



CORAGGIO

Alcohol & Other Drug Prevention Partners Workgroup

Workgroup 2: Align and clearly communicate state-wide strategies, goals and priorities

June 6, 2018

Coraggio Group
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Agenda—June 6, 2018

9:30-9:35	Welcome and Overview
9:35-10:00	Introductions and Reflections
10:00-10:30	Context Frame-Up
10:30-11:00	Team Agreements and Decision-making
11:00-11:15	Physical Activity Break
11:15-11:45	Overview of proposed model to draw on: Collective Impact Model
11:45-11:55	Move rooms from Arthur Room to Ramona Room
11:55-12:45	Lunch & Discuss: Hindsight, Nearsight, Foresight
12:45-1:00	Potential Positive Impacts
1:00-1:30	Defining the Change
1:30-2:00	Change Readiness Assessment: Slider Activity
2:00-2:15	Physical Activity Break
2:15-3:25	Candidate Shared Objective Breakouts & Report Outs
3:25-3:30	Close & Next Steps



Workgroup Members

WORKGROUP MEMBERS

Genevieve Ellis	Washington County Dep. of Health and Human Services
Jessica Jacks	Deschutes County Health Services
Demetria Thompson	Union County Center for Human Development
Monica Yellow Owl	The Klamath Tribes
Abigail Wells	Vibrant Futures Coalition
Anthony Jordan	Multnomah County; Oregon Alcohol and Drug Policy Commission
Jackie <u>Fabrick</u>	OHA-Health Policy and Analytics
Laura Chisolm	OHA-Injury and Violence Prevention Section
Mary Borges	* Temporarily filling in for Laura, OHA Prescription Drug Overdose Program
Jessica Duke	OHA - Adolescent Health
Luci Longoria	OHA – Health Promotion and Chronic Disease Prevention
Amanda Cue	OHA – Health Promotion and Chronic Disease Prevention
Vicky <u>Buelow</u>	OHA – Health Promotion and Chronic Disease Prevention

FACILITATORS

Matthew Landkamer, Coraggio Group
Sarah Lechner, Coraggio Group



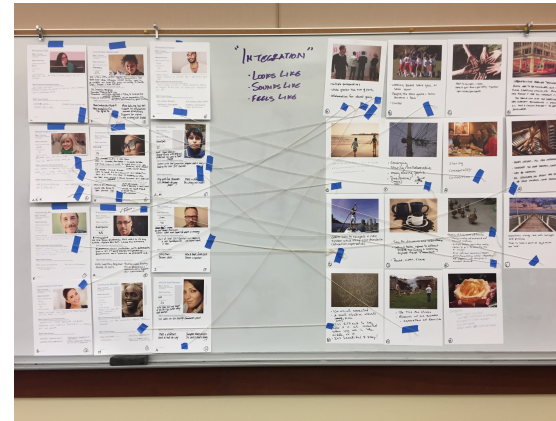
1. What is your name?
2. What is your organization/agency?
3. What is your role?
4. How long you have worked in this field?
5. Why do you do this work?



Align and clearly communicate state-wide strategies, goals and priorities

- Overview of the outreach & engagement process
- Report summary

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Oregon Health Authority, Public Health Division
Health Promotion and Chronic Disease Prevention (HPCDP)

