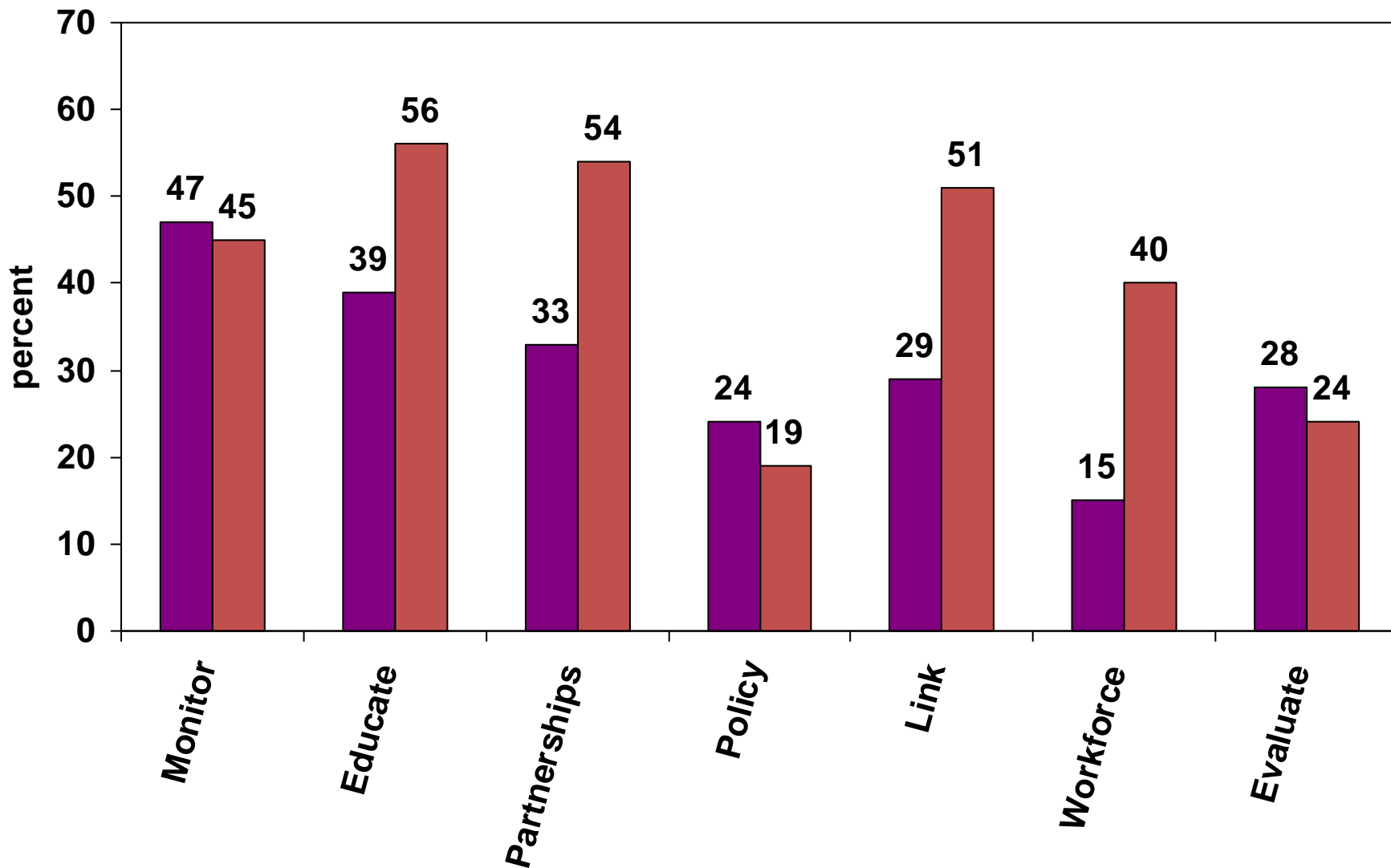


A brief overview of how PSD is getting out of the box

- What we built upon
- Where we started
- How far we have come

National Public Health Performance Standards Assessment - 2005



Background – “Phase” I in 2006

- Formal re-organization - Prevention Services Division created two Centers, Budget & Policy Office
- Consolidated all evaluation and epidemiology functions into a new Branch
- Due to funding from A35 (~\$50M/yr), began consolidating grants processes within Center
- Created informal teams on crosscutting issues including health disparities and training

Underlying principles

- Use a comprehensive, strategic, holistic approach to achieve specific **health outcomes**
- Be data driven (what/where/who to focus on)
- Move toward increased use of evidenced-base practices & programs
- Focus on heath disparities & social determinants
- Be more accountable to demonstrating health outcomes
- **Maintain program-specific, content experts**

Why integrate?

