July 23, 2019
Meeting Packet

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Agenda

New Inpatient Building (NIB) Community Advisory Committee (CAC)
Beth Israel Deaconess Medical Center (BIDMC)
Rabkin Board Room, Shapiro Building
Tuesday, July 23, 2019
5:00 PM – 7:00 PM

I. 5:00 pm – 5:10 pm	Introduction and Welcome
II. 5:10 pm – 5:25 pm	Public Comment Period
III. 5:25 pm – 5:40 pm	Radiology DoN (Tentative)
IV. 5:40 pm – 5:55 pm	Final Health Priorities
V. 5:55 pm – 6:30 pm	Health Priorities Sub Categories
VI. 6:30 pm – 6:55 pm	Allocation
VII. 6:55 pm- 7:00 pm	Summary/Next Steps

NEW INPATIENT BUILDING COMMUNITY ADVISORY COMMITTEE MEETING

Nancy Kasen
Director of Community Benefits

July 23, 2019

Beth Israel Lahey Health

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Community Advisory Committee Goals and Votes

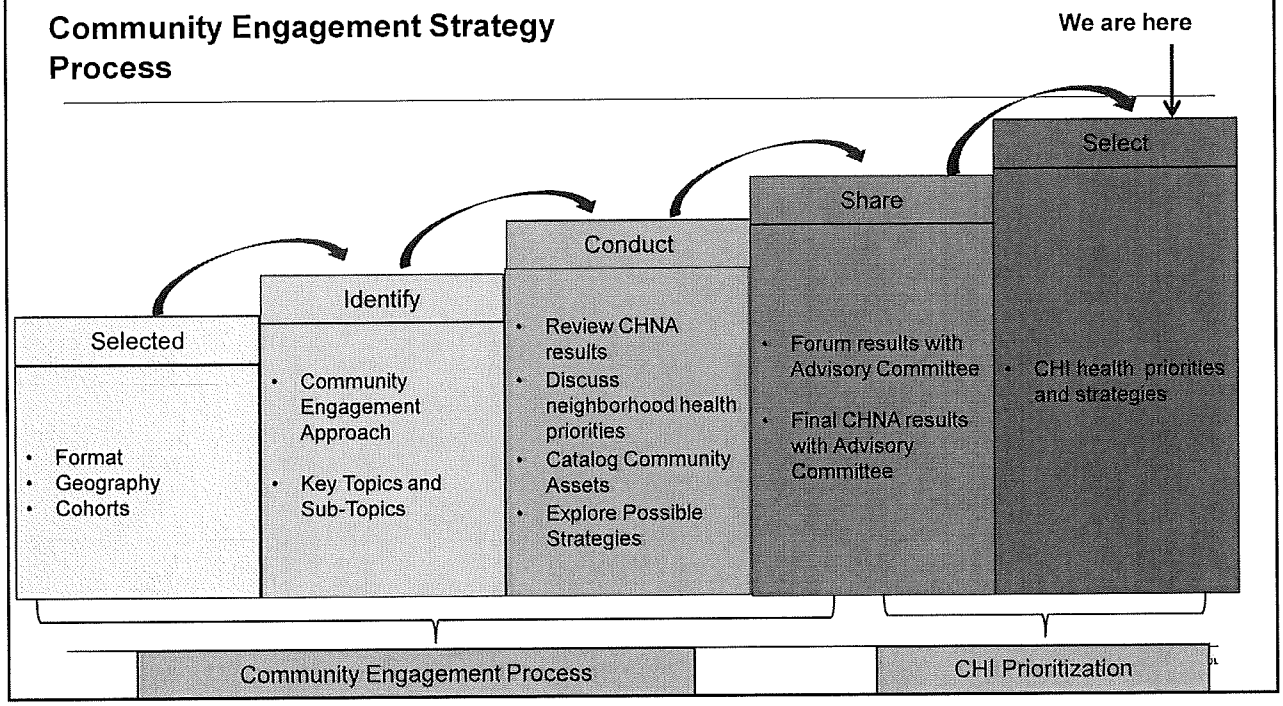
Goals for the meeting:

- Finalize and vote on NIB CHI PriorityAreas
- Discuss and vote on NIB CHI sub-priorities
- Begin discussion on funding strategy/allocation

Votes needed for:

- Approval of meeting minutes
- NIB CHI Priorities
- NIB CHI Sub-Priorities

Community Engagement Strategy Process



Community Advisory Committee MADPH Framing Questions

Consider:

- Who benefits?
- Who is harmed?
- Who influences?
- Who decides?
- What might be any unintended consequences?

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Community Advisory Committee
Public Comment

Welcoming Public Comments

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COMMUNITY ADVISORY COMMITTEE DISCUSSION

NEW CT SCANNER WEST CAMPUS

Presented by BIDMC CT team

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Current Status on the West Campus

Scanner in the ER for emergency exams

- Approximately 2000 exams monthly
- Needs to be immediately available for code stroke, AAA, trauma

Scanner on 3rd floor for inpatient and outpatient use

- Average of 1300 per month
- State of the art scanner for complicated patients

Scanner on the 3rd floor for procedures

- Average of 5 procedures per day
- Average length of procedure 1.5 hours

CT Scanners at capacity

Challenges

ER scanner is at full capacity

- Can not assist with overflow inpatients or outpatients scans
- Wait times are long, additional scanner is needed to decrease wait time for ED patients

Procedure scanner booked 9am-5pm with "add-on" inpatients procedures after hours

- Can not assist with overflow
- procedures for cancer diagnosis scheduled up 10 days away
- procedures for cancer treatment scheduled up 6 weeks away

Disruption to patient care

Problem with ACCESS!

More challenges

Scanner for inpatients and outpatients operating near capacity

- Inpatient flow is unpredictable due to individual patient needs, limits the availability for outpatients.
- Outpatients are being diverted to the other campuses, also operating at capacity. This requires very sick patients to walk 12-15 minutes between MD office and CT scanner

Sick patients need to travel

No back up capabilities

If a scanner goes down, we have to suspend one of the services

Why a new scanner?

Need DON to be submitted

Benefits of additional scanner:

- Less wait time for inpatients
- More availability for outpatients
- Equipment issues would not require suspension of services
- More patients would be able to be scanned in the same building as their MD appointments
- Reduction in wait times for CT-guided procedures
  - Faster diagnosis of cancer
  - Faster cancer treatment

Additional scanner will solve problem of access

NIB CHI PRIORITIES DISCUSSION

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Selection of CHI Priorities
Goals and Things To Keep in Mind

Goal tonight: Finalize 4 priorities & narrow sub-priorities to 2-3 per priority

Things to keep in mind:

- Less is more, if we are going to have an impact;
- Keep in mind the ranking criteria;
  (i.e., Burden, Equity, Impact, Feasibility, and Collaboration)
- Make sure that the priorities are aligned with BCCC, BIDMC CHNA, and DPH;
- Keep in mind the MA DPH Framing Questions

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Selection of CHI Priorities Suggestions

Voted 6.25.19

New following Advisory Committee at 6/25 Meeting discussions

Housing

Jobs and Financial Security

Behavioral Health

Healthy Neighborhoods

Housing
- Affordability
- Homelessness
- Home Ownership
- Gentrification and Displacement

Jobs / Financial Security
- Education / Workforce Training
- Employment opportunities
- Income / Financial supports

Behavioral Health
- Mental Health
- Substance Use
- Access to Services

Healthy Neighborhoods
- Access to Care
- Built Environment
- Environmental Health
- Other SDOHs
- Violence Prevention

Vote: Selection of Final CHI Priorities

The proposal is for inclusion of the following health priority areas in the BIDMC NIB CHI:

Health Priority Areas

- Housing
- Behavioral Health
- Jobs / Financial Security
- Healthy Neighborhoods

Vote approved these priorities following Advisory Committee discussion on 6/25

Selection of CHI Sub-Priorities
Discussion & Polling

Are there any strategies or sub-priorities we've missed?

Conduct first poll with proposed and new strategies

Based on polling results:

- Is there clarity or consensus on sub-priority areas that members feel should be prioritized by CAC?
- Is there clarity or consensus on sub-priority areas that members feel should NOT be prioritized by CAC?
- Who wants to advocate to elevate or demote one of the remaining sub-priority areas?

Conduct Second poll, if necessary

Selection of CHI Sub-Priorities
Recommendation

Housing

Housing
- Affordability
- Homelessness
- Home Ownership
- Gentrification and Displacement

Sub Priorities	Potential Strategies
Affordability	• HOME Investment Partnership Programs • Housing trust fund • Tenant-Based Rental Assistance Programs
Homelessness	• Assertive Community Treatment (ACT) • Critical Time Intervention (CTI) • Housing First
Home Ownership	• HOME Investment Partnership Program • Housing trust funds
~~Gentrification and Displacement~~	~~• Mixed-use development~~ ~~• Zoning regulations for land use policy~~

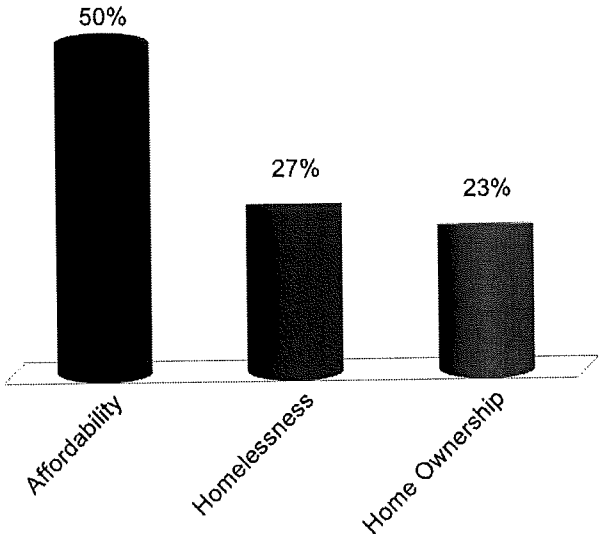
Choose your top two (2) sub priorities for funding.

A. Affordability

B. Homelessness

C. Home Ownership

Decision to fold home ownership and homelessness into Affordability, making "Affordability, Home Ownership, and Homelessness" the sub-priority/strategy.



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Selection of CHI Sub-Priorities Recommendation

Jobs and Financial Security

Jobs / Financial Security
- Education / Workforce Training
- Employment opportunities
- Income / Financial supports

Sub Priorities	Potential Strategies
Education/ Workforce ~~Training~~ Development	• Adult vocational training • Bridge programs for hard-to-employ adults • Career pathways programs • Financial literacy and savings
Employment Opportunities	• Transitional jobs • Youth apprenticeship initiatives
Income /Financial Supports	• Affordable childcare • Financial literacy and savings • Job training / retraining • Small business and micro-finance programs • Targeted financial support programs (e.g. Community Action Program best practices)

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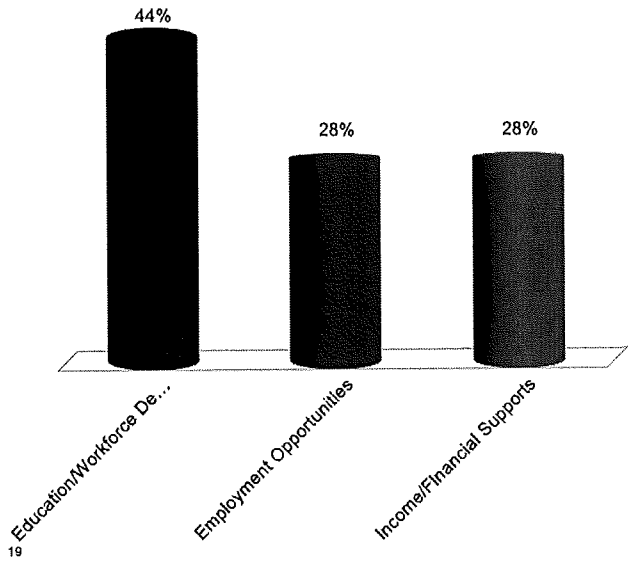
Choose your top two (2) sub-priorities for funding.

A. Education/Workforce Development

B. Employment Opportunities

C. Income/Financial Supports

Decision to keep all three as sub-priorities/strategies.



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Selection of CHI Sub-Priorities Recommendation

Behavioral Health

Behavioral Health
- Mental Health
- Substance Use
- Access to Services

Decision to keep Mental Health and Substance Use as sub-priorities, with "access to services" as a strategy to be funded in both categories.

Sub Priorities	Potential Strategies
Mental Health	• PreVenture (School-based education/screening treatment) • Community-wide trauma-informed approach (SAMHSA) • Comprehensive and Integrated Reentry Services • Targeted media campaigns • Whole School, Whole Community, Whole Child (CDC) • Access to services including increasing workforce
Substance Use	• Access to cultural/linguistic appropriate services • Bridge Programs with Peer Recovery Coaching • Comprehensive and Integrated Reentry Services • PreVenture (school-based education/screening treatment) • Whole School, Whole Community, Whole Child (CDC) • Access to services including increasing workforce
~~Access to Services~~	~~• Enhanced outreach and Community Response Teams~~ ~~• Improve the quality/quantity of support services~~ ~~• Intensive case management/patient navigation~~

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Selection of CHI Sub-Priorities Recommendation

Sub-priorities/strategies for funding TBD

Healthy Neighborhoods

Healthy Neighborhoods
- Access to Care
- Built Environment
- Environmental Health
- Other SDOHs
- Violence Prevention

Sub Priorities	Potential Strategies
Access to Care	• Geriatric services • Primary medical and specialty care
Built Environment	• Access to bike shares and safe bike paths • Main Streets programs • Safe parks and greenspace • Safe streets / walking paths
Environmental Health	• Air and noise pollution • Green / energy efficient technology • Flood protection • Integrated Pest Management
Other SDOH	• Food access and healthy eating • Transportation
Violence Prevention	• After-school programming • Mentoring programs: delinquency • Police-initiated diversion for youth

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ALLOCATION DISCUSSION

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Preliminary Discussion of Allocation for CHI Priorities (with proposed funding percentages)

Housing	Jobs and Financial Security	Behavioral Health	Healthy Neighborhoods
Suggested 1: 15% Suggested 2: 25% Suggested 3: 60%	Suggested 1: 35% Suggested 2: 25% Suggested 3: 10%	Suggested 1: 20% Suggested 2: 25% Suggested 3: 10%	Suggested 1: 30% Suggested 2: 25% Suggested 3: 20%
Housing • Affordability • Homelessness • Home Ownership • Gentrification and Displacement	**Jobs / Financial Security** • Education / Workforce Training • Employment opportunities • Income / Financial supports	**Behavioral Health** • Mental Health • Substance Use • Access to Services	**Healthy Neighborhoods** • Access to Care • Built Environment • Environmental Health • Other SDOHs • Violence Prevention

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Self-Evaluation
COMMUNITY ADVISORY COMMITTEE