Prevention Partner Conversations: Final Report

June 16, 2017

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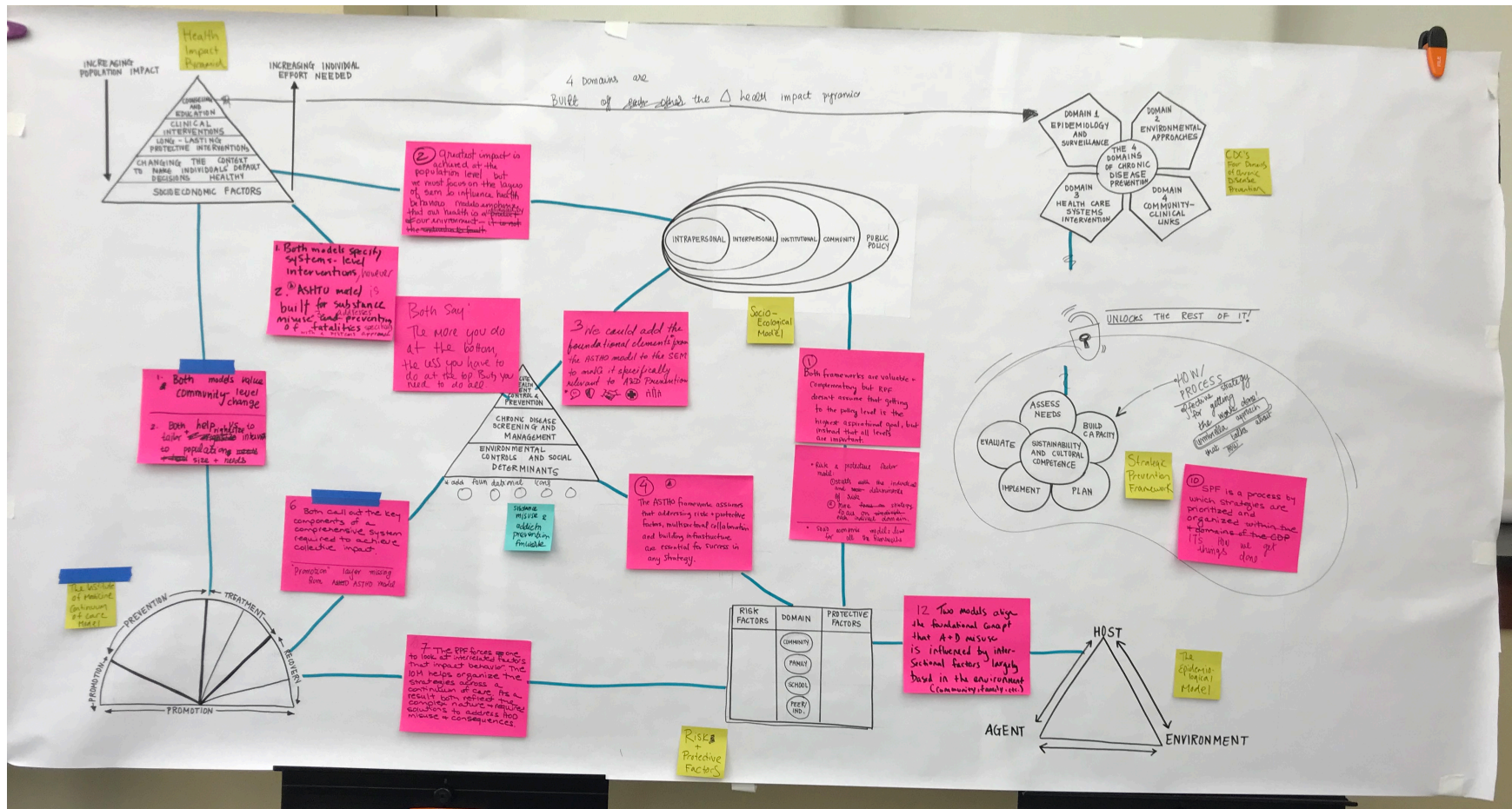
Why: Align and clearly communicate state-wide strategies, goals and priorities?

What we heard, regarding why the work of this workgroup is important:

- Shared decision making
- Not top-down
- Happening now, closely connected
- Transparency
- Focus on common goal
- Evidence of utilization of information gathered, force!
- Moving in the same direction as a group-team
- Greater impact
- Alleviate confusion
- Instill inclusion
- Lack of communication = frustration & feeling bad that I wasn't doing what I was supposed to be doing because I didn't know / wasn't told what I was supposed to do.
- With transparency comes trust
- Ensure we're on the same page—strive towards a shared goal
- Builds understanding between local and state
- Ensure opportunity to communicate local goals, strategy and priorities to state
- Clear Communication of definition between local and state
- Local expertise
- Local CHIP/RHIP/SHIP alignment

Align and clearly communicate state-wide strategies, goals and priorities

Summary of Workgroup 1 process thus far: Crosswalk the language and frameworks of prevention and public health





Overview of this Workgroup:

- 1 deep-dive process design meeting
- Material gathering/synthesis
- 3 follow-up meetings
(a two-hour virtual meeting, a 4hour in-person meeting and another two-hour virtual meeting)
- 1 3-4 hour in-person reflect-and-adjust workshop