- Integration extends the reach of individual programs
- Reduces chaos, confusion and unnecessary duplication
- Solidifies identification and presents a more unified image of public health
-while maintaining program integrity

What did we have in common?

- Target many of the same populations – low income, racial/ethnic and medically underserved
- Work through the same “channels” – communities, health care providers, worksites
- Work with many of the same partners
 - Local public health, community-based agencies School of Public Health, Clinical Guidelines Collaborative, DHS, CDOT, Dept. of Education, Parks & Rec. Housing Authorities, Built Environment Planners,..
- Many people have more than one risk factors
 - childhood adversities associated with elevated risk for problems with eating or weight during adolescence or early adulthood

Challenges & opportunities

- Leading & managing a change process
- Culture formation & learning organization
- Assuring engagement & transparency
- Clarifying roles and responsibilities
- Organizational alignment & infrastructure (business systems, HR, communications)
- Creative tension – getting from here to there
- Elevator speech, sales pitch and partners

What we built upon (2008)

CDC integration demonstration project

- Offered potential to remove external barriers
- Provided visibility within Department/CDC

PSD Improvement Plan

- Goal III: PSD operates w. integrated strategies

Where we started

- Organized Integration Leadership Team of program directors.
- Identified key principles
 - Focused on outcomes
 - Used evidence-based practice and data-driven decisions
 - Capitalized: Staff strengths, Health Care Reform Synergy

Where we started

- Conducting strategic planning:
- Colorado MCH, ISVP, Chronic Disease Priorities, State & National Performance Measures (ROI + avert most disease & injury)
 - Imperatives
 - Policy and environmental change, health communications, public health linkages with health care systems, data and surveillance, partnerships, infrastructure

How far we've come

- Coordinated planning more strategic
 - Framework: data, evidence-base, public health role, “reality check”
 - Identification of FTE and funding (need more)
- Outcomes remain categorical; tactics may be integrated