Beth Israel Lahey Health

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Community Advisory Committee Wrap Up

Advisory Committee Responsibilities / Meeting Agendas:

Meeting Date	Meeting Deliverables
July 23, 2019	• Finalize and Approve Selection of Health Priorities
August: No Meeting	
September 24, 2019	• Review Draft Allocation Plan
October 22, 2019	• Finalize Allocation Plan for CHI Funds • Review Draft of DPH required *Health Priorities Strategy Form*

Evidence-Based Strategies

Updated 7/18/2019

Housing

Homelessness
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Homelessness	**Housing First** Provide rapid access to permanent housing and support (e.g., crisis intervention, needs assessment, case management), usually for chronically homeless individuals with persistent mental illness or substance abuse issues	*Housing First programs address chronic homelessness by providing rapid access to permanent housing, without a pre-condition of treatment, along with ongoing support services such as crisis intervention, needs assessment, and case management. A form of permanent supportive housing, the program usually serves individuals who are chronically homeless and have persistent mental illness or problems with substance abuse and addiction. Clients can be placed in apartments throughout a community (Stergiopoulos 2012) or a centralized housing location with on-site support for those requiring more intensive services; clients receive housing regardless of substance use (Patterson 2013). Unlike standard rapid re-housing programs, there are no time limits for Housing First program participation (Urban-Cunningham 2015).*

Homelessness
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the NH Coalition to End Homelessness
https://www.nhceh.org/research-advocacy/evidence-based-practices

Topic Area	Sample Strategies	Additional Information
Homelessness	**Assertive Community Treatment (ACT)** A team-based model designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious mental illnesses.	*Research has shown that ACT programs can support individuals with the most severe mental illnesses by providing flexible services around the clock. ACT has been proven to reduce hospital stays and jail days in the communities it has been implemented.*
Homelessness	**Critical Time Intervention (CTI)** Time-limited case management focused on supporting people with serious mental illnesses that are being discharged from institutional facilities.	*search has proven CTI programs to be cost-effective in comparison to other case management models. In addition, clients that received CTI services were much more likely to retain housing than clients that received typical post-discharge services.*
Homelessness	**Housing First** An approach to house homeless individuals who have serious mental illnesses and co-occurring substance use disorders.	*This model takes a consumer-based approach in supporting client's needs and encouraging clients to create and implement their own goals while immediately housing clients with no preconditions (except complying with a standard lease agreement). Research has shown that Housing First programs increase housing stability for clients served, are cost effective compared to traditional services that impose sobriety perquisites to housing and increase client utilization of other supportive services.*
Homelessness	**Motivational Interviewing and Motivational Enhancement Therapy (MI)** A goal-oriented style of case management and counseling that supports clients in exploring and resolving their ambivalence toward illicit and detrimental lifestyles to promote behavioral change.	*Motivational Enhancement Therapy (MET) is a slight alternative to MI in that MET uses an empathetic but direct approach at providing feedback to clients in a normative style to enhance and solidify the client's commitment to change. Research has proven that programs implementing MI and MET styles have reduced a variety of problematic behaviors, including behaviors related to substance use.*
Homelessness	**Permanent Supportive Housing (PSH)** A model of providing safe, decent, and affordable housing and services to eligible clients.	*PSH connects clients with supportive services personnel who provide wrap-around case management services to clients serviced in collaboration with property management personnel. Research has shown clients serviced by PSH programs have increased housing stability while reducing institutional stays.*

Homelessness
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Homelessness	**Supported Employment** A service model designed to help persons with mental illnesses participate in the competitive labor market with the goal of obtaining a job of preference.	*While several variations of supported employment models exist, the individual placement and support model is accepted as the standard model of supported employment, as it promotes the six key principles of supported employment: services focused on competitive employment, eligibility based on consumer choice, rapid job search, integration of rehabilitation and mental health, attention to consumer preferences, and time-unlimited and individualized support.*
Homelessness	**Trauma Informed Care** An approach to help engage people with trauma histories in a manner that recognizes the presences of trauma symptoms and acknowledges the role trauma has played in people's lives.	*Several intervention models have been developed to implement Trauma Informed Care strategies, including Addiction and Trauma Recovery Integration Model (ATRIUM), Seeking Safety, and the Sanctuary Model.*

Sample Strategies/Recommendations from the City of Boston

Topic Area	Sample Strategies	Additional Information
Homelessness	**Create Permanent Supportive Housing** • Make underutilized land or air rights on hospital campuses available for permanent supportive housing developments, targeting specific populations if co-location with medical services is a possibility • Capital investments: Provide no-interest or below-market loans to new permanent supportive housing developments. Loans can be low-cost pre-development loans or structured as permanent debt • Supportive services: Provide supportive services for those who are ineligible for existing services or require additional services	*White paper on models for hospital investments in permanent supportive housing, including examples of hospital investments from around the country, is forthcoming.* *Permanent supportive housing supports residents through wrap-around services and community building*
Homelessness	**Discharge from Hospital** Eliminate practice of discharge from hospital to shelter or street	

Homelessness
Sample Evidence-Based Strategies and Outcome Indicators

Homelessness	**Housing Navigators** Invest in housing navigators to help homeless patients search and apply for housing	
Homelessness	**New Pathways to Independence** • End intergenerational cycles by investing in pathways to independence for youth • Partner with BHA and other affordable housing providers to serve mental health needs of residents • Provide funding for service space in production/preservation projects	

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Quality	**Healthy home environment assessments** Train volunteers, professionals, or paraprofessionals to help residents assess and remediate environmental home health risks and recommend low cost changes (e.g., improved ventilation, integrated pest management, etc.)	*Healthy home environment assessments engage home visitors, often community health workers (CHWs), similarly trained asthma outreach workers, other professionals, paraprofessionals, or volunteers to assess and remediate environmental health risks within the home (ALA-MHE, Kearney 2014). Programs typically focus on improving asthma management via low cost changes such as improved ventilation, integrated pest management (IPM), and other forms of allergen control. Programs may also provide low emission vacuums, allergen-impermeable bedding covers, air filters, cleaning supplies, and supplies for roach abatement (Campbell 2015, Krieger 2015).*
Quality	**Integrated pest management for indoor use** Support a four-tiered approach to indoor pest control that minimizes potential hazards to people, property, and the environment	*Integrated pest management (IPM) includes a broad range of methods to control pests that also minimize potential hazards to people, property, and the environment. IPM employs a four-tiered approach – setting action thresholds, identifying and monitoring pests, preventing pests from becoming a threat (e.g., sealing cracks and crevices), and pest control as needed. IPM pest control begins with the least risky approaches (e.g., mechanical controls such as trapping) and moves to targeted pesticide use only if other measures are not successful. Often used in agriculture, IPM can also be used in indoor settings such as homes, schools, workplaces, or other environments that may be affected by mice, roaches, or other pests (US EPA-IPM, UC Ag-IPM).*
Quality	**Housing rehabilitation loan & grant programs** Provide funding, primarily to low or median income families, to repair, improve, or modernize dwellings and remove health or safety hazards	*Housing rehabilitation loan & grant programs provide funding to repair, improve, or modernize dwellings, and remove health or safety hazards from those dwellings. Programs primarily serve families with low and median incomes, and may prioritize services for households with vulnerable members such as young children and elderly adults. These programs can adopt a comprehensive housing improvement strategy or focus on individual housing components such as heating and insulation, plumbing, structural concerns, lead, asbestos, or mold. Programs can be focused at local, state, and federal levels.*

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Quality	**Lead paint abatement programs** Eliminate lead-based paint and contaminated dust by removing or encapsulating lead paint, or removing lead painted fixtures and surfaces	*Lead paint abatement programs eliminate lead-based paint and contaminated dust by removing or encapsulating lead paint or removing lead painted fixtures and surfaces (US HUD-Lead 2012). Approximately 24 million housing units contain serious lead hazards such as peeling lead paint and lead contaminated dust (CDC-Lead prevention); lead-based paint is the most widespread source of high-dose lead exposure for young children (CDC-Lead info for parents). As of 2012, scientists indicate no safe blood lead level (BLL). The Centers for Disease Control and Prevention (CDC) blood lead reference level for initiating public health actions to prevent further exposure and mitigate health effects is 5 micrograms per deciliter (µg/dL); it is estimated that over 500,000 children have BLLs at or above this level (White 2015, NCHH-Lead 2014, CDC-Lead facts).*
Affordability Ownership	**HOME Investment Partnership Program** Provide grants to states and localities to fund activities that build, buy, or rehabilitate affordable housing for rent or homeownership or provide direct rental assistance to low income households	*The HOME Investment Partnership Program (HOME), funded by US Department of Housing and Urban Development (US HUD), provides formula grants to states and localities to fund activities that build, buy, and/or rehabilitate affordable housing. Low income households rent or purchase these homes; HOME may also provide families with direct rental assistance. Participating jurisdictions are required to match every dollar received with 25 cents in funding and determine how to allocate funds; they also often partner with local non-profits (US HUD-HOME, Mickelson 2015).*
Affordability Ownership	**Housing trust funds** Support funds that help create or maintain low income housing, subsidize rental housing, and assist low income homebuyers and non-profit housing developers	*Housing trust funds (HTFs) work to facilitate affordable, quality housing by creating or maintaining low income housing; subsidizing rental housing; and supporting non-profit housing developers. Trust funds may also assist low income homebuyers through down payment support, counseling, or interest subsidies, and may provide gap financing. Housing trust funds exist at federal, state, county, and city levels.*
Affordability	**Low Income Home Energy Assistance Program (LIHEAP)** Provide funds to help low income households meet home energy needs, especially households with members who are young or elderly, or have disabilities	*The Low Income Home Energy Assistance Program (LIHEAP) helps low income households meet their home energy needs. LIHEAP focuses on helping families with at least one member who is young, disabled, or elderly, referred to as 'vulnerable households,' and those with the lowest incomes and highest home energy costs, referred to as 'high burden households' (Murray 2014). Participants are also often at high risk for food insecurity (Frank 2006). LIHEAP is a federal program; states and territories apply for block grants and allocate available funds to approved households using locally designated formulas (US DHHS-LIHEAP).*

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Affordability	**Affordable housing tax increment financing (TIF)** Create designated tax districts that generate revenue to invest in affordable housing initiatives, blight remediation, and economic development efforts	*Tax increment financing (TIF) districts define a district's tax "base" by local property values before improvements are made and designate some or all tax revenue above the base rate to support affordable housing, sidewalk improvements, utility upgrades, and other infrastructure investments in the TIF district (Skidmore 2010). Revenue from the tax base rate continues to support local school districts and local governments. Many states stipulate that TIF districts must be in blighted areas without prospects for growth in property values (Dye 2000). TIFs are often implemented with other programs that support affordable housing and economic development and are often considered tools to support privately and publicly funded development (Bland 2016, CDFA-TIF). Affordable housing reinvestments are most common in urban and suburban TIFs.*
Affordability	**Rent regulation policies** Establish tenant protections via regulations to the housing rental market such as limits on rent increases and eviction protections for tenants with low incomes; typically via rent stabilization	*Rent regulation policies affect the landlord-tenant relationship by establishing protections such as limits to the amount landlords can increase rent for existing tenants; such policies also often prohibit landlords from evicting tenants without just cause. Historically, policies used rent control to set price ceilings or strict limits on rent increases. Most current policies use a rent stabilization approach, which provides a moderate return on investment for landlords with annual rent increases that account for the cost of inflation and any property improvements beyond standard maintenance. Current rent regulations vary by scope, standards for permitted rent increases, and enforcement mechanisms (Pastor 2018). Although many current rent regulation policies do not have income eligibility requirements, policies can be adjusted to focus on tenants with low incomes (McPherson 2004). According to reports from Harvard University's Joint Center for Housing Studies, as of 2017, over 21 million US households spend more than 30% of their income on rent (JCHS-Rental report 2017).*
Gentrification	**Mixed-use development** Support a combination of land uses (e.g., residential, commercial, recreational) in development initiatives, often through zoning regulations or Smart Growth initiatives	*Mixed-use development supports a combination of land uses within a project rather than developing an area for a single purpose. Mixed-use development projects can be site-specific, neighborhood-based, or regional, and can be incorporated into new development, redevelopment, brownfield, and Smart Growth initiatives in urban and rural areas. Mixed-use development areas have high densities and incorporate places to work, shop, or play within residential areas. Such development is sometimes required through municipal zoning regulations or encouraged through Smart Growth initiatives and neighborhood planning efforts.*

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Gentrification	**Zoning regulations for land use policy** Use zoning regulations to address aesthetics and safety of the physical environment, street continuity and connectivity, residential density and proximity to businesses, schools, and recreation, etc.	*Zoning regulations for land use policy include zoning and building codes and other governmental policies and efforts to shape building practices which change the physical environment of cities, towns, and counties. Such regulations often address environmental design elements such as aesthetic and safety aspects of the physical environment, street continuity and connectivity, residential density, mixed-use development, and the proximity of residential areas to stores, jobs, schools, and recreation in existing neighborhood developments. Efforts to update or revise zoning regulations are often precursors to mixed-use development and Smart Growth initiatives (US EPA-SG codes).*

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Healthy People 2020 Topics and Objectives
https://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health/ebrs

Topic Area	Sample Strategies	Additional Information
Quality	**Housing Improvements for Health and Associated Socio-economic Outcomes**	*Poor housing is associated with poor health. This suggests that improving housing conditions might lead to improved health for residents. Improved health is most likely when the housing improvements are targeted at those with poor health and inadequate housing conditions, particularly inadequate heat.*
Affordability	**Tenant-Based Rental Assistance Programs**	*The Community Preventive Services Task Force recommends tenant-based rental assistance programs on the basis of sufficient evidence that such assistance reduces exposure to crimes against person and property and neighborhood social disorder. The Task Force was unable to determine the effectiveness of such programs on housing hazards, youth risk behaviors, and psychological and physical morbidity, because too few studies of adequate design and execution reported these outcomes. This recommendation appears in "The Guide to Community Preventive Services: What Works to Promote Health?"*

Strategies/Recommendations from the City of Boston

Topic Area	Sample Strategies	Additional Information

Housing and Health
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Stability	**Promote housing stability for tenants**	• Create more upstream model focused on interventions prior to eviction filings including mediation, dispute resolution, mental health services, budgeting and financial assistance • Increase mental health supports for families and individuals to ensure successful housing placement and retention • Expand pool of flexible cash resources for arrears and legal support • Intervene or assist residents who have high out-of-pocket medical costs , food insecurity, or unexpected high costs (i.e. a funeral or other items that affect health and ability to pay rent) • Expand Boston's Opportunity Fund, which enables developers to purchase and permanently restrict occupied private market housing, to protect tenants from being displaced and adds to Boston's inventory of affordable housing stock. This can be done by providing low-cost acquisition funding, or permanent subsidies. • Provide low-interest loans which will help increase the number of income-restricted housing for Boston's low-income residents. These loans could be low-cost pre-development loans or structured as permanent debt.