Team Agreements

- Be honest and vulnerable
- Assume best intent
- Be brave
- Avoid jargon; no shame in asking for clarification
- Represent the whole
- Be open-minded; think “outside of the box”
- Be curious
- Do your best to participate
- No “meeting after the meeting”; share w/ whole group
- Communicate as a whole, with agreement



- Discuss proposed decision-making process
 - Agreed to use “thumbs” voting approach to move our process forward with general consensus
- Discuss what will happen with our recommendations
 - Our recommendations will be passed on to the HPCDP team within the Public Health Division



Our Hopes for this Workgroup

- Identify common goals for communication and how the work is done together
- Clear picture of overall objectives – visual, concise
- Solid recommendations re: how to communicate priorities and greater visibility of the alignment on those things
- Model an inclusive practice of checking on what we need to do to work well together – support this work in an ongoing way
- By aligning, recognizing the collective impact we currently have
- 3 to 5 state objectives and under those the strategies the ADRep communities will adopt/options. OHA to lead with local opportunities of strategies that support
- Solid recommendation on a formal process for plan development. Allow for the community uniqueness, but strategy driven, reviewed by professionals.
- Model how to effectively communicate priorities in a way that doesn't feel top down
- Model two-way communication – empower partners to ask questions, etc.
- Commit to trying some new ways of communicating together.



Overview of Collective Impact Model (proposed to inform our approach)



Hindsight; Nearsight; Foresight—Overview

	HINDSIGHT	NEARSIGHT	FORESIGHT
Common Agenda	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X
Shared Measurement Systems	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X
Mutually-Reinforcing Activities	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X
Continuous Communication	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X 	<ul style="list-style-type: none"> • X • X • X

Hindsight; Nearsight; Foresight—Common Agenda

	HINDSIGHT	NEARSIGHT	FORESIGHT
Common Agenda	<ul style="list-style-type: none"> • Every county, community and tribe created their own unique plan for substance abuse prevention • We may have been working on similar things, but it was driven at a local level, and we communicated that to the state • State did not have a strategic plan that informed what we were doing, until the SPF (~2009) came about—that was the first time there was more direction from the state • In tobacco prevention, there had been statewide strategic plans since the late 90s, some effort to comply with existing tobacco laws around retail sales • Public Health led tobacco prevention; AMH was charged with tracking some aspects of tobacco retail sales • AMH asked us to provide quantitative data on our strategies, but it was demographic data that didn't prove effectiveness—driven by federal block grants • County teams were focused on direct service, DFCs drove an expansion to a different lens on how to look at prevention 	<ul style="list-style-type: none"> • Our first quarter reporting was much more qualitative, and we got to talk more in-depth about what we are seeing in our communities, and what's effective • Currently a statewide health improvement plan that has elements touching the alcohol and other drug work, though some find it confusing still, re: what we are working towards • Pieces are there, but there may not yet be a common agenda • State plan has felt disconnected from CCO plans and local plans • Focus on RHIP plan being connected to local plan • HPCDP also has a five-year strategic plan with alcohol and other drug use are included as top priorities. This plan influences the statewide HIP. • Adolescent and School Health also has a strategic plan • Common agenda is: reduce substance addiction, and reduce substance misuse, chronic disease and secondary harms 	<ul style="list-style-type: none"> • We need to talk about prevention in the future—ACES needs to be part of that conversation • Efforts woven together as a state; working in a more integrated fashion • Nimbleness (e.g. the challenge might be other than opioids in a few years) • Build sustainable systems that can withstand the ebbs and flows of funding • May go broader to include mental health promotion and prevention

