only include health outcomes. The VOI approach may also include more difficult-to-measure outcomes such as employee well-being, morale, and organization performance.

How long into the future do the benefits occur? Businesses may take a very short-term approach ranging from months, one year, to three years, to satisfy shareholder needs. Public health often takes a longer view. Governmental bodies conducting analyses of legislative, regulatory, and policy initiatives often examine costs and benefits over a five- or ten-year period. Cost-effectiveness analyses of many chronic disease programs are designed to capture health care savings and health impact over the lifetime of the population, as long as the impacts occur.

Ultimately, the length of time for the analysis depends on the goals of the organization conducting it, the decision that it will inform, and the audience for the results.

Whose bottom-line matters? Sometimes the organization that pays for the intervention does not receive the savings from it. If the organization wants to determine the ROI from its investment, they may not want to include savings that they do not receive. This could produce an CEA or ROI result that appears to show that the investment would return a limited value for the organization although a more sizable value for a wider community of stakeholders.

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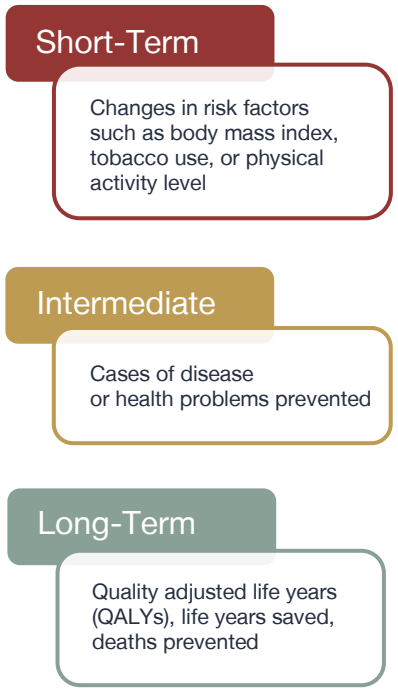
Types of Outcomes in Economic Evaluations:[116,122]

- ***Outcomes*** from investments—often referred to as benefits—come in many forms. Examples include improved health, savings in health care costs, increased worker productivity, and better health-related quality of life. Community interventions that impact health can also produce other social, environmental, and economic outcomes.[108,117]
- ***Health Outcomes:*** Health outcomes are the changes in an illness, injury, or health condition that affect physical or psychological health, life expectancy, and health-related quality of life. Health outcomes can be measured for individuals and for populations. Health outcomes can be categorized as short, intermediate, and long term.[116,122] Here are some examples: cases prevented, injuries prevented, life years saved, quality-adjusted life years (QALYs) saved,
- ***Other Outcomes:*** Often health interventions are implemented in community settings. Interventions might be school based, occur in the workplace, or affect the community environment. Intervention outcomes in these settings could include changes in educational attainment, social services use, and justice system costs.[116,122] A few types of community outcomes are listed below.



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Environmental outcomes result from changes to the physical landscape of a community such as constructing cycling and walking paths, acquiring parks and green space, changing zoning ordinances, and passing air and water quality policies. Environmental outcomes may include increased biodiversity, better air quality, and improved community well-being.[116,122]

Social outcomes are those that strengthen the community's social fabric. Interventions that promote safe neighborhoods, affordable housing, an improved choice of stores and restaurants selling healthy food, and adoption local school policies that promote health all improve the social fabric. Outcomes may include improved neighborhood security, increased health equity, and community vibrancy and resiliency.[116,122]

Economic outcomes are the changes in community income and employment.[116,122] For example, investment in a more vibrant retail streetscape that promotes walking and cycling may result in increased economic activity and employment in a community.