Access

ACCESS TO CARE – FAMILY AND SOCIAL SUPPORT
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from County Health Rankings & Roadmaps
https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Family and Social Support	**Activity programs for older adults** Offer group educational, social, or physical activities that promote social interactions, regular attendance, and community involvement among older adults.	*Programs for older adults offer educational, social, or physical activities in group settings that encourage personal interactions, regular attendance, and community involvement. Activity programs are a potential means to reduce social isolation; isolation among older adults is associated with poorer health outcomes (Coyle 2012).*
Family and Social Support	**Early childhood home visiting programs** Provide at-risk expectant parents and families with young children with information, support, and training regarding child health, development, and care from prenatal stages through early childhood via trained home visitors.	*In early childhood home visiting programs trained personnel regularly visit at-risk expectant parents and families with young children and provide them with information, support, and/or training regarding child health, development, and care based on families' needs. Home visitors can be nurses, social workers, parent educators, paraprofessionals, lay workers from within the community, or others. Home visiting often begins prenatally and continues during the child's first two years of life, but may also begin after birth, last only a few months, or extend until kindergarten (HRSA-MIECHV 2017, Sama-Miller 2017).*
Family and Social Support	**Nurse-Family Partnership (NFP)** Provide home visiting services to low income, first time mothers and their babies, starting during pregnancy and continuing through a child's second birthday.	*The Nurse-Family Partnership (NFP) is a voluntary home visiting program that supports low income, first-time mothers and their babies. Specially trained registered nurses provide support, advice, and education on diverse topics regarding child and maternal health, development, and care. Visits to families begin during pregnancy and continue until a child's second birthday (NFP).*
Family and Social Support	**Early Head Start (EHS)** Provide child care, parent education, physical health and mental health services, and other family supports to pregnant women and parents with low incomes and children aged 0 to 3.	*Early Head Start (EHS) is a federally funded program for low income pregnant women, parents, and children aged 0 to 3. The program's comprehensive approach includes child care, parent education, health and mental health services, and family support. EHS programs can be home-based, center-based, or offer a mix of home and center services (ECLKC-EHS).*

ACCESS TO CARE – FAMILY AND SOCIAL SUPPORT
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Family and Social Support	**Outdoor experiential education and wilderness therapy** Support outdoor pursuits that emphasize inter- and intra-personal growth through overcoming obstacles (e.g., challenge courses, wilderness excursions, etc.).	*Outdoor education, experiential education, and wilderness therapy programs involve adventure-based activities and outdoor pursuits that emphasize inter- and intra-personal growth through overcoming obstacles. Examples include: camping, challenge courses, rope courses, and wilderness excursions such as trekking, canoeing, sailing, and cycling. Programs often focus on youth, and can be implemented alone or with other types of therapy.*
Family and Social Support	**Extracurricular activities for social engagement** Support organized social, art, or physical activities for school-aged youth outside of the school day.	*Extracurricular activities include any organized social, art, or physical activities for school-aged youth that occur during out-of-school time, usually before- or after-school or during the summer. Extracurricular activities can be offered through school, community, or religious organizations. Examples include clubs, school newspapers, music groups, student councils, debate teams, theater, volunteering programs, sports, and youth groups; programs sometimes include academic components.*
Family and Social Support	**Group-based parenting programs** Teach parenting skills in a group setting using a standardized curriculum, often based on behavioral or cognitive-behavioral approaches and focused on parents of at-risk children.	*Group-based parenting programs use standardized curriculums to teach parenting skills in a group setting. Programs are usually based on behavioral or cognitive-behavioral approaches and often target parents whose children display or are at risk for aggressive and disruptive behaviors, possess low self-esteem or poor social skills. In some programs, participants' children are at risk of, or diagnosed with, Conduct Disorder or Oppositional Defiant Disorder (Cochrane-Furlong 2012). Programs can be for parents of children of all ages, but are most often designed for those with children under 12 years old.*
Family and Social Support	**Community Water Fluoridation** Adjust and monitor fluoride in public water supplies to reach and retain optimal fluoride concentrations.	*Communities that fluoridate water adjust and monitor fluoride in public water supplies to reach optimal fluoride concentrations. As of 2015, the US Public Health Service (US PHS) recommends that community drinking water contain .7 ppm of fluoride, down from the previous standard, a range of .7 to 1.2 ppm, set in 1962 (US PHS-Fluoride, Truman 2002). This change accounts for other sources of fluoride (e.g., toothpaste) and was intended to avoid the unwanted health effects of excessive fluoride (US PHS-Fluoride, EPA-Fluoride 2011).*

ACCESS TO CARE – POLICIES & PROGRAMS
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from County Health Rankings & Roadmaps
https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Policies & Programs	**Federally Qualified Health Centers (FQHCs)** Increase support for non-profit health care organizations and deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay; often called community health centers (CHCs).	*Federally qualified health centers (FQHCs) are public and private non-profit health care organizations that receive federal funding under Section 330 of the Public Health Service Act. Governed by a community board, FQHCs deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay. FQHCs are located in high need communities in urban and rural areas (HRSA-Health centers). Often called Community Health Centers (CHCs), FQHCs can also include migrant health centers, health care for the homeless centers, public housing primary care centers, and outpatient health programs or facilities operated by a tribe or tribal organization (CMS-FQHC).*
Policies & Programs	**Medical Homes** Provide continuous, comprehensive, whole person primary care that uses a coordinated team of medical providers across the health care system.	*Medical homes provide continuous, comprehensive, whole person primary care (NCQA-PCMH, AHRQ-PCMH). In this model of care, primary care providers and their teams coordinate care across the health care system, working with patients to address all their preventive, acute, and chronic health care needs, and arranging care with other qualified health professionals as needed. Medical homes offer enhanced access, including expanded hours and easy communication options for patients. They also practice evidence-based medicine, measure performance, and strive to improve care quality (AHRQ-PCMH).*
Policies & Programs	**Mental health benefits legislation** Regulate mental health insurance to increase access to mental health services, including treatment for substance use disorders.	*Mental health benefits legislation regulates health insurance to increase access to mental health services, including treatment for substance use disorders. Parity, a key part of most mental health benefits legislation, stipulates that health insurance plans do not impose greater restrictions for mental health coverage than for physical health coverage (CG-Mental health).*

ACCESS TO CARE – POLICIES & PROGRAMS
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Policies & Programs	**Rural training in medical education** Expand medical school training and learning experiences focused on the skills necessary to practice successfully in rural areas.	*Rural training tracks and programs focus medical school training and learning experiences on the skills necessary to practice medicine in rural communities. These initiatives often recruit students from rural backgrounds and students who have expressed an interest in practicing medicine in small towns and rural locations (Wendling 2016); recruitment often starts in high school and continues through medical school (Wheat 2017, Wheeler 2017).*
Policies & Programs	**School-based health centers** Provide health care services on school premises to attending elementary, middle, and high school students; services provided by teams of nurses, nurse practitioners, and physicians.	*School-based health centers (SBHCs) provide elementary, middle, and high school students a variety of health care services on school premises or at offsite centers linked to schools. Teams of nurses, nurse practitioners, and physicians often provide primary and preventive care and mental health care; reproductive health services may be offered in middle and high schools, as allowed by district policy and state law. Providers at SBHCs often manage chronic illnesses such as asthma, mental health conditions, and obesity. Most patients treated at SBHCs are children insured by Medicaid or children without insurance (CG-SBHC, Keeton 2012). SBHCs are most common in urban areas and may be funded at the federal, state, or local level (SBHA-SBHC).*
Policies & Programs	**Telemedicine** Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth.	*Telemedicine, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services. Services can encompass primary and specialty care, referrals, and remote monitoring of vital signs, and may be provided via videoconference, email, smartphones, wireless tools, or other modalities (ATA). Telemedicine can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.*

ACCESS TO CARE – POLICIES & PROGRAMS
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Policies & Programs	**Text message-based health interventions** Provide reminders, education, or self-management assistance for health conditions, especially chronic diseases, via text message.	*Text messaging interventions provide patients with reminders, education, or self-management assistance for health conditions. Interventions are most frequently used as part of broader health promotion efforts or to help individuals manage chronic diseases. Text messaging is a low-cost platform which can be combined with other approaches or delivered as part of a stepped care or progressive intervention that is tailored to patients' needs, beginning with the least intensive treatment and moving to more intensive, and often expensive, treatments as needed (Tofighi 2017). Text message software and smartphone apps can be integrated into electronic health records (EHRs) to send alerts and reminders to patients (Perri-Moore 2016).*

ACCESS TO HEALTH SERVICES

Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Healthy People 2020 Topics and Objectives
https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Topic Area	Sample Strategies	Additional Information
Prevention	**Diabetes Prevention: Interventions Engaging Community Health Workers** Engage community health workers for diabetes prevention to improve glycemic (blood sugar) control and weight-related outcomes among people at increased risk for type 2 diabetes.	*Community health workers (including promotores de salud, community health representatives, community health advisors, and others) are frontline public health workers who serve as a bridge between underserved communities and healthcare systems. Interventions that focus on diabetes prevention aim to reduce one or more risk factors for type 2 diabetes among members of the community by improving their diet, physical activity, and weight management. Interventions may include education about diabetes prevention and lifestyle changes, or informal counseling, coaching, and extended support for people with a higher risk for diabetes. Programs may be offered in homes or community-based settings.*
Prevention	**Cancer Screening: Reducing Structural Barriers for Clients – Breast Cancer and Colorectal Cancer** Design interventions to reduce structural barriers to increase screening for breast cancers and colorectal cancers.	*Interventions may include increasing hours of operation, providing child care, or addressing language or cultural factors.*
Intervention	**Cardiovascular Disease: Interventions Engaging Community Health Workers** Design interventions that engage community health workers to prevent cardiovascular disease (CVD).	*Interventions that engage community health workers to focus on CVD prevention implement 1 or more of the following models of care: screening and health education; outreach, enrollment, and information; team-based care; patient navigation; community organization.*
Intervention	**Interventions to Improve Access to Primary Care for People Who Are Homeless** Design interventions to improve access to primary care for people who are homeless, without serious mental illness, and living in urban centers.	*People who are homeless encounter barriers to primary care despite having, on average, greater needs for health care than people who are not homeless.*

ACCESS TO HEALTH SERVICES
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Intervention	**Mental Health and Mental Illness: Interventions to Reduce Depression Among Older Adults – Home-Based Depression Care Management** Design interventions to establish depression care management at home for older adults with depression to improve short-term depression outcomes.	*Home-based depression care management involves: active screening for depression; measurement-based outcomes; trained depression care managers; case management; patient education; and a supervising psychiatrist.*
Physical Access	**Health Equity: School-Based Health Centers** Implement and maintain school-based health centers (SBHCs) in low-income communities to improve educational and health outcomes.	*Improved educational outcomes include school performance, grade promotion, and high school completion. Improved health outcomes include the delivery of vaccinations and other recommended preventive services, asthma morbidity, emergency department and hospital admissions, contraceptive use among females, prenatal care and birth weight, and other health risk behaviors. SBHCs provide health services to students pre-K–12 and may be offered on-site or off-site. SBHCs are often established in schools that serve predominantly low-income communities.*
Physical Access	**Vaccination Programs: Special Supplemental Nutrition Program for Women, Infants & Children (WIC) Settings** Coordinate vaccination interventions in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) settings to increase vaccination rates in children.	*Vaccination interventions in WIC settings aim to assess the immunization status of participating infants and children and help them get recommended vaccinations. At a minimum, these interventions involve the periodic assessment of each child's immunization status and referral of underimmunized infants and children to vaccination providers as appropriate.*
Physical Access	**Vaccination Programs: Schools and Organized Child Care Centers** Establish school and organized child care center–located vaccination programs to increase vaccination rates and decrease rates of vaccine-preventable disease and associated morbidity and mortality.	*Vaccination programs in schools or organized child care centers are multicomponent interventions delivered onsite to improve immunization rates in children and adolescents. These programs include 2 or more of the following components: immunization education and promotion, assessment and tracking of vaccination status, referral of under-immunized school or child care center attendees to vaccination providers, or provision of vaccinations.*

ACCESS TO HEALTH SERVICES
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Reducing Costs	**Vaccination Programs: Reducing Client Out-of-Pocket Costs** Design interventions that reduce client out-of-pocket costs to improve vaccination rates.	*Reducing out-of-pocket costs to clients for vaccinations involves program and policy changes that make vaccinations or the administration of vaccinations more affordable. Costs can be reduced by paying for vaccinations or administration, providing new or expanded insurance coverage, or lowering or eliminating patient out-of-pocket expenses at the point of service (e.g., copayments, coinsurances, and deductibles).*
Reducing Costs	**Cardiovascular Disease: Reducing Out-of-Pocket Costs for Cardiovascular Disease Preventive Services for Patients with High Blood Pressure and High Cholesterol** Design interventions to reduce patient out-of-pocket costs (ROPC) for medications to control high blood pressure and high cholesterol when combined with additional interventions aimed at improving patient-provider interaction and patient knowledge, such as team-based care with medication counseling, and patient education.	*ROPC involves the following program and policy changes that make cardiovascular disease preventive services more affordable: medications; behavioral counseling (e.g., nutrition counseling); and behavioral support (e.g., community-based weight management programs, gym membership). Costs for these services can be reduced by providing new or expanded treatment coverage and lowering or eliminating patient out-of-pocket expenses (e.g., copayments, coinsurances, deductibles).*
Collaborative Care	**Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders** Implement a collaborative care model for the management of depressive disorders to improve depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.	*Collaborative care is a multicomponent, health care system–level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to: improve the routine screening and diagnosis of depressive disorders; increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; improve clinical and community support for active patient engagement in treatment goal setting and self-management.*

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Primary Care	**Centering Pregnancy** Provide prenatal care in a group setting, integrating health assessment, education, and support.	*Centering Pregnancy is a multifaceted model of group care that integrates health assessment, education, and support into a unified program within a group setting. Eight to twelve women with similar gestational ages meet to learn care skills, participate in a facilitated discussion, and develop a support network with other group members.*
Primary Care	**Community Health Workers (CHW)** Engage professional or lay health workers to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes; also called promotores de salud.	*Community health workers (CHW) serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. CHW services are usually provided to underserved communities and to individuals at high risk of poor health outcomes.*
Primary Care	**Federally Qualified Health Centers (FQHCS)** Increase support for non-profit health care organizations and deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay; often called community health centers (CHCs).	*Federally qualified health centers (FQHCs) are public and private non-profit health care organizations that receive federal funding under Section 330 of the Public Health Service Act. Governed by a community board, FQHCs deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay. FQHCs are located in high need communities in urban and rural areas (HRSA-Health centers).*
Primary Care	**School-based Health Centers** Provide health care services on school premises to attending elementary, middle, and high school students; services provided by teams of nurses, nurse practitioners, and physicians.	*School-based health centers (SBHCs) provide elementary, middle, and high school students a variety of health care services on school premises or at offsite centers linked to schools. Teams of nurses, nurse practitioners, and physicians often provide primary and preventive care and mental health care; reproductive health services may be offered in middle and high schools, as allowed by district policy and state law. Providers at SBHCs often manage chronic illnesses such as asthma, mental health conditions, and obesity. Most patients treated at SBHCs are children insured by Medicaid or children without insurance (CG-SBHC, Keeton 2012). SBHCs are most common in urban areas and may be funded at the federal, state, or local level (SBHA-SBHC).*