Hindsight; Nearsight; Foresight—Shared Measurement Systems

	HINDSIGHT	NEARSIGHT	FORESIGHT
Shared Measurement Systems	<ul style="list-style-type: none"> • Wasn't a surveillance person dedicated to identifying & evaluating those measurement systems in the past • Measurements were based on the Block Grant or other funding streams • Lots of different approaches (Student wellness survey, Oregon's healthiest teen, federal data) but no alignment, disaggregated, no way to compare. Not much confidence or power in the system. These surveys were in competition with one another- unclear which to prioritize. • An inability to align on shared measures led us to have multiple surveys. There were competing agendas related to sexual health and violence, etc. Issues around resourcing etc. • Survey design issues: were missing lots of critical data, phrasing was confusing • MDS & OPDS reporting tools were arduous and did not capture valuable information 	<ul style="list-style-type: none"> • Going back to one combined youth survey in 2020, and content/communications are going to be revised. Still, however, a lot of confusion and challenges to gain buy-in with partners. There is technical assistance available, but many people aren't aware of what is available. More needs to be done to create greater equity in dispersing resources. • New survey and data around adult perceptions related to marijuana. Example of a tool for gathering knowledge, attitude and opinion data and turn it around quickly. Result of increased capacity and dedicated surveillance resources • Working on more robust across the lifespan data and information to look more at excessive alcohol use. • MDS & OPDS no longer exist. New system being developed to go beyond numbers served to capture the approach and strategies that support effective community work. • Variance in where prevention sits (in public health, behavioral health or it may stand alone, early childhood, etc.). This creates a deficit in terms of accessing information and influences 	<ul style="list-style-type: none"> • Resourcing and supporting the collection and analysis of data in a way that is more supportive to tribal communities • Stable surveillance systems built. This will involve having to set the reset button on some systems in support of better data. This will require additional training. • A more robust system with strong data we can rely on. • Better engagement around planning data; tapping into community knowledge and building it into the planning processes • Use data to better illustrate & understand inequity • Policy database refresh to capture policies that are implemented across Oregon. Available to use in planning and alignment. • Relying on data that isn't self reported to see more accurate representation • A widely available place that the statewide data could be accessed (like or within the behavioral health mapping tool)

Hindsight; Nearsight; Foresight—Mutually-Reinforcing Activities

	HINDSIGHT	NEARSIGHT	FORESIGHT
Mutually-Reinforcing Activities	<ul style="list-style-type: none"> • Connections not drawn between evidence-based practices and tribal best practices • We had DFCs and prevention conferences where people could come together to learn best practices, as well as build relationships 	<ul style="list-style-type: none"> • HPCDP doing parts of each aspect of the work, but also acting as a connector—don't need to know everything about everything, but able to connect dots. A lot of other entities doing this as well. • Helping people throughout the scope of service—you can't have one without the other, in terms of health promotion, prevention, treatment, recovery, etc. • PHA has the potential to draw connections between evidence-based practices and tribal best practices • OHA can help us understand how we can be effective “up-river” • Lack of training and educational opportunities • People are working on the same things, but potentially in a way that isn't mutually-reinforcing because we aren't connected enough 	<ul style="list-style-type: none"> • Need for alignment and strategic planning time together—has its own need and value • Leadership at each level (state and local) can be the vehicle to move towards mutually-reinforcing work—how does the expertise in both settings reinforce the work? • Draw on expertise and leadership from every part of the prevention community • How do we ensure we have all the right people at the table/at the forum, given that prevention is housed in all these different areas? • Counties and tribes coordinating on strategies together?

Hindsight; Nearsight; Foresight—Continuous Communication

	HINDSIGHT	NEARSIGHT	FORESIGHT
Continuous Communication	<ul style="list-style-type: none"> • When prevention moved from AMH to PHD, the communication was unsatisfactory • Tribes had one point of contact. This was nice, given that many Tribes also just had one person; resulted in strong relationships • Conferences served as a valuable venue for communication • Prevention coordinators use to meet twice annually and had one point of contact 	<ul style="list-style-type: none"> • Shift from 1:1 communication to a team-based approach to communication • Not doing conferences and doing webinars instead saves resources but impacts relationships • Email is used to communicate. Lots of new groups and listservs and calls have been established, but they are incomplete or we end up on the wrong list. They can be valuable but at times the goals are unclear. • We have lots of different points of connection within OHA. It is confusing and messages can be conflicting. • Acknowledging we are in a time with so many potential tools and communication lines to choose from and that involving more people comes with challenges and complexity and lots of individual needs. 	<ul style="list-style-type: none"> • Greater transparency re: transition and what we're working on as communication systems shift • OHA needs to do a better job of communicating in a way that keeps end user in mind (including language, reading comprehension, etc.) • Bring people along in transitions so that they are in on the "why" (nothing about me without me) • Clearly communicate the benefits and why of changes, intended impacts, etc. • Continuous communication about strategic priorities. Two way. • Ensure there are point people/the right mix on lists and groups to ensure representation and communication



Defining the Change—1

How much of our prevention partner community will be affected by the transition to working in a collective impact model (CIM)?