Organizational performance outcomes that are important to businesses and other organizations are often difficult to measure. Examples include employee well-being, customer well-being, organizational functioning, and other elements important for organizational goals. They are sometimes considered intermediate outcomes and are most frequently used in VOI. [116,122,124]

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Q7 Q7. The CEA and the ROI for a set of interventions point to different choices. How can this be resolved?[12,90,91,92,93]

Often the conclusions drawn from CEA and ROI results differ because the goals for the analysis are different. CEAs often identify the best use of resources regardless of who owns the resources. Most public health CEAs examine the benefits to health over the lifetimes of the population receiving them. Businesses may have different investment goals and be most interested in the resources they invest and those that they receive. Often, businesses have a much shorter timeline; they need to see positive returns in as little as one to three years. Having a pair of differing results can be very useful for finding a solution. The CEA helps identify the investments with the greatest health improvements. The ROI can be used to explore why a business may not find this a good investment. Businesses and community organizations can work together to find win-win solutions. Is it possible to find cost sharing strategies for funding a program? What incentives can be provided to encourage businesses to invest? Are there packages of interventions that can provide a range of short and longer-term benefits? Knowing where key differences lie is key to finding solutions.

Q8 Can ROI analysis for different interventions be compared?[92,98,99]

It can be problematic to compare ROIs and other ratios for different interventions unless they were done as part of the same study. Even the same intervention offered by different organizations may have different costs and outcomes. There may be differences in the demographics and health status of the employee population or differences in enrollment in, long-term adherence to, and effectiveness of the

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intervention. Thus, caution should be used in comparing one business's ROI analysis with another's.

Q9 Why should businesses and public health consider community impacts in economic evaluations?[13,114,115,116,117]

Businesses are inextricably linked with communities. Their employees reside in the community. The community is the potential source of their future workforce. Businesses who work with the community to create a culture of health may find this to be an effective and cost-effective strategy as the community's health and health care access can influence the business's health care costs. In this way, a community's well-being may also contribute to business success. More information on the economic benefits of considering the community can be found in the report "Good Health is Good Business," released by the de Beaumont Foundation and in the Surgeon General's report on Community Health and Economic Prosperity.[13,45]

Q10 Can combining interventions improve ROI?[116]

Community collaboratives frequently package interventions into bundles or portfolios of interventions. This may increase the overall impact of the investment and decrease implementation costs. It also may create synergistic effects among the interventions increasing overall effectiveness. Bundling may increase the ROI for the package of interventions compared to the sum of the returns each individual intervention. For examples, refer to the Choosing Interventions subsection in **Step IN** that discusses possible interventions for your community collaborative.

APPLY

The Economic Case for Hypertension Control: What We Know

This section provides economic information on hypertension and strategies to prevent and control it. The three examples described here have all been used to inform decisionmakers and support the economic case for hypertension and healthy heart initiatives.[125] The first example is a CDC fact sheet that describes the national problem and the health and economic impact of some effective strategies for hypertension prevention and control. Businesses and collaboratives can use this fact sheet to make the case for improving heart health through hypertension control as it demonstrates the size and cost of the problem to society and the healthcare system and identifies evidence-based practices to improve hypertension control, and presents information on their value.


POWER OF PREVENTION

The Health and Economic Benefits of Preventing Chronic Diseases

HIGH BLOOD PRESSURE

High blood pressure is a common and dangerous condition and a key risk factor for heart disease and stroke. It is defined as having a blood pressure of 130/80 mm Hg or higher or taking medicine to control blood pressure. Healthy lifestyle behaviors—like eating a diet high in fruits and vegetables and low in sodium and being physically active—can help prevent and control high blood pressure.

