Central Oregon Health Council

RHIP Cardiovascular Disease & Diabetes Prevention Workgroup
Deschutes County Health Services—Stan Owen
2577 NE Courtney Drive, Bend OR 97701
Bend, Oregon

Agenda: January 23, 2018 from 3:30pm-5:00pm

1. **3:30-3:35** **Introductions—All**
2. **3:35-3:40** **Active Modes of Transportation RFP Update—MaCayla Arsenault**
3. **3:40-4:50** **Nutrition A3 Development—Sarah Worthington and Steve Strang**
4. **4:50-5:00** **Next Steps/Action Items—Sarah Worthington & Steve Strang**

Next Meeting: **Scheduled for February 27 from 3:30-5:00pm**

RHIP Cardiovascular Disease & Diabetes Updated Data

Green= Target met
Orange= Progress
Red= Moving in wrong direction
* This number may be statistically unreliable and should be interpreted with caution.

Overweight Teens — OHT Survey

8th Grade
Target: 14%

	State	Region	Crook	Deschutes	Jefferson
2013	14.8%	16%	15.2%	13.6%	22.6%
2015	15.4%	12.2%* ↓	20.4% ↑	11.0%* ↓	14.3% ↓

11th Grade
Target: 13%

	State	Region	Crook	Deschutes	Jefferson
2013	13.6%	14%	10.6%	12.8%	20.5%
2015	15.4%	13.8% ↓	17.4% ↑	12.8%*	18.7% ↓

Adult Smoking — BRFSS
Target: 16%

	State	Region	Crook	Deschutes	Jefferson
2013	19.0%	16%	31.0%	16.3%	24.1%
2015	17.9%	18.0% ↑	26.3% ↓	17.3% ↑	12.7% ↓

Teen Smoking — OHT Survey

8th Grade
Target: 3%

	State	Region	Crook	Deschutes	Jefferson
2013	4.1%	6%	8.9%	5.0%	4.9%
2015	4.3%	3.7% ↓	3.1% ↓	3.5%* ↓	5.8% ↑

11th Grade
Target: 9%

	State	Region	Crook	Deschutes	Jefferson
2013	9.4	12%	16.8%	10.7%	12.3%
2015	8.8	4.5% ↓	9.2% ↓	3.4%* ↓	8.8% ↓

Adults with no Leisure Activity BRFSS

Target: 14% Crook, 12% Deschutes, 15% Jefferson

	State	Region	Crook	Deschutes	Jefferson
2013	18.0%	-	15.8%	13.5%	16.7%*
2015	16.8%	-	29.3%↑	12.7%↓	19.3%*↑

Teens with 0 days PA OHT Survey

8th Grade

Target: 5%

	State	Region	Crook	Deschutes	Jefferson
2013	6.2%	6%	4.0%	5.9%	6.9%
2015	6.7%	3.9%↓	4.9%↑	3.4%*↓	6.6%↓

11th Grade

Target: 10%

	State	Region	Crook	Deschutes	Jefferson
2013	11.1%	11%	8.2%	12.6%	9.8%
2015	11.6%	4.1%*↓	11.1%↑	2.4%*↓	11.2%↑

OHT Survey Participants

8th Grade

	State	Region	Crook	Deschutes	Jefferson
2013	-	1,026	178	648	200
2015	-	568	165	291	112

11th Grade

	State	Region	Crook	Deschutes	Jefferson
2013	-	625	114	471	154
2015	-	367	102	87	178

Central Oregon Health Council	Description:		Value Stream ID:		Site / Location:		Event Number:	Revision:	1.0
	Sponsor:		Process Owner/Team Lead:		Facilitator:		Sensei:		

Current Date: | Event Date:

Team Members:

1

2

3

4

5

6

7

8

9

1: REASONS FOR ACTION — Go | No Go

Major Elements

- Problem Statement: A factual statement, clear, concise, hurts. Use the voice of the customer.
- Aim: Where we want to be, think big, reach beyond what we think we can achieve.
- Boundaries: Show what is in or out of scope.
- Trigger & End: The start and finish of a process (only applicable to processes with a clear beginning and end)

Unclear reason - unclear action

2: INITIAL STATE — Go | No Go

Understand the Situation

What – What is happening now?