1 = affects only a workgroup

5 = affects the entire community

Group's Average: 4.5



What is the number of partners impacted by the change to a CIM?

1 = less than 10

2 = 10 to 200

3 = 200 to 500

4 = 500 to 1000

5 = over 1000

Group's Average: 3.8



How much variation is there between how different groups are impacted by a change to a CIM?

1 = all groups are impacted the same

5 = all groups will experience the change differently

Group's Average: 4.1



What type of change is the change to a CIM?

1 = single aspect, simple change

5 = many aspects, complex change

Group's Average: 4.4



To what degree will the change to a CIM cause changes in processes?

1 = no change

5 = this will change all of our processes

Group's Average: 3.4



To what degree will the CIM change result in changes to technology and systems?

1 = no change

5 = will change all of our technology and systems

Group's Average: 2.9

To what degree will the CIM change cause changes to job roles?

1 = no change

5 = will cause all job roles to change

Group's Average: 3.6



To what degree will the CIM change result in organizational restructuring at any partner organization?

1 = no change

5 = will require a complete restructuring

Group's Average: 2.6



What will be the overall amount of change due to the change to a CIM?

1 = incremental change

5 = radical change

Group's Average: 2.9



What impact will the CIM change have on individual compensation?

1 = no impact to pay or benefits

5 = large impact on pay or benefits

Group's Average: 1.4

To what degree will the change to a CIM cause a reduction in staffing levels?

1 = no change expected

5 = significant change expected

Group's Average: 1.3



What is the timeframe for the length of the change to a CIM?

1 = Either very short (<month) or very long (> year)

5 = 3-month to 12-month initiative

Group's Average: 1



Change Readiness Assessment

How do you feel about the need for a change to a Collective Impact Model (CIM)?



What has been the impact of past changes?



How much change are you currently experiencing within the prevention community?



How would you describe the results of past changes in the prevention community?



Does the prevention community have a culture of responsiveness to change?