High Blood Pressure in the United States

- Nearly 1 in 2 US adults (108 million) has high blood pressure, and most of them (87 million) may need to both change their lifestyle and take prescription medicine.[1]
- About 3 in 4 US adults with high blood pressure (82 million) don't have it under control (defined as blood pressure less than 130/80 mm Hg).[1]
- High blood pressure rates vary by race and ethnicity. Over half (54%) of blacks, 46% of whites, 39% of Asians, and 36% of Hispanics in the United States have high blood pressure. Only 21% of blacks, 26% of whites, 14% of Asians, and 18% of Hispanics with high blood pressure have it under control.[1]
- Nearly 500,000 US deaths each year are linked to high blood pressure as a primary or contributing cause.[2]

Strategies That Work

CDC supports state, local, tribal, and territorial heart disease and stroke prevention programs that help millions of Americans control their high blood pressure and

The Benefits of Using Proven Strategies

Many effective strategies to manage high blood pressure are a good value in terms of cost per quality-adjusted life year (QALY) gained.* For example:

- Team-based care to improve blood pressure control has a median cost of $10,396 to $14,972[2014] per QALY gained.[3]
- The use of community health workers, especially as part of a team, has a median estimated cost of $17,670[2014] per QALY gained.[4]
- When used with other approaches, self-measured blood pressure monitoring has a median cost of $2,800 to $10,800[2015] per QALY gained.[5]

* Public health interventions that cost less than $50,000 per QALY are widely considered cost-effective.
‡ Costs were measured in †2010 US dollars, ‡2015 US dollars, and ²2014 US dollars. Older cost estimates are likely to be underestimates.

CDC

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
@CDCChronic | www.cdc.gov/chronicdisease

CDC Fact sheet
https://www.cdc.gov/chronicdisease/programs-impact/pop/pdfs/high-blood-pressure-H.pdf

Several examples for other health conditions are also available on CDC's Power of Prevention site. [126]

Five Questions:[116,122]

There are five questions that a business case – or other economic evaluation – can answer. This information may be critical to making your case, whether it is for your value proposition or to inform partners who are considering investing in cardiovascular health strategies.

1) How big is the problem?
2) What can we do about it?
3) How much will it cost us?
4) What health impact will the investment have?
5) What financial metrics or successes can we achieve?

The community business case: A community collaboration may wish to develop the economic business case for investments in their own community. The coalition can then project the impact of reaching one of the targets set forth by the American Heart Association or CDC's Million Hearts campaign for the reduction of cardiovascular disease or hypertension. Here is some information they would need to estimate their economic burden of disease:[116,122]

- Community demographic information.
- Population growth rate.
- Baseline prevalence of hypertension, CVD, or CVD events.
- Health care costs (published literature).

A coalition can use published cost-effectiveness information to make the case for implementing a selected hypertension control initiative. Two examples of this approach are noted below.

1) In 2015, the California Department of Public Health published a report with county-level estimates of the economic impact of certain chronic diseases for each California county.[127] He used demographic information from the census, county-specific prevalence estimates from a variety of sources, the CDC Chronic Disease Cost Calculator (Version 2), and Medicare geographic adjusters to estimate the number of cases and the 2010 cost for the six leading chronic conditions in the state, including CVD. This data is publicly available. This process can be replicated for other locations in the US.

   The spreadsheet/report as shown in the Appendix, shows how this information can be updated to make the case for state and local investments in CVD and other chronic conditions.[128]

   Health Care Costs of Just Three Chronic Conditions Associated with Tobacco Use, Poor Nutrition, and Physical Inactivity in 2017.[128]

County	Cardiovascular Disease	Diabetes	Cancer	Total
California	**$48,546,938,780**	**$16,816,948,124**	**$18,078,264,891**	**$83,442,151,795**
Alameda	$2,105,937,757	$744,408,517	$796,011,198	$3,646,357,472
Alpine	$1,762,590	$494,886	$347,929	$2,605,405
Amador	$74,310,600	$19,502,275	$28,085,407	$121,898,282
Butte	$345,262,242	$91,037,692	$137,373,274	$573,673,207
Calaveras	$86,128,093	$23,034,434	$29,264,806	$138,427,333
Colusa	$26,456,633	$8,944,408	$7,442,878	$42,843,919
Contra Costa	$1,604,243,605	$515,126,860	$655,253,124	$2,774,623,589
Del Norte	$37,785,701	$10,363,502	$13,102,906	$61,252,109
El Dorado	$271,806,995	$75,165,693	$102,904,308	$449,876,996
Fresno	$1,056,011,091	$384,436,743	$350,343,350	$1,790,791,184
Glenn	$37,788,139	$11,371,091	$14,505,161	$63,664,391
Humboldt	$189,071,362	$50,062,558	$73,157,858	$312,291,778
Imperial	$202,795,810	$94,765,528	$53,038,622	$350,599,960