Where – Where does the problem occur?
When – When does it?
How – How often does it occur?
Who – Who is affected?

Determine the metric for measurement and the baseline for your data.

"A problem well-defined is a problem half solved."

3: TARGET STATE: — Go | No Go

Set the Target

Expressed in the same terms as initial state.

When possible, use the voice of the customer.

Aim high for the required target, not just what we think we can achieve. The Target metric must align with the metric determined in Box 2.

Document how you will measure going forward.

4: GAP ANALYSIS — Go | No Go

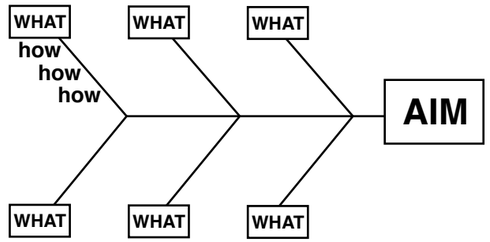
(At this stage an outsider's lens is valuable. Bring fresh eyes into the group for this section.)

Identify all possible causes or gaps for the situation

If you had to be at future state tomorrow, identify all of the things that are standing in the way or are absent. What we need to do to accomplish the aim?

Ask "why" or "how" to find the root cause – treat the root cause, not the symptom.

Suggested Tool: Reverse Fishbone



The Reverse Fishbone only works well for new problems, not existing processes

5: SOLUTION APPROACH — Go | No Go

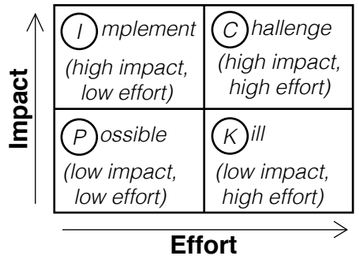
Scientific Approach: Hypothesize

If we implement "X", then we expect "Y" outcome.

Prioritize solutions and identify their potential impact.

Statistics or measurement of expected improvement are not required here.

Suggested Tool: PICK Chart



Plot proposed initiatives on the PICK Chart based on their perceived impact and effort. Take action based on the quadrant they land in.

The PICK Chart works best when there seem to be too many "If we, then we" statements.

6: RAPID EXPERIMENTS — Go | No Go

Check & Course-correct

What we're going to try to test the hypothesis.
What we tried, tested, implemented.
What are the conclusions?

If the Aim remains elusive, return to Box 4 and repeat the cycle until the Aim has been achieved.

7: COMPLETION PLAN — Go | No Go

Create an Action Plan

- Create an action plan to implement the solution
- Track progress and review status
- Small tests of change and then spread
- What worked, what didn't work, review gaps - Plan, Do Check, Act (PDCA)

Action	*Who*	*When*	*Status*
Collect	*Dan*	*xx/xx*	*Done*

8: CONFIRMED STATE — Go | No Go

Metrics Tracking

Track your metrics over time to visualize trends.

Verify the solution and learnings.

When box 8 = box 3 you've reached your target.

Track and Verify the Solution is working!

9: INSIGHTS — Go | No Go

Learning

Share the learning so we can continually improve through the future.

What worked well, what didn't work well?
What did we learn?
What would we do differently?

Executive Summary ~ Assessment of Central Oregon Nutritional Programs

Lack of access to and understanding of how to cook with fresh food is an obstacle to addressing diet-modifiable diseases such as cardiovascular disease and type 2 diabetes. In Central Oregon, this represents a major concern given that 1 of 5 residents are food insecure, or do not know where their next meal will come from, and the rates of diet-modifiable chronic diseases continue to rise. One way to overcome this barrier is through nutritional programs that provide assistance and/or education, promote a healthy diet, and teach the link between diet and health. However, knowledge of how patients access such programs and how practitioners refer their patients to these nutritional programs (NP) is lacking.