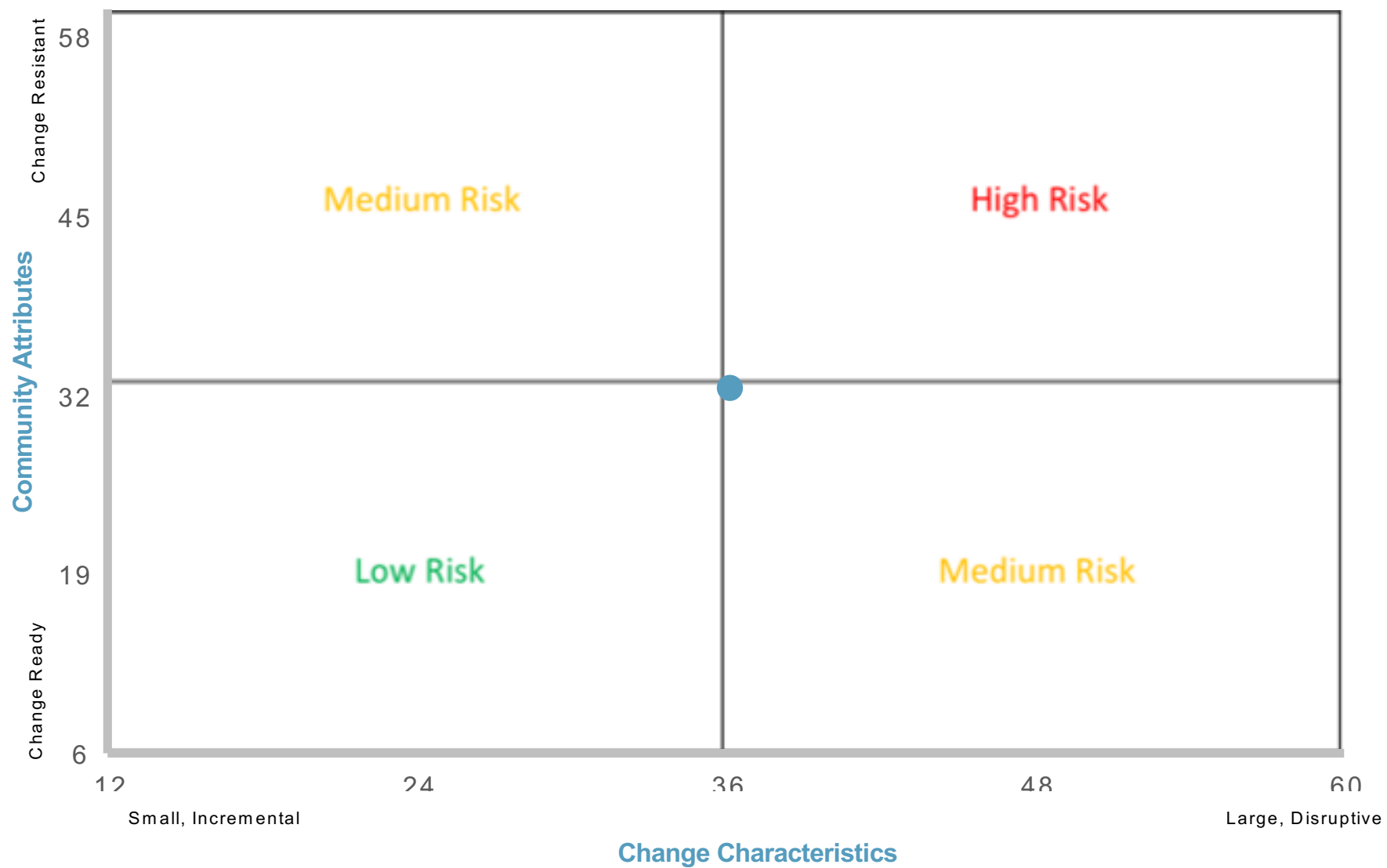


How much are prevention partners encouraged to try new things and embrace change?



Total
score:
32.5

Change Readiness Assessment



Setting Priorities: What informs how we focus our work?

- Youth surveys
- SAMHSA requirements
- Logic model
- Adult data
- Consequence data
- Community readiness
- Community capacity
- Evidence based strategies – rigorous research
 - CDC preventative task force
- GONA (Gathering Of Native Americans) - CB Process for identifying prior __?__ strategy
- Assessment and planning frameworks
 - SPF
 - Risk & Protective Factors
 - ER
- Strategic Plans
- Focus groups /listening sessions
- Stakeholder feedback
- Governor
- Evidence based models – evaluation results
- Needs assessment
- Laws/rules
- Partners
- Emerging issues/emergencies
- Initiatives (Triple Aim)
- Capacity
- Community health assessments/surveys
- Community guide for preventive services CDC
- IOM (National academies)
- Political feasibility (desire from leaders, mandates)
- Focus groups
- Community listening sessions
- Evidence-based practices
- Trend data
- ACHA/NCHA Survey (college health survey)
- Rave oversamples (BRFSS)
- BSEE Survey
- CCO Data
- Panel surveys (attitude/beliefs)

In your group, identify 3-5 objectives that are:

- Common goals of both OHA and local/county prevention partners
- Specifically measurable using data that is currently collected
- Good representatives of overall progress



Draft Potential Shared Objectives List

- Reduction in teen binge drinking... ATOD
- Eliminate alcohol consumption by pregnant women
- Parental disapproval
- Increase perception of harm of... ATOD attitudes
- Improve/change community laws and norms that are favorable to ATOD use/misuse
- Youth 1st use
- Ease of access
- Reduce binge drinking/heavy drinking among adults
- Increase community capacity for prevention and policy
- Number of policies and practices change/adopted re: AOD
- Reduce harms associated with AOD (mortality)
- Decreased mortality (due to substance abuse, suicide by overdose) and morbidity (ER, services use, hospitalizations)
- Attitudes and perceptions (intermediate)
 - Decreased use of substances
- Binge – adults and youth
 - MJ
 - Rx Drugs
- Per capita consumption decreased – Alcohol and tobacco
- Decreased exposure access – advertising SHS
- Increased exposure to prevention messages
- # of policies passed
- Decreased adult cigarette smoking (and smokeless) among adults
- Decrease adult excessive alcohol use
- Decrease alcohol gallons consumed
- Increase age of onset of alcohol use
- Increase age of onset of MJ/Tobacco use
- Decrease youth adult binge drinking
- Decrease poly-substance use
- Decrease risk of substance use-adult, and misuse-youth, through self-management
- Decrease per capita cigarette sales
- Reduce youth smoking prevalence (and smokeless tobacco)