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Primary Care	**School dental programs** Provide sealants, fluoride treatment, screening, and other preventive dental care on school grounds via partnerships with dental professionals.	*School dental programs include screening students for dental needs, sealant programs to protect students' permanent molars, fluoride treatment, and other preventive dental care. Services can be provided by dental professionals, often those employed by Federally Qualified Health Centers (FHQCs), via mobile vans parked at schools, or stationary or portable equipment within schools; services may be provided only in schools or students may be linked to clinics for additional care. Programs often serve school districts with high proportions of low income children and districts in rural areas (CG-Oral health, ASTDD-Isman 2011).*
Primary Care	**Health insurance enrollment outreach & support** Provide health insurance outreach and support to assist individuals whose employers do not offer affordable coverage, who are self-employed, or who are unemployed	*Health insurance enrollment outreach and support programs assist individuals whose employers do not offer affordable coverage, who are self-employed, or unemployed with health insurance needs. Such programs can be offered by a variety of organizations, including government agencies, schools, community-based or non-profit organizations, health care organizations, and religious congregations. Outreach activities vary greatly, and can include community health worker (CHW) efforts, other person-to-person outreach, mass media and social media campaigns, school-based efforts, case management, or efforts in health care settings. Outreach can occur at local events, via hotlines, or at fixed locations (e.g., community centers, non-profit offices, etc.) and are often supported through grants from federal agencies or private foundations.*
Primary Care	**Patient Financial Incentives for Preventive Care** Use payments, vouchers, and other incentives to encourage patients to undergo preventive care such as screenings, vaccinations, etc.	*Financial incentives such as payments, vouchers, and tickets for prize drawings can be used to encourage patients to undergo preventive care such as screenings, vaccinations, and other brief interventions. Personal incentive programs are usually offered through the public sector and typically offer incentives to low income individuals (Sutherland 2008).*

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Primary Care	**Medical Homes** Provide continuous, comprehensive, whole person primary care that uses a coordinated team of medical providers across the health care system.	*Medical homes provide continuous, comprehensive, whole person primary care (NCQA – PCMH, PCPCC – PCMH). In this model of care, personal physicians and their teams coordinate care across the health care system, working with patients to address all their preventive, acute, and chronic health care needs, and arranging care with other qualified health professionals as needed. Medical homes offer enhanced access, including expanded hours and easy communication options for patients. They also practice evidence-based medicine, measure performance, and strive to improve care quality (AHRQ-PCMH).*
Primary Care	**Patient Shared Decision Making (SDM)** Support joint decision making between health care practitioners and patients through shared decision making (SDM); part of patient-centered care.	*Under a shared decision making (SDM) process, health care practitioners and patients work together to make joint decisions about a patient's care. SDM requires that patients be educated about and understand risks and benefits of their options (Cochrane-Legare 2010). SDM is an important part of patient-centered care; education is often through the use of decision aids, such as pamphlets, videos, and computerized tools.*
Primary Care	**Patient Navigators** Provide culturally sensitive assistance and care coordination, and guide patients through available medical, insurance, and social support; also called systems navigators	*Patient navigators provide culturally sensitive assistance and care coordination, determining individual barriers and guiding patients through available medical, insurance, and social support systems. Navigators are usually employed by hospitals or clinics, and may be fully integrated into a primary care team.*
Primary Care	**Higher Education Financial Incentives for Health Professionals Serving Underserved Areas** Expand incentives such as scholarships and loans with service requirements and loan repayment or forgiveness programs for health care providers who practice in rural or other underserved areas.	*Financial incentive programs such as scholarships and loans with service requirements, educational loans with a service option, and loan repayment or forgiveness programs to encourage health care providers to serve in rural or other underserved areas. uch incentives are available to various types of providers, including physicians, nurse practitioners, physician assistants, nurses, dentists, and mental health providers, but typically focus on primary care and family medicine* practitioners (Geletko 2014).

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Primary Care	**Healthy Literacy Interventions** Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase overall literacy.	*Health literacy is the degree to which people obtain, process, and understand basic health information and services in order to make appropriate health decisions (IOM Neilson-Bohlman 2004). Low levels of health literacy are associated with poor health outcomes and limited use of preventive care (AHRQ-Berkman 2011, Taggart 2012). Up to one-half of the US population has limited health literacy; elderly and low-income individuals are most likely to have lower levels of health literacy (Eichler 2009). Approaches to improving health literacy include simplifying health education materials (written, video, audio, and computer formats), improving patient-provider communication, and improving overall literacy.*
Primary Care	**Telemedicine** Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth.	*Telemedicine uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services encompassing primary and specialty care, referrals, and remote monitoring of vital signs, and may be provided via videoconference, email, smartphones, wireless tools, or other modalities (ATA). Telemedicine can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.*
Primary Care	**Text message-based health interventions** Provide reminders, education, or self-management assistance for health conditions, especially chronic diseases, via text message.	*Text messaging interventions provide patients with reminders, education, or self-management assistance for health conditions. Interventions are most frequently used as part of broader health promotion efforts or to help individuals manage chronic diseases. Text messaging is a low-cost platform which can be combined with other approaches or delivered as part of a stepped care or progressive intervention that is tailored to patients' needs, beginning with the least intensive treatment and moving to more intensive, and often expensive, treatments as needed (Tofighi 2017). Text message software and smartphone apps can be integrated into electronic health records (EHRs) to send alerts and reminders to patients (Perri-Moore 2016).*

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Primary Care	**Tiered Drug Formularies** Vary patient drug costs by tier; e.g., generic drugs have the lowest co-pay or cost sharing in tier one, then preferred brand name medications (tier two), then non-formulary drugs (tier three).	*A drug formulary is a list of generic and brand name drugs that are preferred by a health plan based upon their effectiveness and cost-savings. Formularies can have a single tier, where all drugs have the same cost to patients, or multiple tiers, where cost varies. Many formularies are three-tiered: generic drugs have the lowest co-pay or cost sharing (tier one); preferred brand name medications have a higher co-pay or cost sharing (tier two), and non-formulary drugs have the highest co-pay or cost sharing (tier three).*
Primary Care	**J-1 Physician Visa Waivers** Expand use of J-1 physician visa waivers for foreign-born physicians who have trained in the US and will serve patients in designated Health Professional Shortage Areas (HPSAs). *(insufficient evidence)*	*Foreign-born physicians who train in the US using a J-1 visa may receive a J-1 visa waiver to practice in a designated Health Professional Shortage Area (HPSA) immediately following their training, rather than returning to their home nation. To be eligible for a waiver, physicians must be sponsored by a state public health department or its equivalent. Waivers have a three-year service commitment and are provided by the federal government as part of the Conrad State 30 Program, which allows each state to recruit up to 30 physicians for the program (US DS-Waiver eligibility, Patterson 2015). Historically, the program has focused on placing primary care physicians in rural areas; recently, it also supports placement of specialists in non-rural underserved areas (Patterson 2015).*
Primary Care	**Consumer Directed Health Plans** Establish high deductible health plans, often paired with pre-tax medical expense accounts such as Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs).	*Consumer-directed health plans (CDHPs) are high deductible health plans (HDHP) often paired with medical expense accounts funded with pre-tax dollars. These accounts may be Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs). Employers fund HRAs and permit employees to use them for medical costs up to a stated limit. Employers may help fund HSAs, but employees manage funds and retain them when changing jobs. Federal law requires minimum deductibles for HSAs, but not for HRAs (Haviland 2011). HSA HDHPs have legal maximum out-of-pocket costs, but HRA HDHPs do not have legal limits on out-of-pocket costs (KFF-Employer health benefits 2013).*

ACCESS TO PRIMARY CARE
Sample Evidence-Based Strategies and Outcome Indicators

STRATEGIC DIRECTIONS FROM THE NATIONAL PREVENTION STRATEGY REPORT
http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

Sample Strategies

- Support the National Quality Strategy's focus on improving cardiovascular health.
- Use payment and reimbursement mechanisms to encourage delivery of clinical preventive services
- Expand use of interoperable health information technology.
- Support implementation of community-based preventive services and enhance linkages with clinical care.
- Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.
- Enhance coordination and integration of clinical, behavioral, and complementary health strategies

Outcome Indicators:

- Proportion of medical practices that use electronic health records
- Proportion of adults aged 18 years and older with hypertension whose blood pressure is under control
- Proportion of adults aged 20 years and older with high low-density lipoprotein (LDL) cholesterol whose LDL is at or below recommended levels
- Proportion of adults aged 50 to 75 years who receive colorectal screening based on the most recent guidelines
- Proportion of children and adults who are vaccinated annually against seasonal influenza

Behavioral Health

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Guide to Community Preventive Services (The Community Guide)
Direct Link: https://www.thecommunityguide.org/

Topic Area	Sample Strategies	Additional Information
Mental Health	**Collaborative Care for Management of Depressive Disorders** Implement a multi-component, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists.	*The Community Preventive Services Task Force (CPSTF) recommends collaborative care for the management of depressive disorders based on strong evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.* *The CPSTF also finds that collaborative care models provide good economic value based on the weight of evidence from studies that assessed both costs and benefits.*
Mental Health	**Mental Health Benefits Legislation** Work to pass mental health benefits legislation, particularly comprehensive parity legislation, to improve access, financial protection, and increase appropriate utilization of mental health services for people with mental health conditions.	*The Community Preventive Services Task Force (CPSTF) recommends mental health benefits legislation, particularly comprehensive parity legislation, based on sufficient evidence of effectiveness in improving financial protection and increasing appropriate utilization of mental health services for people with mental health conditions. There is also evidence that mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health and reduced suicide rates.* *Evidence from a concurrent economic review indicates that mental health benefits expansion did not lead to any substantial increase in cost to health insurance plans, measured as a percentage of premiums.*
Mental Health	**Trauma Informed Care** Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life- including service staff.	Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life- including service staff. The intention of Trauma-Informed Care is not to treat symptoms or issues related to sexual, physical or emotional abuse or any other form of trauma but rather to provide support services in a way that is accessible and appropriate to those who may have experienced trauma. When service systems operating procedures do not use a trauma-informed approach, the possibility for triggering or exacerbating trauma symptoms and re-traumatizing individuals increases https://www.nctsn.org/trauma-informed-care

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Mental Health	**The Whole School, Whole Community, Whole Child, or WSCC model,** is CDC's comprehensive framework for addressing health, including mental and emotional health in schools.	**The Whole School, Whole Community, Whole Child, or WSCC model,** is CDC's framework for addressing health in schools. The WSCC model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices. The WSCC model has 10 components: 1) Physical education and physical activity. 2) Nutrition environment and services, 3) Health education, 4) Social and emotional school climate, 5) Physical environment, 6) Health services, 7) Counseling,, 78psychological and social services, 8) Employee wellness, 9) Community involvement, 10) Family engagement. https://www.cdc.gov/healthyschools/wscc/index.htm
Mental Health	**Home-based Depression Care Management** Implement a home-based depression care management program that includes • Active screening for depression • Measurement-based outcomes • Trained depression care managers • Case management • Patient education, and a • Supervising psychiatrist	*The Community Preventive Services Task Force (CPSTF) recommends depression care management at home for older adults with depression on the basis of strong evidence of effectiveness in improving short-term depression outcomes.*
Mental Health	**Clinic-based Depression Care Management** Implement a clinic-based depression care management program that includes • Active screening for depression • Measurement-based outcomes • Trained depression care managers providing case management, and • Primary care provider and patient education, antidepressant treatment and/or psychotherapy, and a supervising psychiatrist	*The Community Preventive Services Task Force (CPSTF) recommends depression care management in primary care clinics for older adults with major depression or chronic low levels of depression (dysthymia) on the basis of sufficient evidence of effectiveness in improving short-term depression outcomes.*

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Healthy People 2020 Topics and Objectives
https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

Topic Area	Sample Strategies	Additional Information
Mental Health	**Comprehensive and Integrated Reentry Services** Offer trauma-informed residential, non-residential, and reentry treatment services for female offenders. Partner Healthcare organizations and offering substance abuse and mental health services should partner with other domestic violence, family preservation. Interventions provided within a gender-specific framework acknowledge the various pathways into the criminal justice system and focus on strengths-based treatment approaches and skill-building. A trauma–informed approach to treatment incorporates "new medical and mental health service delivery approaches specifically designed for women with co-occurring mental health/ substance abuse disorders and histories of physical and sexual abuse" (Massachusetts Department of Correction, RFR 08-9004-R21, p. 54).	*Women in both MCI Framingham and the houses of correction have a high level of drug- and alcohol-related offenses. Sixty percent of women in DOC custody have open mental health cases. Women in prison are widely documented to have had experienced emotional, physical, and/or sexual abuse.* *Gender-specific approaches that are multidimensional and are based upon social and cultural factors including class, race, abuse/trauma history, mental illness and substance abuse issues, and family relationships offer greater success (Bloom & Covington, 2000; Bloom, Owen, & Covington, 2003; Sydney, 2006). Interventions acknowledge the various pathways into the criminal justice system and focus on strengths-based treatment approaches and skill-building*
Mental Health	**Crisis Response Teams (CRT)** provide information, support, and referrals designed to offer immediate, compassionate, and practical resources for those impacted by trauma and serious loss.	CRT provides free, 24/7, 365 day supports to those affected by a trauma or serious loss during the initial hours after an incident The most typical requests for service are in response to fatal traffic collisions, those in mental health crisis, completed suicide, homicide, death or serious injury of a child, workplace violence, and accidental or sudden death discovered by a family member, friend, or co-worker. https://www.samhsa.gov/sites/default/files/nc-oy1-task-3-building-comm-based-suicide-crisis-respons-team-2018-12-06.pdf

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Mental Health	**Intensive Case Management (ICM)** teams are a team-based approach that supports individuals through a case management approach , the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. It has a moderately strong evidence base. It is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period.	*Intensive Case Management can include:* • One-on-one case manager to client relationship using a recovery-oriented approach (the team of case managers many include Housing and Complementary Support Workers). • The case manager brokers access to mainstream services that the client identifies as needed to attain his or her goals. • The case manager often accompanies clients to meetings and appointments in support of their goals/needs. • Case managers are available on a regular schedule; caseloads are often shared to assure coverage of 7 days per week/12 hours a day. • The staff to client ratio is generally 1 case manager per 20 clients. • The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4233116/
Mental Health	**Mental Health Benefits Legislation** Advance mental health benefits legislation, particularly comprehensive parity legislation, to improve financial protection and increase appropriate utilization of mental health services for people with mental health conditions.	*The Community Preventive Services Task Force recommends mental health benefits legislation, particularly comprehensive parity legislation, to improve financial protection and increase appropriate utilization of mental health services for people with mental health conditions. There is also evidence that mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates. Mental health benefits legislation involves changing regulations for mental health insurance coverage to improve financial protection (i.e., decrease financial burden) and to increase access to, and use of, mental health services. Such legislation can be enacted at the federal or state level.*