Appendix:
Click here to view the full spreadsheet of all counties

2) The San Diego Accountable Community for Health undertook an economic evaluation to show the impact on the county's working age population that could be achieved by reaching the AHA's 2030 goals.[125] Their goal was to develop information that was compelling as well as relevant to employers so that they could use the information in a way to strengthen their partnerships within the business community. They measured their success by measuring heart attacks that were prevented, health care costs saved, and worker productivity losses that were averted.

San Diego Accountable Community for Health Infographic

Demographic data was used for the county and a recently published assessment of the number of heart attacks in the five years before and after implementing a campaign to upgrade the standard of care delivered by health care providers in the county. They demonstrated that by 2030 they would be able to prevent 3,300 heart attacks, avert 234,000 days of lost productivity, and avert $129 million in health care costs and productivity losses. The information was presented as infographics to deliver a simple and impactful message.

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TIPS

You may want to consider selecting the county as an area for analysis because data are not universally available for smaller areas. For example, data on some health conditions are not avaliable at census tract level. Some large metropolitan areas may have the required data. Here are three examples of data reported by geographical units you can explore:

- CDC Social Determinants of Health: Know What Affects Health, Sources for Data on SDOH.[129]
- County Health Rankings and Roadmaps. Find More Data. [130]
- US Census Bureau, Health.[131]

EVOLVE

Would it be useful for your organization to use economic information or conduct an economic evaluation? How will you make that decision? Do you have enough knowledge and resources? We have included several resources that can help answer these questions and describe how they can be most useful.

Even if you plan to hire a consultant, you will likely need a general understanding of economic evaluations and the methods used to conduct them. This will enable you to decide on the appropriate question and the type and scope of analysis.

We have selected a short list of references designed for the public health practitioner, the community organizer, or the business representative.

The **first** reference provides more detail on the foundations of economic evaluation, including information on the following topics:[122]

- The types of economic evaluations;
- What it takes to conduct one;
- How to use the information, and provides;
- Several data tables for adjusting and calculating costs.

This is a reference for defining, describing, and conducting economic evaluations.

Prevention Effectiveness: A Guide to Decision Analysis and Economic Evaluation, 2nd Ed, Editors Haddix AC, Teutsch SM, Corso PS. Oxford University Press, 2003.

The **second** reference is a step-by-step guide for conducting an ROI analysis produced by the Agency for Health Care Quality.[132] It includes step-by-step directions and explanations, worksheets for the reader's use, and a worked example. This reference may also be useful when conducting ROI for other interventions or health investments.

This reference is useful when conducting ROI for business investments.

Step-by-Step Guide
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/combined/f1_combo_returnoninvestment.pdf

These two references provide examples that may assist you in understanding how all the elements of a valuation come together in an analysis.

Glossary, References, and Appendix

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GLOSSARY

Blending, braiding, and aligning – a phrase used to describe integrating multiple funding streams to support a common activity, initiative, or project for greater impact.

Business plan – a written document that describes in detail how a business or enterprise — usually a startup — defines its objectives and how it is to go about achieving its goals. A business plan lays out a written roadmap for the organization from its marketing, financial, and operational standpoint.

Community benefit –refers to a broad spectrum of charitable services, activities, and resources that nonprofit hospitals and health systems allocate to meet their tax-exempt requirements. https://www.thecachecenter.org/what-is-community-benefit.

Core practices - the day-to-day or regular activities or policies of an organization.