The High Desert Food & Farm Alliance (HDFFA) is a regional non-profit whose mission includes increasing access to fresh foods by all Central Oregonians. HDFFA responded to a request by the Central Oregon Health Council (COHC) to improve the health of Central Oregonians through the formation of clinical community linkages. This assessment was conducted to understand the current state of NP in the tri-county region using qualitative and quantitative methods and targeting three groups: 1) residents who are users or potential users of a NP; 2) health care practitioners (HCP) who (may) refer patients to a NP and; 3) professionals who currently implement a NP.

Four key findings and recommendations were provided as an outcome of the study. ***The first key finding*** was that generally, residents and HCP were aware of nutrition assistance programs (such as WIC) versus nutritional education programs (such as cooking classes). Specifically, 80% of respondents who had participated in a NP had joined an assistance program. HCP also stated that over 75% of their patients would benefit from better nutrition and education but only 14% of resident respondents stated they had ever been referred to a NP. Our recommendation is to create a comprehensive and reliable resource to facilitate referrals and decrease duplication of efforts across programs to allow all users to effectively plan enrollment into programs.

The ***second key finding*** is that most residents do not make a connection between their own health and their diet. Resident respondents generally lacked interest in knowing more about NP, while HCP stated they were not enthusiastic about making referrals due to this lack of interest; furthermore, residents did not view their HCP as a source for information. Our recommendation is to conduct a "food as medicine" campaign to educate the public about eating a fresh food diet to be(come) healthy in conjunction with the a nutrition program resource.

The ***third key finding*** is that those most at risk for diet-modifiable diseases, because of low fresh food consumption, are not routinely referred to nutrition education programs. Our recommendation is to systematize identification of individuals who are food insecure and/or have a diagnosis of (pre)diabetes and cardiovascular disease and automatically refer those patients to nutrition education programs.

The ***fourth key finding*** is that fresh food is too expensive for most people and HCP agree that fresh foods are critical to implementing nutrition education programs. We recommend a fresh food prescription voucher program for low-income residents that provides fresh food as nutrition assistance in conjunction with nutrition education and coaching by HCP. The administrative aspects of the program can be implemented and managed by a community organization while the referring practitioner can focus on managing the health of the patient. This program is a model for the clinical community linkages that were stated as critical in the COHC Regional Health Improvement Plan.

HIGH DESERT FOOD & FARM ALLIANCE
CENTRAL OREGON INTERGOVERNMENTAL COUNCIL
cultivaré, llc health & nutrition research
Project funded by:
Central Oregon Health Council

Overview of Central Oregon Nutritional Programs Assessment

Objective: To establish and disseminate a comprehensive needs assessment of nutritional programs in Central Oregon and identify gaps and barriers regarding their availability, dissemination, and implementation.

Methods and Analysis: Quantitative and qualitative analyses from survey and focus groups from:

1. Central Oregon residents
2. Health Care Practitioners
3. Program Implementers

Key Findings

Residents do not personally connect eating a fresh food diet with better health.

< 10% of residents want to learn about nutritional programs from their doctor

14% of residents have been referred to a nutritional program

Residents and practitioners were less aware of nutrition *education* compared to nutrition *assistance* programs.

80% of residents who participated in a program joined a nutrition *assistance* program

Patients with the highest risk of diet-modifiable disease were not routinely referred to a Nutrition Program

75% of providers say their patients would benefit from better nutrition *and* education

Obstacles to enrollment

Time and
lack of interest

The cost of fresh food is too high for many who want to implement what they learn in their nutrition education classes.

Barriers to eating fresh food

Cost
Food insecurity
Being male
Less educated
Too expensive
Diagnosis of diabetes or heart disease

Recommendation

Develop and implement an online resource for nutrition education programs to facilitate health care referrals and usage.

Promote a "*food as medicine*" marketing campaign to increase the understanding of the link between diet and health.

Systematically identify people at risk for diet-modifiable diseases and/or food insecurity and automatically refer them to a Nutrition Program

Implement a Veggie Rx program (fresh food prescription) with the medical community alongside nutrition education programs for low-income residents.