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Mental Health	**Collaborative Care for the Management of Depressive Disorders** Promote collaborative care opportunities for the management of depressive disorders to improve depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression.	*The Community Preventive Services Task Force recommends collaborative care for the management of depressive disorders to improve depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. Collaborative care is a multicomponent, health care system–level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to: improve the routine screening and diagnosis of depressive disorders; increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; improve clinical and community support for active patient engagement in treatment goal setting and self-management.*
Mental Health	**Depression Screening in Adults** Provide screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	*The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. This is a B recommendation, which means the USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.*
Mental Health	**Depression Screening in Children and Adolescents** Provide screening for depression in the general adult population, including pregnant and postpartum women.	*The U.S. Preventive Services Task Force (USPSTF) recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. This is a B recommendation, which means the USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.*

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Mental Health	**Interventions to Reduce Depression Among Older Adults – Clinic-Based Depression Care Management** Offer depression care management in primary care clinics for older adults with major depression or chronic low levels of depression (dysthymia) to improve short-term depression outcomes.	*The Community Preventive Services Task Force recommends depression care management in primary care clinics for older adults with major depression or chronic low levels of depression (dysthymia) to improve short-term depression outcomes. Clinic-based depression care management involves active screening for depression, measurement-based outcomes, trained depression care managers, case management, a primary care provider and patient education, antidepressant treatment and psychotherapy, and a supervising psychiatrist.*
Mental Health	**Interventions to Reduce Depression Among Older Adults – Home-Based Depression Care Management** Offer depression care management at home for older adults with depression to improve short-term depression outcomes.	*The Community Preventive Services Task Force recommends depression care management at home for older adults with depression to improve short-term depression outcomes. Home-based depression care management involves: active screening for depression; measurement-based outcomes; trained depression care managers; case management; patient education; and a supervising psychiatrist.*
Mental Health	**Cognitive-behavioral therapy to reduce psychological harm from traumatic events among children and adolescents** Provide individual cognitive-behavioral therapy (CBT) and group CBT for symptomatic youth who have been exposed to traumatic events to reduce psychological harm. Therapists administer CBT individually or in a group and treatment may be accompanied by therapy sessions for or with parents.	*The Community Preventive Services Task Force recommends group cognitive-behavioral therapy for symptomatic youth who have been exposed to traumatic events to reduce psychological harm. Cognitive-behavioral therapy is used to reduce psychological harm among children and adolescents who have psychological symptoms resulting from exposure to traumatic events.*

Outcome Indicators:

- Reduced prevalence of poor mental health
- Reduced suicide rate
- Reduced proportion of adults who experience major depressive episode (MDE)

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

SAMHSA Toolkits

https://www.mentalhealthamerica.net/positions/evidence-based-healthcare

Topic Area	Toolkits	Additional Information
Mental Health	**Assertive Community Treatment (ACT or PACT)** Widely-adopted and –accepted program to provide a full range of services within a community setting to people who have severe mental illnesses such as schizophrenia, bipolar disorder, depression or schizoaffective disorder.	*A multi-disciplinary team provides assistance in a number of areas including daily activities, family life, health, medication support, housing assistance, financial management, entitlements, substance abuse treatment and counseling. The key to its success is a high staff to consumer ratio (at least one to 10 consumers), provision of services where they are needed (in the community), uninterrupted care as someone from the team is always available, a non-coercive and recovery-oriented approach, and time-unlimited support.*

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Toolkits	Additional Information
Mental Health	**Supported Employment** Program that aids people in recovery in finding competitive jobs (defined as at least minimum wage jobs open to the general public) that are well suited to their interests and abilities.	*Supported employment is based upon six principles which include: (1) eligibility is based on choice (no one is excluded), (2) employment is integrated with treatment, (3) competitive employment is the goal, (4) job search starts soon after a person expresses interest in working (there are no prerequisites such as training classes or intermediate work experience), (5) follow-along supports are continuous, and (6) Job-seeker preferences are important. Employment specialists work alongside people in recovery to ensure that these six principles are met.*
Mental Health	**Integrated Treatment for Co-occurring Disorders** A treatment model in which the same treatment team provides both mental health and substance abuse treatment for people with "dual disorders" (simultaneously occurring substance abuse and mental illness). Integrated treatment improves chances for meaningful recovery.	*Within this model, people in recovery receive case management, outreach and other much-needed services such as housing and supported employment. Counseling services are tailored to those who have dual disorders and include assessment, motivational treatment and substance abuse counseling. Family members are also educated about the mental illness and substance abuse, and are given support as well.*
Mental Health	**Family Psychoeducation** A practice that forges partnerships between people in recovery and their families and treatment teams, who come together to support recovery. Families are given information about mental health and substance use conditions and develop coping skills.	*This practice has several phases. (1) The first phase involves family members in introductory sessions where they meet with a practitioner and explore the warning signs of illness, the family's reactions to symptoms and behaviors, and feeling of loss and grief, and set goals for the future. (2) The second phase is an educational workshop in which families come together to learn about the biology of the illness, normal reactions, managing stress and safety measures. (3) The final component is problem-solving sessions in which the person, family and treatment team meet every two weeks for the first few months to learn to deal with problems in a pragmatic, structured way.*
Mental Health	**Permanent Supportive Housing** A program to provide housing distinct from social supports for people with mental health and substance use disorders.	*The SAMHSA toolkit defines Permanently Supportive Housing. https://store.samhsa.gov/system/files/sma10-4510-06-buildingyourprogram-psh.pdf*
Mental Health	**Treatment of Depression in Older Adults**	*The evidence-based practices discussed by SAMHSA include: (1) Cognitive behavioral therapy, (2) Behavioral therapy, (3) Problem-solving treatment, (4) Interpersonal psychotherapy, (5) Reminiscence therapy, (6) Cognitive biblio-therapy, (7) Antidepressant medications, (8) Multidisciplinary geriatric mental health outreach services, and (9) Collaborative and integrated mental and physical health care. Although partially covered by (8), MHA stresses the use of community-based, multidisciplinary mobile geriatric teams*

MENTAL/BEHAVIORAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Toolkits	Additional Information
Mental Health	**Consumer-operated Services**	*Include single service providers for drop-in programs, support groups, housing, employment, training, and consultation; general recovery resource, education, and self-advocacy centers; and multiservice organizations that provide an array of services and resources. The organization must be 90% or more owned, directed and operated by people in recovery.*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Alcohol Use	**Administrative license suspension/revocation laws** Enable law enforcement officials to take an individual's drivers license when that individual refuses or fails a chemical test such as a breathalyzer.	*Administrative license suspension or revocation laws for alcohol-impaired driving enable law enforcement officials to take an individual's drivers license when that individual refuses or fails a chemical test such as a breathalyzer. Such suspensions or revocations last for a period of time specified by state law (NHTSA-Goodwin 2013).*
Alcohol Use	**Alcohol Brief Interventions** Provide information and increase motivation to change or prevent problematic alcohol consumption in a short session; also called alcohol screening & brief intervention.	*Alcohol brief intervention programs provide information and increase motivation to change or prevent problematic alcohol consumption in a short session; sessions usually last five to ten minutes, with a maximum duration of one hour. Brief interventions often include screening, feedback on clients' behavior, and advice and decision making support to encourage change (Cochrane-Carney 2016). Such interventions can be administered in person by health care providers, trained counselors, social workers or others, or delivered through electronic devices such as computers, telephones, or mobile devices (CG-Alcohol).*
Alcohol Use	**Alcohol outlet density restrictions** Limit increases in the number and concentration of alcohol outlets by area or by population through licensing or zoning regulations.	*States and municipalities can limit increases in the number and concentration of alcohol outlets by area or by population through licensing or local zoning processes (CG-Alcohol). Such restrictions can apply to on-premise settings (e.g., bars and restaurants), off-premise outlets (e.g., liquor stores, grocery and convenience stores), or both. Approaches to regulate alcohol outlets vary by state preemption statute: some regulate alcohol retail licensing exclusively, some grant local licensing authorities and issue state minimum standards (e.g., minimum distances between alcohol outlets or distances from schools, or maximum number of licenses per area), others grant local zoning authorities (CDC-Alcohol PSR 2013, CAMY-Alcohol outlet density).*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Alcohol Use	**Alcohol taxes** Increase the price of alcohol via regular adjustments to taxes levied for beer, wine, and liquor purchases.	*States and municipalities can add an excise tax or a sales tax to alcoholic beverages, increasing the price paid for such beverages. Alcohol excise taxes are usually based on the volume of beverage purchased while sales taxes charge a percentage of a product's cost. The effects of excise taxes on price can erode over time due to inflation if taxes are not adjusted regularly; sales taxes increase with price changes so are not affected by inflation. Sales and excise taxes can be implemented simultaneously or separately. Tax amounts often differ for beer, wine, and liquor (CG-Alcohol, Mosher 2017).*
Alcohol Use	**Blood alcohol concentration laws** Set legal limits for drivers' blood alcohol concentrations (BACs).	*Blood alcohol concentration (BAC) laws set legal limits for drivers' blood alcohol concentration. In the United States, lower BAC limits are set for drivers under the legal drinking age. In other countries, lower levels often apply to newly licensed drivers or newly licensed drivers under a specified age (CG-Motor vehicle injury). High BAC levels have a detrimental effect on drivers' physical and cognitive abilities, including muscle coordination, speed control, and perception (NHTSA-Drunk driving).*
Alcohol Use	**Breath testing checkpoints** Implement checkpoints where law enforcement officers can stop drivers suspected of drinking and driving and assess their level of alcohol impairment; also called sobriety checkpoints.	*Law enforcement officers use breath testing checkpoints, also called sobriety checkpoints, to stop drivers and assess their level of alcohol impairment. There are two types of checkpoints: selective breath testing (SBT), where officers must suspect a driver's impairment to request a breath test; and random breath testing (RBT), where officers can test all drivers for blood alcohol levels. SBT is used in some US states; RBT is not used in the US. Checkpoints may be publicized through paid or unpaid media coverage, or occur without publicity (CG-Motor vehicle injury).*
Alcohol Use	**Dram shop liability laws** Hold alcohol retailers legally responsible for injuries or damage caused by providing alcohol to intoxicated or underage customers; also called commercial host liability laws.	*Dram shop liability laws, also called commercial host liability laws, hold an alcohol retailer legally responsible for injuries or damage caused by selling or serving alcohol to intoxicated or underage customers. In states with such laws, retailers have civil liability when an injured third party files a lawsuit (ChangeLab-CHL, US DHHS-Underage drinking 2017). Laws vary in total liability and criteria for limitations on damages, who may be sued, and elements or standards of proof (US DHHS-Underage drinking 2017, NCSL-Dram shop).*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Alcohol Use	**Drug Courts** Use specialized courts to offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration.	*Drug courts are specialized courts that offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration. These courts intensively supervise offenders, require drug testing and treatment (US GAO-Maurer 2011), and impose graduated sanctions for failed drug tests or program non-compliance (Messina 2012). Drug courts can specialize in subpopulations such as juvenile offenders or adults charged with drunk driving (Campbell-Mitchell 2012).*
Alcohol Use	**Enhanced enforcement of laws prohibiting alcohol sales to minors** Initiate or increase retailer compliance checks for laws that prohibit alcohol sales to minors, often as part of a multi-faceted effort.	*Enhanced enforcement programs initiate or increase the frequency of retailer compliance checks for laws prohibiting the sale of alcohol to minors. Retailer compliance checks are generally conducted by local law enforcement or alcohol beverage control agencies along with other efforts to reduce underage drinking (e.g., mass media campaigns publicizing enforcement activities). Violators receive legal or administrative sanctions (CG-Alcohol).*
Alcohol Use	**Family treatment drug courts** Use specialized courts to work with parents involved in the child welfare system who may lose custody of their children due to substance abuse.	*Family treatment drug courts (FTDCs) work with parents involved in the child welfare system who may lose custody of their children due to substance abuse. FTDCs include intensive judicial monitoring, substance abuse treatment, frequent drug testing, comprehensive wrap-around services, and rewards and sanctions linked to program compliance. Eligible families are referred to FTDCs by a parent's attorney, a social worker, a FTDC administrator, or a family court judge; program participation is voluntary (Green 2007, Gifford 2014). FTDCs address both child safety issues and parental substance abuse treatment (Lloyd 2015).*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Alcohol Use	**Ignition interlock devices** Strengthen policies that mandate ignition interlock installation in vehicles to prevent operation by a driver with a high blood alcohol concentration.	*Ignition interlocks are devices that can be installed in vehicles to prevent operation by a driver who has a blood alcohol concentration (BAC) above a specified level. Interlocks are most often installed in vehicles of people who have been convicted of alcohol-impaired driving. Interlocks can be mandated by courts or offered by state licensing agencies as an alternative to a suspended driver's license, often as a provision of a restricted license. Requirements for use of interlock devices varies by state based on BAC level, number of offenses, and other conditions. Interlocks are generally installed for the length of time a license would be suspended, usually 6 to 24 months (CG-Motor vehicle injury). States can levy penalties on offenders for failure to install devices (CDC-Ignition interlock).*
Alcohol Use	**Mass media campaigns against alcohol-impaired driving** Use mass media campaigns to persuade individuals to avoid drinking and driving or to prevent others from doing so; campaigns often focus on fear of arrest or injury to self, others, or property.	*Mass media campaigns to reduce alcohol-impaired driving aim to persuade individuals to avoid drinking and driving or to prevent others from doing so. Campaigns often focus on fear of arrest or fear of injury to self, others, or property, and often characterize drinking drivers as irresponsible and dangerous to others (CG-Motor vehicle injury).*
Alcohol Use	**Mentoring programs: delinquency** Enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period; mentors have greater knowledge, skills, etc. than mentees.	*Mentoring programs focused on reducing delinquency enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period. Mentors have greater knowledge, skills, or experience than mentees, but are not in professional or pre-determined relationships with the mentees such as parent-child or teacher-student (Campbell-Tolan 2013).*
Alcohol Use	**Minimum drinking age laws** Maintain the current age below which the purchase or public consumption of alcoholic beverages is illegal; currently 21 in all states.	*Minimum legal drinking age (MLDA) laws specify an age below which the purchase or public consumption of alcoholic beverages is illegal. In the United States, the age in all states is currently 21 years (CG-Motor vehicle injury).*
Alcohol Use	**Multi-component community interventions against alcohol-impaired driving** Work to reduce alcohol-impaired driving via sobriety checkpoints, responsible beverage service training, education and awareness activities, and other efforts.	*Multi-component interventions with community mobilization focused on alcohol-impaired driving can include many components, such as: sobriety checkpoints, training in responsible beverage service, education and awareness-raising efforts, and limiting access to alcohol (CG-Motor vehicle injury).*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Alcohol Use	**Alcohol access restrictions in public places** Restrict alcohol availability and use at sporting events, other public events (e.g., concerts and street fairs) and in public spaces such as parks and beaches.	*A variety of policies can be used to restrict the availability and use of alcohol at sporting events, other public events such as concerts and street fairs, and public spaces such as parks and beaches. Restrictions can be implemented voluntarily by event organizers or through local legislation. Efforts include total bans on alcohol consumption at certain times or places, designated drinking and alcohol-free areas, prohibition of alcoholic beverages in open containers, limits on the number of alcoholic beverages per sale, and establishment of standard enforcement procedures for monitoring and violation (UMN-AEP, Lenk 2010).*
Alcohol Use	**Mass media campaigns against underage & binge drinking** Use television, radio, print, and social media efforts to increase adult awareness of underage drinking and its consequences.	*Mass media campaigns utilize television, radio, print, and social media to increase adult awareness of underage drinking and its consequences. Campaigns may also include efforts to provide adults with the knowledge and skills to take actions that help prevent underage drinking (IOM-Underage drinking 2004, SAMHSA-Talk).*
Alcohol Use	**Social host laws** Adopt laws that hold private property owners who provide alcohol to minors or obviously intoxicated individuals on their property liable if someone is killed or injured as a result	*Social host liability laws hold private property owners who provide alcohol or allow its provision to minors or obviously intoxicated individuals on their property liable if someone is killed or injured as a result of the provision of that alcohol. Social host liability varies from state to state, and can take the form of criminal or civil actions.*