Core values - the fundamental beliefs of an organization that can serve as a foundation for implementing core practices.

Cost-benefit analysis (CBA) – a type of economic analysis in which all of the costs and all of the benefits are converted into monetary (dollar) values and results are expressed as either the net present value or the dollars of benefits per dollars of costs expended.

Cost-effectiveness analysis (CEA) – an economic analysis in which all of the costs are related to a single common health outcome. Results are usually stated as additional cost expended per additional health outcome achieved. CEAs compare one or more health interventions with one another or with the current status quo.

GLOSSARY

Cost-utility analysis (CUA) – a type of cost-effectiveness analysis in which benefits are expressed as the number of life years saved adjusted to account for loss of quality from morbidity of the health outcome or side effects of the intervention. The most common outcome measure in CUA is the quality-adjusted life year (QALY).

Operating Principles – shared agreements a group creates together on how they want to interact with each other.

Pay for success contracting – an innovative contracting model that drives resources toward high-performing social programs. PFS contracts track the effectiveness of programs over time to ensure that funding is directed toward programs that succeed in measurably improving the lives of people most in need. https://www.thirdsectorcap.org

Perspective – the viewpoint from which the economic evaluation is conducted and refers to which costs and benefits are included. The societal perspective, which is the perspective of society as a whole, includes all of the costs and all of the benefits regardless of who incurs them and who receives them.

Social impact investing – investments made into companies, organizations, and funds with the intention to generate a measurable, beneficial social impact alongside a financial return.

Quality adjusted life year (QALY) – a frequently used outcome measure that incorporates the quality or desirability of a health state with the duration of survival. Quality of life is integrated with length of life using a multiplicative formula.

GLOSSARY

Return on investment (ROI) analysis – a form of financial analysis that calculates the ratio between the net profit and cost of investment. A high ROI means the investment's gains compare favorably to its cost.

Value on Investment (VOI) – a valuation method for estimating the value from a financial investment that considers both the quantifiable and more intangible value produced by the investment. VOI is a term increasingly popular for valuation of investments in employee wellness.

Value proposition – a short description of what the collaborative provides for its partners and stakeholders in exchange for its funders' financial support. The value proposition demonstrates why a program or collaborative is unique and has the potential for success.

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APPENDIX

Health Care Costs of Just Three Chronic Conditions Associated with Tobacco Use, Poor Nutrition, and Physical Inactivity in 2017. [97]

County	Cardiovascular Disease	Diabetes	Cancer	Total
California	$48,546,938,780	$16,816,948,124	$18,078,264,891	$83,442,151,795
Alameda	$2,105,937,757	$744,408,517	$796,011,198	$3,646,357,472
Alpine	$1,762,590	$494,886	$347,929	$2,605,405
Amador	$74,310,600	$19,502,275	$28,085,407	$121,898,282
Butte	$345,262,242	$91,037,692	$137,373,274	$573,673,207
Calaveras	$86,128,093	$23,034,434	$29,264,806	$138,427,333
Colusa	$26,456,633	$8,944,408	$7,442,878	$42,843,919
Contra Costa	$1,604,243,605	$515,126,860	$655,253,124	$2,774,623,589
Del Norte	$37,785,701	$10,363,502	$13,102,906	$61,252,109
El Dorado	$271,806,995	$75,165,693	$102,904,308	$449,876,996
Fresno	$1,056,011,091	$384,436,743	$350,343,350	$1,790,791,184
Glenn	$37,788,139	$11,371,091	$14,505,161	$63,664,391
Humboldt	$189,071,362	$50,062,558	$73,157,858	$312,291,778
Imperial	$202,795,810	$94,765,528	$53,038,622	$350,599,960