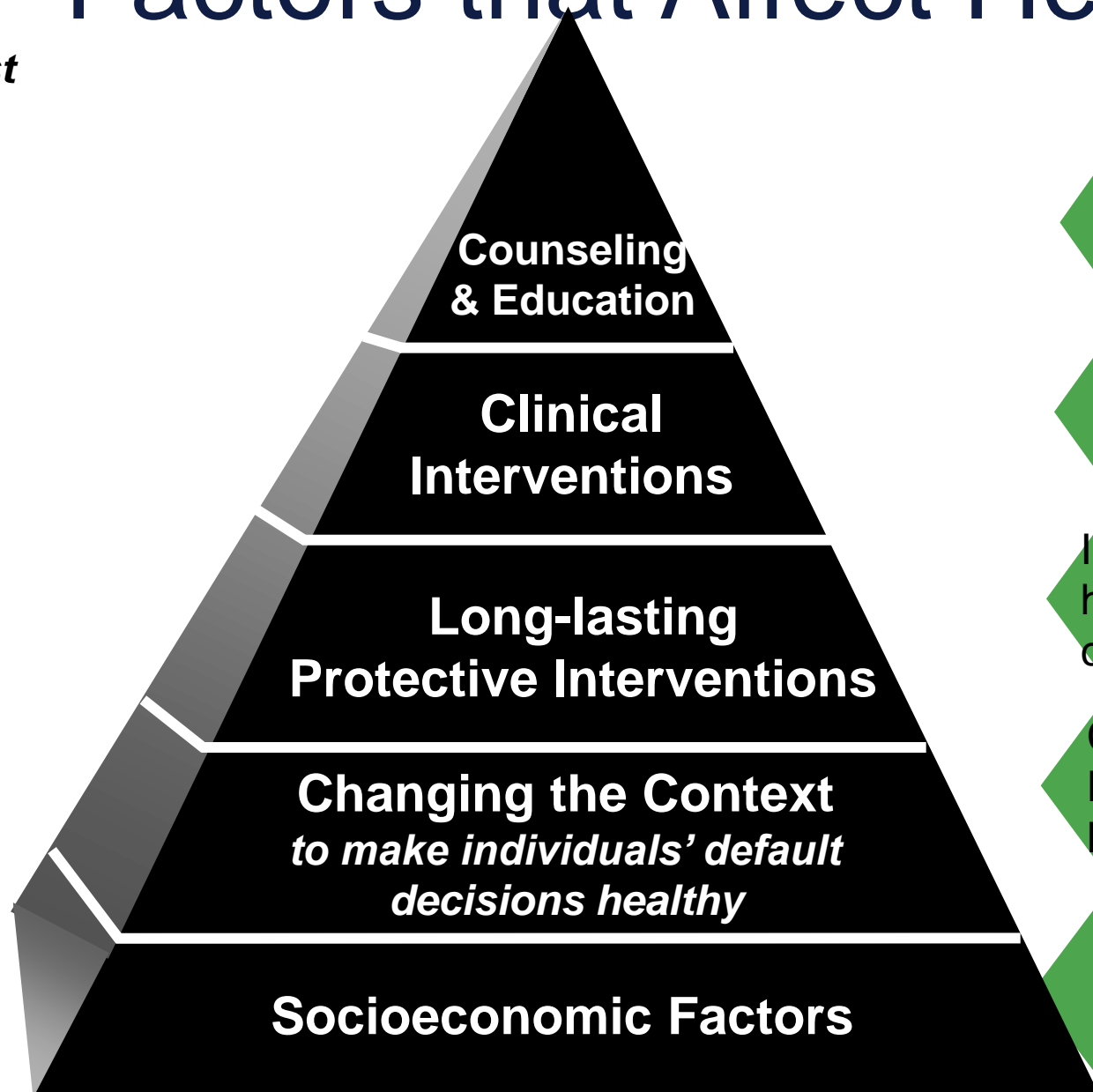
Factors that Affect Health

Examples

Smallest Impact



Largest Impact



Be physically active
But wear a helmet.

Problem drinking
screening and brief
counseling 8th

Immunizations, child
home visits treatment,
colonoscopy

Child Safety Seat
Laws, smoke-free
laws, BAC limit 0.08%

Poverty, education,
housing, inequality



An Explanatory Framework for Conceptualizing the Social Determinants of Health

**NATIONAL INFLUENCES
GOVERNMENT POLICIES
CULTURES**

SOCIAL DETERMINANTS OF HEALTH

+

INDIVIDUAL FACTORS

=

POPULATION HEALTH OUTCOMES

LIFE COURSE

EARLY CHILDHOOD
CHILDHOOD
ADOLESCENCE
ADULTHOOD

ECONOMIC OPPORTUNITY	COMMUNITY ENVIRONMENT	SOCIAL FACTORS
<ul style="list-style-type: none"> • Adequate income • Jobs • Educational attainment 	<ul style="list-style-type: none"> • Quality housing • Quality schools • Access to recreational facilities • Access to healthy foods • Transportation resources • Access to healthcare • Clean and safe environment 	<ul style="list-style-type: none"> • Participation • Social network/ social support • Leadership • Political influence • Organizational networks • Racism

HEALTH BEHAVIORAL	MENTAL/ PSYCHO-SOCIAL
CULTURAL NORMS	
<ul style="list-style-type: none"> • Diet & nutrition • Physical activity • Smoking • Alcohol consumption & addictive behaviors • Preventive health care use • Violence/ intentional injury • Unintentional injury • Parenting skills 	<ul style="list-style-type: none"> • Self esteem • Emotional state • Coping • Attachment • Demand/ strain • Sense of control • Stress • Perceptions • Expectations • Mental state

QUALITY OF LIFE
MORBIDITY
MORTALITY
LIFE EXPECTANCY

How far we've come

- Strategies

- Functions

- Health Communications/Marketing, Health Equity
 - Data/Surveillance/Evaluation, Fiscal and Grants Management ,Strategic Planning
 - Training
 - Coordinating efforts (BRFSS questions, press releases, policy training/approach, single website, youth survey)

Headed in the right direction

- More staff are being freed-up to do their best work
 - content experts can focus on content, process experts on processes
- More staff at all levels are engaging in work “outside” their boxes, seeing connections
- Moving from a “me” mentality to a “we” mentality
- In the “we” is where the best program level integration efforts happen