SUBSTANCE ABUSE - ALCOHOL
Sample Evidence-Based Strategies and Outcome Indicators

Sample Objectives and Strategies:

Objective A: By DATE, reduce the use of alcohol and drugs among youth (10-18 years of age) in the X County from X% to X%.
Sample Strategies:
1. Develop and implement media campaigns directed at youth that disseminates information to increase knowledge, alter attitudes, advise about treatment options
2. Review and change local or state policies related to alcohol abuse prevention by minors, if appropriate (i.e., community laws prohibiting alcohol advertising in close proximity to schools, billboards, sides of buses, and in other public areas)
3. Implement evidence based prevention education programs in schools and outside of schools that teach critical personal and social skills that promote health and well-being among youth and helps them avoid substance abuse
4. Implement existing substance abuse models that strengthen families, parenting skills and other established strong consistent norms about alcohol and drug use
5. Promote public policy to reduce provision of alcohol by caregivers to minors
6. Implement education efforts aimed at caregivers to reduce provision of alcohol to minors

Outcome Indicators:
% high school students who report binge drinking (had 5 or more alcoholic drinks in a row or within a couple of hours, on at least one of the past 30 days)

Objective B: By DATE, decrease the incidence of alcohol and drug abuse among adults in X County from X % to X%
Sample Strategies:
1. Develop or work with existing substance abuse prevention coalitions that focus on building community capacity, increasing service integration, influencing policy change, conducting needs assessments, and developing appropriate community programs.
2. Identify, purchase (or develop) and disseminate alcohol and drug abuse prevention patient education materials for adults for each region
3. Implement community-based education programs on alcohol abuse (Cognitive-behavioral therapy, motivational enhancement, and 12-step facilitation) using strategies appropriate to culture, language, and literacy skills
4. Implement alcohol screening in all points of entry into the health care system (ask about alcohol use, assess for alcohol related problems, advise, determine level of risk/dependence and refer to specialist if indicated)

Outcome Indicators
% of adults aged 18 years and older who binge drink on or more occasions in the last 30 days (BRFSS)
% of adults aged 18 years and older who report either binge drinking or heavy drinking (County Health Rankings)

Objective C: By DATE, increase awareness among parents and other caregivers of youth (10-18 years of age) about the dangers of binge drinking and alcohol abuse in X County
Sample Strategies:
1. Develop and implement media campaigns directed towards parents
2. Identify, purchase and distribute educational materials for parents appropriate for each region
3. Implement evidence based education programs for parents on attitudes and behaviors related to binge drinking and alcohol abuse

Outcome Indicators:
Media campaign developed and implemented throughout the County
Educational programs implemented throughout the region

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

This document includes a sampling of strategies on the following topic areas:

- Preventing opioid overdose
- Improving opioid overdose response
- Improving treatment access/utilization to reduce overdose risk

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Strategies for Opioid Users/ Bystanders	**Good Samaritan drug overdose laws** Provide immunity from arrest, charge, or prosecution for drug possession or paraphernalia when individuals experiencing or witnessing drug overdose summon emergency services.	*Good Samaritan drug overdose laws provide immunity from arrest, charge, or prosecution for drug possession or paraphernalia when individuals who are experiencing or witnessing an overdose summon emergency services (Davis 2013, NPHL 2016, NCSL-Overdose). Good Samaritan laws vary by state; some states also provide expansive protection from violations of probation, parole, and restraining order and other protection from arrest on outstanding minor warrants (Davis 2013, NPHL 2016). Good Samaritan drug overdose laws often accompany efforts to expand layperson's ability to administer naloxone in opioid overdose situations (NCSL-Overdose).*
Strategies for Opioid Users/ Bystanders	**Medication-assisted treatment access enhancement initiatives** Provide medications such as methadone to individuals diagnosed with opioid use disorder in outpatient, residential, and hospital settings, usually with counseling and behavioral therapies; often called MAT	*Medication-assisted treatment (MAT) for opioid dependence provides medications to individuals diagnosed with opioid use disorder, usually with counseling and behavioral therapies. As of August 2017, the US Food and Drug Administration (FDA) has approved methadone, buprenorphine, and extended release injectable naltrexone for MAT. Methadone is only dispensed through Opioid Treatment Programs (OTPs) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA); buprenorphine is distributed through OTPs and prescribers who complete required training. Naltrexone can be prescribed by any provider authorized to dispense medications (SAMHSA-MAT). As of 2014, only 28% of patients in treatment services with primary heroin admissions received MAT (SAMHSA-TEDS 2016). Limited insurance coverage and appointment availability and lack of prescribing physicians are often barriers to MAT (Pew-MAT 2016, Burns 2016); efforts to enhance access include building availability and capacity to distribute (Jones 2015b, CHCF 2016) and expanding Medicaid coverage for MAT (ASAM 2013).*
Strategies for Opioid Users/ Bystanders	**Proper drug disposal programs** Establish programs that accept expired, unwanted, or unused medicines from designated users and dispose of them responsibly.	*Proper drug disposal programs accept expired, unwanted, or unused medicines from designated users and dispose of them responsibly. Programs can use in-person drop-offs, mail-in efforts, or permanent secure collection receptacles and can be administered by state or local governments, municipal trash and recycling services, pharmacies, hospitals, clinics, or community organizations partnered with law enforcement. A 2014 amendment to the federal Controlled Substances Act allows the US Drug Enforcement Administration (DEA) to register authorized collectors of controlled substances, allowing collection of pharmaceutical controlled and non-controlled substances, but not illicit drugs (US DEA-Disposal regulations 2014).*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Strategies for Opioid Users in Treatment	**Drug Courts** Use specialized courts to offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration	*Drug courts are specialized courts that offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration. These courts intensively supervise offenders, require drug testing and treatment (US GAO-Maurer 2011), and impose graduated sanctions for failed drug tests or program non-compliance (Messina 2012). Drug courts can specialize in subpopulations such as juvenile offenders or adults charged with drunk driving (Campbell-Mitchell 2012).*
Strategies for Opioid Users in Treatment	**Bridge Programs.** The Bridge program is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS).	**Bridge Programs.** The Bridge model treats emergency rooms and acute care hospitals as a critical window for initiating treatment. When patients in opioid withdrawal come seeking medical care, including for reasons not related to opioid use, they will be offered a dose of medication such as buprenorphine to ease severe symptoms of withdrawal, and then they will be connected with outpatient treatment in the community. Studies have shown that patients given this option of medication designed for addiction treatment are more likely to remain in care than those who are given referral information alone
Strategies for Opioid Users in Treatment	**PreVenture** School-based intervention aimed at reducing adolescent drug and alcohol use in high-risk teenagers.	*Preventure is a school-based intervention aimed at reducing adolescent drug and alcohol use in high-risk teenagers. Students with high-risk personality profiles as identified by a screening questionnaire are invited to participate in two 90-minute group workshops. The workshops focus on motivating adolescents to understand how their personality style leads to certain emotional and behavioral reactions. Four different workshops are run, each focused on developing specialized coping skills relevant to following personality styles: Sensation seeking; Impulsivity; Anxiety sensitivity; Negative thinking. https://positivechoices.org.au/teachers/preventure*
Strategies for Opioid Users in Treatment	**Family treatment drug courts** Use specialized courts to work with parents involved in the child welfare system who may lose custody of their children due to substance abuse	*Family treatment drug courts (FTDCs) work with parents involved in the child welfare system who may lose custody of their children due to substance abuse. FTDCs include intensive judicial monitoring, substance abuse treatment, frequent drug testing, comprehensive wrap-around services, and rewards and sanctions linked to program compliance. Eligible families are referred to FTDCs by a parent's attorney, a social worker, a FTDC administrator, or a family court judge; program participation is voluntary (Green 2007, Gifford 2014). FTDCs address both child safety issues and parental substance abuse treatment (Lloyd 2015).*
Strategies for Prevention	**Mentoring programs: delinquency** Enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period; mentors have greater knowledge, skills, etc. than mentees	*Mentoring programs focused on reducing delinquency enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period. Mentors have greater knowledge, skills, or experience than mentees, but are not in professional or pre-determined relationships with the mentees such as parent-child or teacher-student (Campbell-Tolan 2013).*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Healthy People 2020 Topics and Objectives
https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse

Topic Area	Sample Strategies
Strategies for Prevention	**HP2020 Objectives:** ***SA 2.4*** *Increase the proportion of high school seniors never using substances – Illicit drugs* ***SA 12*** *Reduce drug-induced deaths.* ***SA 13.1*** *Reduce the proportion of adolescents reporting use of alcohol or any illicit drugs during the past 30 days.* ***SA 13.3*** *Reduce the proportion of adults reporting use of any illicit drug during the past 30 days.* ***SA 19*** *Reduce the past-year nonmedical use of prescription drugs.*
Strategies for Criminal Justice System	**HP2020 Objectives:** ***SA 5*** *(Developmental) Increase the number of drug, driving while impaired (DWI), and other specialty courts in the United States.*
Strategies for Screening & Treatment	**HP2020 Objectives:** ***SA 7*** *Increase the number of admissions to substance abuse treatment for injection drug use* ***SA 8*** *Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.* ***SA 9*** *(Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED).*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the Massachusetts Collaborative for Action, Leadership, and Learning (MassCall2)
http://masstapp.edc.org/sites/masstapp.edc.org/files/MassCALL2_Guidance_Document.pdf

Topic Area	Sample Strategies
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #1:** *Provide information/training to opioid users and bystanders (friends, family, co-users) on overdose risk factors – including:* • *Danger of using alone* • *Concomitant use of alcohol, benzodiazepines, or other drugs* • *Re-initiation of use after periods of abstinence*
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #2:** *Provide information/training to opioid users and bystanders (friends, family, co-users) on overdose prevention strategies*
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #12:** *Train opioid users and bystanders (friends, family members, co-users) on recognizing the signs of overdose*
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #13):** *Reduce barriers to contacting emergency medical services in the event of an overdose*
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #14:** *Educate users/bystanders in appropriate overdose management strategies such as rescue breathing and contacting emergency medical services*
Strategies for Opioid Users/ Bystanders	**MASSCALL2 #15:** *Educate users/bystanders in the use of overdose reversal strategies such as administration of Naloxone/Narcan*
Strategies for Opioid Users /Bystanders	**MASSCALL2 #16:** *Train groups who frequently come in contact with opioid users or overdose hot-spots (e.g., non-healthcare staff in police stations, rehabilitation hostels, residential hotels) in the use of overdose reversal strategies such as administration of Naloxone/Narcan*
Strategies for Opioid Users in Treatment	**MASSCALL2 #7:** *Provide information on how to reduce overdose risk for opioid users admitted to treatment – including:* • *Information on loss of drug tolerance after completion or withdrawal from treatment* • *Increased risk of overdose for clients in the first few weeks of initiating methadone substitution therapy* • *Increased risk of overdose using heroin or other opiates while on methadone or other replacement/maintenance therapy* *Incorporate information on opioid overdose prevention into relapse management trainings – how to avoid overdose if relapse occurs*
Strategies for Opioid Users in Treatment	**MASSCALL2 #8:** *Identification of individuals at-risk for overdose through screening detoxification patients for mental health issues (depressive symptoms) and other risk factors for overdose – particularly for history of prior overdose*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies
Strategies for Opioid Users in Treatment	**MASSCALL2 #9:** *Provide education and support for individuals completing detoxification – particularly information on loss of tolerance after detoxification*
Strategies for Opioid Users in Treatment	**MASSCALL2 #18:** *Educate patients enrolled in or leaving treatment/detoxification in appropriate overdose management strategies such as rescue breathing and contacting emergency medical services*
Strategies for Opioid Users in Treatment	**MASSCALL2 #19:** *Educate patients enrolled in or leaving treatment/detoxification in the use of overdose reversal strategies such as administration of Naloxone/Narcan*
Strategies for Healthcare Providers	**MASSCALL2 #3:** *Identification of individuals at-risk for overdose through screening conducted by emergency department (ED) staff, emergency medical technicians (EMT), and/or hospital staff – including history of prior overdose*
Strategies for Healthcare Providers	**MASSCALL2 #4:** *Identification of individuals at-risk for overdose through targeting intravenous drug users with soft tissue infections seeking care in the Emergency Department, hospital, or primary care physician*
Strategies for Healthcare Providers	**MASSCALL2 #5:** *EMTs and first responders distribute information about causes and consequences of overdose to victims and bystanders – especially those refusing transport to the hospital*
Strategies for Healthcare Providers	**MASSCALL2 #6:** *Deliver overdose risk and response training to clients recruited from needle exchange sites*
Strategies for Healthcare Providers	**MASSCALL2 #17:** *Train needle exchange clients in overdose reversal strategies such as administration of Naloxone/Narcan*
Strategies for Healthcare Providers	**MASSCALL2 #23:** *Provide treatment information, referrals, or linkages with support services or treatment for overdose victims*
Strategies for Healthcare Providers	**MASSCALL2 #24:** *Brief motivational interviewing to promote entry into treatment*
Strategies for Healthcare Providers	**MASSCALL2 #25:** *Provide follow-up services by health promotion advocates after an overdose to encourage initiation of treatment services*
Strategies for Healthcare Providers	**MASSCALL2 #26:** *Train community physician/primary care practitioners on making treatment referrals for opioid dependent patients and identified doctor shoppers*
Strategies for Healthcare Providers	**MASSCALL2 #27:** *Train pharmacists on educational strategies and referral services to treatment for suspected intravenous drug users purchasing syringes*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies
Strategies for Healthcare Providers	**MASSCALL2 #28:** *EMTs and first responders distribute information treatment options to overdose victims – especially those refusing transport to the hospital*
Strategies for Criminal Justice System Personnel	**MASSCALL2 #10:** *Provide incarcerates with a history of opioid use with overdose prevention information upon release from prison or jail – including information about risks of re-initiation of use after release*
Strategies for Criminal Justice System Personnel	**MASSCALL2 #11:** *Utilize parole/probation officers to provide former incarcerates that have a history of opioid use with overdose prevention information during re-entry into the community*
Strategies for Criminal Justice System Personnel	**MASSCALL2 #20:** *Work with police and law enforcement to address user/bystander fear of contacting emergency medical services out of fear for police involvement*
Strategies for Criminal Justice System Personnel	**MASSCALL2 #21:** *Educate incarcerates with a history of opioid use in appropriate overdose management strategies such as rescue breathing and contacting emergency medical services*
Strategies for Criminal Justice System Personnel	**MASSCALL2 #22:** *Train incarcerates with a history of opioid use in the use of overdose reversal strategies such as administration of Naloxone/Narcan upon release from prison or jail*
Strategies for Criminal Justice Personnel	**MASSCALL2 #29:** *Provide incarcerates with a history of opioid use with linkages to community treatment services upon release from prison*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Evidence-Based Strategies for Preventing Opioid Overdose Provided by the Centers for Disease Control and Prevention

Centers for Disease Control and Prevention. Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018. Accessed 7/01/2019 from http://www. cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf.