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County	Cardiovascular Disease	Diabetes	Cancer	Total
Inyo	$34,524,295	$9,133,706	$11,931,186	$55,589,188
Kern	$873,375,059	$310,751,654	$264,303,036	$1,448,429,750
Kings	$134,871,452	$51,295,665	$35,978,129	$222,145,247
Lake	$110,255,070	$30,180,773	$38,488,882	$178,924,726
Lassen	$35,331,697	$10,094,346	$9,162,894	$54,588,937
Los Angeles	$12,210,365,150	$4,709,926,941	$4,547,059,232	$21,467,351,322
Madera	$181,991,853	$62,610,878	$60,142,096	$304,744,826
Marin	$468,497,991	$127,542,461	$232,860,560	$828,901,012
Mariposa	$35,049,502	$9,242,815	$11,259,539	$55,551,856
Mendocino	$137,426,054	$37,630,868	$52,005,558	$227,062,480
Merced	$272,193,245	$101,271,835	$84,775,405	$458,240,485
Modoc	$17,258,034	$4,511,174	$4,944,674	$26,713,882
Mono	$14,777,348	$4,438,557	$3,675,254	$22,891,159
Monterey	$500,541,526	$177,263,837	$185,573,591	$863,378,954
Napa	$231,101,475	$67,352,171	$92,997,715	$391,451,360

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County	Cardiovascular Disease	Diabetes	Cancer	Total
Nevada	$183,423,165	$46,824,834	$72,974,905	$303,222,904
Orange	$4,055,829,015	$1,355,140,723	$1,585,023,827	$6,995,993,565
Placer	$563,009,928	$154,454,974	$195,994,225	$913,459,127
Plumas	$37,769,116	$9,831,385	$13,649,822	$61,250,324
Riverside	$2,844,673,684	$955,260,118	$862,648,964	$4,662,582,766
Sacramento	$1,783,335,918	$571,305,847	$686,450,460	$3,041,092,225
San Benito	$60,760,801	$23,203,590	$20,835,613	$104,800,005
San Bernardino	$2,141,931,102	$806,037,449	$698,718,240	$3,646,686,791
San Diego	$3,952,158,292	$1,289,674,874	$1,500,265,504	$6,742,098,671
San Francisco	$1,303,898,650	$472,706,194	$538,504,482	$2,315,109,326
San Joaquin	$814,438,027	$285,522,167	$265,727,174	$1,365,687,367
San Luis Obispo	$425,686,873	$117,476,534	$155,257,354	$698,420,761
San Mateo	$1,179,732,568	$391,004,024	$532,053,229	$2,102,789,821
Santa Barbara	$590,591,952	$186,309,438	$238,399,611	$1,015,301,000
Santa Clara	$2,452,786,693	$865,124,843	$1,009,396,987	$4,327,308,523

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County	Cardiovascular Disease	Diabetes	Cancer	Total
Santa Cruz	$337,530,663	$104,886,400	$139,317,972	$581,735,036
Shasta	$288,666,803	$74,794,305	$116,081,703	$479,542,811
Sierra	$6,137,331	$1,645,275	$1,997,866	$9,780,473
Siskiyou	$82,547,180	$21,537,582	$28,286,469	$132,371,232
Solano	$572,133,760	$194,718,805	$210,252,045	$977,104,610
Sonoma	$726,876,016	$205,056,051	$288,787,432	$1,220,719,499
Stanislaus	$616,706,492	$203,609,740	$200,732,964	$1,021,049,195
Sutter	$119,523,362	$37,924,908	$39,757,744	$197,206,015
Tehama	$95,737,817	$26,348,380	$35,835,704	$157,921,900
Trinity	$25,334,503	$6,627,317	$8,915,918	$40,877,737
Tulare	$469,817,951	$173,756,547	$150,680,888	$794,255,386
Tuolumne	$104,398,772	$27,093,691	$46,353,552	$177,846,016
Ventura	$1,103,562,881	$367,120,158	$428,812,481	$1,899,495,519
Yolo	$232,410,130	$75,709,514	$83,876,031	$391,995,675
Yuba	$78,608,962	$24,280,588	$26,687,153	$129,576,703

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