Topic Area	Sample Strategies	Additional Information
Opioid Use	**Targeted Naloxone Distribution**	*Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Targeted distribution programs seek to train and equip individuals who are most likely to encounter or witness an overdose—especially people who use drugs and first responders— with naloxone kits, which they can use in an emergency to save a life. There are many different approaches to distributing naloxone to people at high risk of experiencing or witnessing an overdose. Effective approaches include community distribution programs, co-prescription of naloxone, and equipping first responders.*
Opioid Use	**Medication-Assisted Treatment (MAT)**	*MAT is a proven pharmacological treatment for opioid use disorder. The backbone of this treatment is FDA approved medications. Agonist drugs, methadone and buprenorphine, activate opioid receptors in the brain, preventing painful opioid withdrawal symptoms without causing euphoria; naltrexone blocks the effects of opioids. MAT is effective at reducing use and helping people to lead normal lives.*
Opioid Use	**Academic Detailing**	*"Detailing" is a structured educational strategy developed by commercial manufacturers of medical and pharmaceutical technologies to market these products to prescribers and pharmacists. "Academic detailing" consists of structured visits to healthcare providers by trained professionals who can provide tailored training and technical assistance, helping healthcare providers use best practices.*
Opioid Use	**Eliminating Prior-Authorization Requirements for Medications for Opioid Use Disorder**	*In this scenario, health insurance providers cover the cost of MAT as a standard benefit and all requirements that a physician contact the insurance provider for approval prior to writing the prescription (a process called "prior authorization") are removed. Without these prior authorization requirements, prescriptions for MAT medications to treat opioid use disorder can be written and filled as soon as a physician deems this treatment necessary, free from artificial delays.*
Opioid Use	**Screening for Fentanyl in Routine Clinical Toxicology Testing**	*The standard panel of substances included in routine clinical drug screens (carried out in hospitals, clinics, treatment centers, etc.) should include screening for fentanyl exposure, particularly in jurisdictions where fentanyl is known to be prevalent in the local illicit drug market.*
Opioid Use	**911 Good Samaritan Laws**	*The term "911 Good Samaritan Law" refers to local or state legislation that may provide overdose victims and/or overdose bystanders with limited immunity from drug-related criminal charges and other criminal or judicial consequences that may otherwise result from calling first responders to the scene. The scope of 911 Good Samaritan Laws varies across U.S. states, but each is written with the goal of reducing barriers to calling 911 in the event of an overdose.*

SUBSTANCE ABUSE - OPIOID USE

Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Opioid Use	**Naloxone Distribution in Treatment Centers and Criminal Justice Settings**	*Naloxone distribution programs in criminal justice and treatment facilities (both inpatient and outpatient) target individuals who are about to be released from supervision and/or cease treatment to receive overdose response training and naloxone kits prior to their exit from the program or facility.*
Opioid Use	**MAT in Criminal Justice Settings and Upon Release**	*In this intervention, MAT should be made available as a standard of care for incarcerated individuals with opioid use disorder. Those receiving MAT when they enter a criminal justice setting may continue receiving this treatment, and those who are not on treatment may initiate and continue this form of care while incarcerated and then be linked with appropriate care providers to continue MAT upon release.*
Opioid Use	**Initiating Buprenorphine-based MAT in Emergency Departments**	*Patients receiving care in emergency departments who have untreated opioid use disorder are referred to a provider for long-term buprenorphine-based MAT. This referral is accompanied by initial doses of buprenorphine or a short-term prescription that can be filled right away. The patient can begin treatment immediately, instead of waiting several days for their appointment with a new provider.*
Opioid Use	**Syringe Services Programs**	*Sometimes called "needle exchange" or "syringe exchange," syringe services programs provide access to clean and sterile equipment used for the preparation and consumption of drugs as well as tools for the prevention and reversal of opioid overdose, such as naloxone training and distribution, fentanyl testing strips, and more. Comprehensive syringe services programs also provide additional social and medical services such as: safe disposal of syringes and needles; testing for HIV and hepatitis C infection and linkage to treatment; education about overdose and safer injection practices; referral and access to drug treatment programs, including MAT; tools to prevent HIV and other infectious disease, such as condoms, counseling, or vaccinations; and linkage to medical, mental health, and social services.*

SUBSTANCE ABUSE - TOBACCO
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Tobacco Use	**Cell Phone-Based Tobacco Cessation Interventions** Deliver tobacco cessation advice and motivational messages via text or video message	*Cell phone-based tobacco cessation interventions generally include cessation advice, motivational messages, or content to distract from cravings and can be delivered via text, smartphone applications (apps), or video messages. Messages may be tailored to participant characteristics (e.g., gender, age, ethnicity) or personalized to individual participants. Messages may be sent automatically or sent based on participants' needs. Some interventions include interactive features or connect participants to each other virtually for additional support (Cochrane-Whittaker 2016, Scott-Sheldon 2016).*
Tobacco Use	**Health care provider reminder systems for tobacco cessation** Implement systems that help health professionals support patient tobacco cessation, often with referrals, self-help pamphlets, and pharmacotherapy	*Provider reminder systems remind or encourage health professionals to support tobacco cessation among their patients. Such systems can include provider trainings, organizational protocols or referral processes, financial remuneration for providers, and materials such as self-help pamphlets and pharmacotherapy (e.g., nicotine replacement therapy (NRT)) (Rosseel 2012). A 2013 survey suggests that physicians are more likely to advise quitting than to discuss cessation strategies or medications (NCQA 2013).*
Tobacco Use	**Internet-based tobacco cessation interventions** Use websites, computer programs, and other electronic means to provide information, strategies, or behavioral support to tobacco users who want to quit, sometimes with counseling or pharmacotherapy	*Internet-based tobacco cessation interventions provide information, strategies, or behavioral support to assist tobacco users who want to quit (CG-Tobacco use). Such interventions include websites, computer programs, or other electronic aids (Chen 2012). Interventions may rely solely on internet technology or include components such as in-person counseling, pharmacotherapy (e.g., nicotine replacement therapy (NRT)), remote counseling, or text messaging (Cochrane-Taylor 2017).*

SUBSTANCE ABUSE - TOBACCO
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Tobacco Use	**Mass media campaigns against tobacco use** Use broad media-based efforts to educate large groups of current and potential tobacco users about the dangers of tobacco use	*Mass media campaigns use television, print, digital or social media, radio broadcasts, or other displays to share messages with large audiences (Cochrane-Carson-Chahhoud 2017). Tobacco-specific campaigns educate current and potential tobacco users about the dangers of tobacco and often include graphic portrayals or emotional messages to influence attitudes and beliefs about tobacco use (CG-Tobacco use).*
Tobacco Use	**Smoke-free policies for indoor areas** Implement private sector rules or public sector regulations that prohibit smoking indoors or restrict it to designated, often outdoor, areas	*Smoke-free policies for indoor areas prohibit smoking in designated enclosed spaces. Private sector smoke-free policies can ban smoking on worksite property or restrict it to designated, often outdoor, locations. Smoke-free state laws and local ordinances can establish standards for all workplaces, designated workplaces, and other indoor spaces. Policies can be comprehensive, prohibiting smoking in all areas of workplaces, restaurants, and bars, or limit smoking to designated areas via partial bans (Cochrane-Frazer 2016). Restrictions may also extend to adjacent outdoor areas (CG-Tobacco use). Some local governments cannot enact smoke-free measures due to state preemption legislation (Grassroots Change).*
Tobacco Use	**Statewide comprehensive tobacco programs** Coordinate state and community-level cessation and prevention interventions and provide information on the dangers of tobacco using a combination of educational, regulatory, clinical, social, and economic strategies	*Statewide comprehensive tobacco control programs coordinate state and community-level cessation and prevention interventions and provide information on the dangers of tobacco via educational, regulatory, clinical, social, and economic strategies (CDC-King 2014), such as restrictions on tobacco product marketing and availability, mass media campaigns, cessation services, or smoke-free policies. Programs often provide assistance to community-based organizations and coalitions that implement local tobacco control programs and policies. Statewide programs also conduct surveillance, evaluation, and program monitoring (CG-Tobacco use).*
Tobacco Use	**Tobacco cessation therapy affordability** Reduce patients' out-of-pocket costs for cessation therapies such as nicotine replacement therapy (NRT) and cessation counseling participation	*Tobacco cessation therapies such as nicotine replacement therapy (NRT) and individual, group, and telephone counseling often include out-of-pocket costs for patients. Efforts to increase affordability of cessation therapies can include eliminating patients' out-of-pocket expenses or reducing patients' expenses by eliminating co-payments, limits on duration of treatment, prior authorization, or annual limits on quit attempts (CG-Tobacco use). As of 2016, the US Food and Drug Administration (FDA) has approved nine therapies for tobacco cessation: individual counseling, group counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal sprays, nicotine inhalers, Bupropion, and Varenicline (CDC-MMWR-DiGiulio 2016).*

SUBSTANCE ABUSE - TOBACCO
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Tobacco Use	**Tobacco quitlines** Deliver phone-based behavioral counseling for tobacco users who want to quit with follow-up calls scheduled proactively following initial contact	*Quitlines provide behavioral counseling to tobacco users who want to quit. Cessation specialists schedule follow-up calls after the specialist or tobacco user makes initial contact using a proactive quitline; reactive quitlines rely solely on tobacco users to make future contact. Some quitlines provide additional interventions such as mailed materials, web-based support, text messaging, or tobacco cessation medications (CG-Tobacco use). Many quitlines offer services in multiple languages (NAQC-US)*
Tobacco Use	**Tobacco taxes** Increase tobacco per unit prices through taxes at the federal, state, or local level	*Taxes at the federal, state, or local level can increase the price consumers pay for tobacco. Revenue generated from tobacco taxes may fund tobacco prevention and control interventions. Some local governments cannot enact such measures due to state preemption legislation (CG-Tobacco use).*
Tobacco Use	**E-cigarette regulations** Regulate use of e-cigarettes, especially among youth, via age restrictions, marketing restrictions, expanded smoke-free policies, etc.	*Electronic cigarettes, or e-cigarettes, are a type of electronic nicotine delivery system (ENDS) which deliver nicotine via water vapor. E-cigarettes are regulated by the US Food and Drug Administration (FDA) as of 2016 (US FDA-E-cigarette regulations) and can contain flavors such as chocolate, mint (CDC MMWR-Corey 2013), or gummy bear (Wilson 2013). State and local governments can restrict access to e-cigarettes through efforts such as bans on sales to minors, mandates for face-to-face sales, and limits on promotion (US DHHS SG-E-cigarette 2016, CDC Vital signs-E-cigarette). Some state laws preempt local efforts (Grassroots Change) and most smoke-free air policies do not include ENDS as ENDS release vapor (ChangeLab-E-cigarettes 2014, Gourdet 2014). E-cigarettes are sometimes used by current smokers who want to decrease tobacco use or quit (Malas 2016).*
Tobacco Use	**Minimum tobacco age laws** Increase the minimum legal tobacco age to purchase or publicly consume tobacco to 21; also called Tobacco 21	*Minimum legal age for tobacco laws specify an age below which the purchase or public consumption of tobacco is illegal, often 18, 19, or 21. Some states have age restrictions for sales but have not passed laws setting a minimum consumption age. Initiatives to increase the age to 21 are often referred to as 'Tobacco 21.' Estimates indicate 95% of adult smokers began smoking before age 21 (CTFK-Minimum tobacco age).*

SUBSTANCE ABUSE - TOBACCO
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Tobacco Use	**Smoke-free policies for multi-unit housing** Implement private sector rules or public sector regulations that prohibit smoking in and around multi-unit housing	*Smoke-free multi-unit housing policies prohibit smoking in apartments, duplexes, and similar residences. Policies can apply to both common areas and individual units, and often include adjacent outdoor areas. Private sector rules apply to privately owned rental properties and owner-occupied units such as condo complexes; state and local ordinances apply to public and subsidized housing. Non-smoking residents of multi-unit housing are often exposed to secondhand smoke (SHS) in their homes from other units or common areas (Snyder 2016). The US Surgeon General indicates there is no risk-free level of SHS exposure (US DHHS SG-Smoking 2014). Residents, especially children, can also be exposed to thirdhand smoke (tobacco residue on surfaces and furnishings), in their home (Bartholomew 2015, Matt 2011). Some local governments cannot enact smoke-free measures due to state preemption legislation (Grassroots Change).*
Tobacco Use	**Tobacco retailer licensing** Require retailers to purchase licenses, typically annually, to sell tobacco products; retailers must abide by all tobacco control laws to maintain licenses	*Tobacco retailer licensing laws require retailers to purchase licenses and follow all tobacco control laws in order to sell tobacco products such as cigarettes, smokeless tobacco, cigars, and electronic cigarettes. Licenses are location-specific, non-transferable, and typically renewed annually. Licensing laws may restrict retailers' proximity to youth-oriented facilities such as schools or playgrounds and limit retailer density (Ackerman 2017, PHLC-McLaughlin 2010). Penalties for violations vary by severity of infraction and can include license suspension or revocation. Some state laws preempt local retailer licensing; in municipalities with local licenses, retailers typically must purchase state and local licenses (Satterlund 2014, Ackerman 2017, PHLC-Licensing and zoning).*
Tobacco Use	**Tobacco retailer location restrictions** Set the number, type, proximity, and density of tobacco retailers, especially near homes and schools, via state or local zoning, licensing restrictions, or other regulations	*States or municipalities can limit where tobacco products are sold, proximity of tobacco retailers to each other, and to homes and schools via zoning regulations, retailer licensing laws, and other regulations (e.g., bans on sales). Licensing laws restrict which businesses can sell tobacco products; zoning regulations prohibit sale of tobacco products in designated zones (e.g., near youth oriented facilities such as schools, parks, or playgrounds) (PHLC-Licensing and zoning). Municipalities may also ban the sale of tobacco products in pharmacies and educational institutions (Ackerman 2017). Laws can be enacted individually or as part of broader land use and development plans (TCN 2012).*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the National Institute of Justice
Direct Link: **CrimeSolutions.gov**

The Blueprints initiative (http://www.Colorado.edu/ cspv/blueprints/modelprograms.html) reviewed research on 600 delinquency, drug, and violence prevention and intervention programs.

Justice & Health Innovation Bulletin (https://lac.org/what-we-do/criminal-justice/expanding-health-coverage-among-justice-involved-people/working-with-bja-to-improve-health-coverage-and-care-in-the-justice-system/)

Topic Area	Sample Strategies	Additional Information
Mental Health Substance Use Violence	**Drug Court-Facilitated Medicaid Enrollment.** With the help of a Navigator or through a hospital or other entity qualified to make presumptive eligibility determinations, ensure drug court participants are able to access the substance use disorder treatment and other healthcare services they need. Health organizations should offer Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for those under 21, and Essential Health Benefits (including substance use disorder (SUD) and mental health (MH) services to those involved in the criminal justice system.	*Drug court personnel should work with the justice system, the state Medicaid office, and their clients to ensure that all drug court participants are screened for Medicaid eligibility or eligibility for a health plan through the exchange. https://lac.org/what-we-do/criminal-justice/expanding-health-coverage-among-justice-involved-people/working-with-bja-to-improve-health-coverage-and-care-in-the-justice-system/[1] "Medicaid and Financing Health Care for Individuals Involved in the Criminal Justice System," Council of State Governments Justice Center. Available at http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf* *See also: State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings: http://www.jhsph.edu/research/centers-and-institutes/center-for-mental-health-and-addiction-policy-research/research/economics-and-services-research/arnold-foundation-project-map/*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Mental Health Substance Use Violence	**Fill Gaps in Substance Abuse and Mental Health Disorder Treatment Coverage** Cover needed residential SUD and mental health care, including those not covered by Medicaid due to the Institutions for Mental Disease (IMD) exclusion. The IMD exclusion is a provision of Medicaid law that prohibits the use of federal Medicaid financing for care provided to patients in residential mental health and SUD facilities that are larger than 16 beds. The IMD exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for inpatient psychiatric services provided to beneficiaries under age 21. Among recommendations is to promote the development of residential treatment facilities that are 16 beds or smaller that will not trigger IMD and to leverage other funding to support SUD and MH services**.**	*Opportunities to leverage funds could be from the federal Substance Abuse Prevention and Treatment Block Grant, implementation of Medicaid/CHIP Rule for Mental Health Parity and Addition Equity, Medicaid waivers, and the savings from Medicaid Expansion. Recommended by the U.S. Department of Justice, Bureau of Justice Assistance (BJA) and criminal justice advocacy partners. https://lac.org/what-we-do/criminal-justice/expanding-health-coverage-among-justice-involved-people/working-with-bja-to-improve-health-coverage-and-care-in-the-justice-system/* *See also: State and Local Initiatives to Enroll Individuals in Medicaid in Criminal Justice Settings: http://www.jhsph.edu/research/centers-and-institutes/center-for-mental-health-and-addiction-policy-research/research/economics-and-services-research/arnold-foundation-project-map/*
Violence – Women, Recidivism	**Comprehensive and Integrated Reentry Services** Offer trauma-informed residential, non-residential, and reentry treatment services for female offenders. Partner Healthcare organizations and offering substance abuse and mental health services should partner with other domestic violence, family preservation. Interventions provided within a gender-specific framework acknowledge the various pathways into the criminal justice system and focus on strengths-based treatment approaches and skill-building. A trauma–informed approach to treatment incorporates "new medical and mental health service delivery approaches specifically designed for women with co-occurring mental health/ substance abuse disorders and histories of physical and sexual abuse" (Massachusetts Department of Correction, RFR 08-9004-R21, p. 54).	*Women in both MCI Framingham and the houses of correction have a high level of drug- and alcohol-related offenses. Sixty percent of women in DOC custody have open mental health cases. Women in prison are widely documented to have had experienced emotional, physical, and/or sexual abuse.* *Gender-specific approaches that are multidimensional and are based upon social and cultural factors including class, race, abuse/trauma history, mental illness and substance abuse issues, and family relationships offer greater success (Bloom & Covington, 2000; Bloom, Owen, & Covington, 2003; Sydney, 2006). Interventions acknowledge the various pathways into the criminal justice system and focus on strengths-based treatment approaches and skill-building*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Violence – Families	**Family Connections Policy Framework** This effort should be undertaken with the cooperation of experts, including the Departments of Social Services, Transitional Assistance, Mental Health, Public Health, and community-based agencies. Maintain parent/child bonds between mothers in prison and their children by: a.) support contact visiting between mother and child; b.) support and monitoring children separated from their mothers; and c.) assist with parenting skills and address drug abuse problems, and histories of emotional, sexual, and physical abuse. Mentorship for youth with currently or formerly incarcerated parents is of additional value. Massachusetts Models: Aid to Incarcerated Mothers, South Middlesex Family Preservation Program, Spectrum Women and Children's Program, Women in Transition Program	*70-80 percent of women in prison are mothers and most of these parents were primary caregivers. Most children have little if any regular contact with their incarcerated mothers. Without skilled intervention, children can develop serious behavioral problems and negative coping patterns, including poor school performance, sexual aggression, gang involvement, substance abuse, and juvenile delinquency (one study found that 29 percent of the 11- to 14-year-olds with mothers in prison subsequently were arrested and/or incarcerated)..* *Children with contact with their parent have fewer disruptive and anxious behaviors (Sack & Seidler, 1978; Stanton, 1980) and overall improved outcomes (Edin, Nelson, & Paranal, 2004; Klein, Bartholomew, & Hibbert, 2002; La Vigne et al., 2005). These direct benefits to the child coupled with the benefits for the mother, including lowered recidivism rates and maintaining contact can yield positive outcomes for all involved (Adams & Fischer, 1976; Glaser, 1969; Hairston, 2002; Holt & Miller, 1972; Klein et al., 2002; Ohlin, 1954).* *Sources: Kates, Erika; Ransford, Paige; and Cardozo, Carol, "Women in Prison in Massachusetts: Maintaining Family Connections" (2005). Publications from the Center for Women in Politics and Public Policy.* *31. http://scholarworks.umb.edu/cwppp_pubs/31* *Kates, Erika; Mignon, Sylvia; and Ransford, Paige, "Parenting from Prison: Family Relationships of Incarcerated Women in Massachusetts" (2008). Center for Women in Politics and Public Policy Publications. Paper* *3. http://scholarworks.umb.edu/cwppp_pubs/3*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Violence - Families	**Functional family therapy (FFT)**. Interventions aim to establish and maintain new patterns of family behavior to replace the dysfunctional ones. FFT integrates behavioral (e.g., communication training) and cognitive behavioral interventions (e.g., assertiveness training, anger management) into relational-focused treatment protocols.	*Initial emphases on engaging and motivating family members, followed by extensive efforts at individual and family-level behavior change, and concluding with interventions to sustain such behavior change. (http://www.fftinc.com).* *Mental health, substance abuse, and educational services are deficient for many youth in residential placements and these programs with high social and economic costs are not effective at deterring criminal activity (Sediak and McPherson 2010). Effective, and less costly programs are community-based and address key risk factors (e.g., improving family functioning, decreasing association with deviant peers), are rehabilitative in nature, use behavioral interventions within the youth's natural environment, are well specified, and include intensive support for intervention fidelity.*
Mental Health Substance Use Violence	**Mentally Ill Offender Community Transition Program (Washington)** The program is targeted at individuals whose mental illnesses are seen as instrumental in their offenses, and who are likely to qualify for and benefit from publicly supported treatment in the community. The overall goal is to reduce recidivism.	*Participants in the program were less likely to be convicted of any new offense and convicted of felony offenses, compared with the matched comparison group. The difference was statistically significant.* *Meta-analyses indicate better efficacy for programs initiated prior to release and then transitioned into community-based settings (with high retention and adequate length of treatment). Equally, or more effective, is outpatient treatment used with diversion sentencing that does not entail a retention component.*
Violence Youth Therapies	**Multisystemic therapy** (MST) A community- and family-based treatment that focuses on youth with serious clinical problems. MST interventions are comprehensive and flexible—with the capacity to address pertinent factors at the individual (e.g., cognitive biases), family (e.g., affective and instrumental relations), peer (e.g., prosocial versus antisocial nature of peer associations), school (e.g., academic performance), and community (e.g., availability of prosocial activities for youth) levels.	*Validated system and treatment standards, including the link between therapist treatment fidelity and desired youth and family outcomes (Schoenwald, 2008).* *Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009)* *19 randomized trials and two quasi-experimental studies. Significantly decreased recidivism and thereby increased community safety, and decreased out-of-home placements and costs. Benefits to youth and families served included keeping the youth at home while reducing symptoms and behavior problems.*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Violence Youth Therapies	**Mulltidimensional treatment foster care** (MTFC) a community-based foster care alternative to state detention and group care facilities, particularly for cases in which other intensive in-home and out-of-home services have failed.	*Components: behavior therapy and cognitive behavioral approaches implemented within a social ecological framework that emphasizes the critical role of parental supervision and monitoring in engaging the youth in prosocial peer activities, disengaging him or her from deviant peers, and promoting positive school performance. (http://www. mtfc.com)* *Five randomized and two quasi-experimental research trials for youth with serious antisocial behavior who cannot be maintained in their homes.*
Violence - Youth Diversion	**Police-Initiated Diversion for Youth to Prevent Future Delinquent Behavior** This practice includes pre-court interventions or strategies that police can apply as an alternative to court processing or the imposition of formal charges against low-risk youth. This approach is designed to reduce reoffending by minimizing youth contact with the criminal justice system and divert youth toward services that address their psychosocial development and other needs that contribute to their at-risk behavior.	*Core components: Police officers provide a general explanation to youth and their parents about the legal and social ramifications of continued delinquent behavior. Some variations of this practice allow for victim participation, such as cautions or restorative cautions, which include structured discussion between the victim(s) and the youth.* *Link: https://www.crimesolutions.gov/PracticeDetails.aspx?ID=86* *The practice is rated Effective for reducing future delinquent behavior. The mean odds ratio across the 31 included studies was 0.77. A modest, but not statistically significant, effect was found in favor of the referral-to-services condition.*
Violence - Youth Diversion	**Adolescent Diversion Project (Michigan State University)** A strengths-based, advocacy oriented program that diverts arrested youth from formal processing in the juvenile justice system and provides them community-based services	*Caseworkers (i.e., university student volunteers) spend 6–8 hours per week with the juveniles in their home, school, and community. The caseworkers work one-on-one with juveniles in order to provide them with services tailored to their specific needs. Caseworkers focus on improving juveniles' skills in several areas, including family relationships, school issues, employment, and free-time activities.* *Link: https://www.crimesolutions.gov/ProgramDetails.aspx?ID=332* *The program was associated with a significant reduction in the rates of official delinquency of participating juveniles as compared to juveniles formally processed in the system. However, the program did not significantly affect youths' self-reported delinquency.*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Re-entry/recidivism	**Jail-based Reentry Specialist Program** This was a two-phase reentry program with an overall goal of reducing recidivism and improving inmates' transition into the community. Phase 1 provided inmates with in-jail programming and services to prepare them for release. Phase 2 provided inmates with up to 12 months of supportive services in the community.	*More details: https://crimesolutions.gov/ProgramDetails.aspx?ID=494* *Willison, Bieler, and Kim (2014) found that the Allegheny County Jail-Based Reentry Specialist Program had a statistically significant impact on the probability of future arrests. Program participants had a 10 percent chance of rearrest, compared with a 34 percent chance for the comparison group (a significant difference).*
Re-entry/recidivism	**Therapeutic Communities** Residential drug treatment programs in prisons or jails for treating substance-abusing and addicted offenders. There is a strong emphasis on participation by all members of the program, with the goal of reducing substance abuse and recidivism.	*More detail: https://crimesolutions.gov/ProgramDetails.aspx?ID=54* *An evaluation of the Amity In-Prison Therapeutic Community found that participants had statistically significant lower levels of reincarceration rates when compared to the control groups. Weakness: incarceration was the only outcome assessed and not yet replicated.*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Intimate Partner Violence	**Advocacy Interventions** Advocacy interventions for women who have experienced intimate partner violence aim to empower women and link them to helpful services in the community. The goals of advocacy interventions include helping abused women to access necessary services, reducing or preventing incidents of abuse, and improving women's physical and psychological health. The core activities of secondary and tertiary advocacy interventions can vary from program to program. The activities provided by advocacy interventions can include • Providing legal, housing, and financial advice • Facilitating access to and use of community resources such as shelters, emergency housing, and psychological interventions • Providing safety planning advice	*More detail:* https://crimesolutions.gov/PracticeDetails.aspx?ID=55 *Ramsay and colleagues (2009) examined the results from two studies examining the effects of advocacy interventions in reducing physical abuse for women who have experienced intimate partner violence, at 12- and 24-month follow-up periods. The significant effect size (OR=0.43) suggested that women who received advocacy interventions experienced significantly less physical abuse, compared with women in the control groups. However, this finding should be taken with some caution as the analysis relied on the results from only two studies.* *Ramsay, Jean, Yvonne Carter, Leslie Davidson, Danielle Dunne, Sandra Eldridge, Gene Feder, Kelsey Hegarty, Carol Rivas, Angela Taft, and Alison Warburton. 2009. "Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women Who Experience Intimate Partner Abuse." Campbell Systematic Reviews 5.*

MENTAL/BEHAVIORAL HEALTH AMONG FORMERLY INCARCERATED; VIOLENCE; RE-ENTRY/RECIDIVISM
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Intimate Partner Violence	**Acceptance and Commitment Therapy for Partner Aggression** An emotional- and behavioral-skills enhancement program targeted at adults who engaged in aggressive behavior with their partners. This group-format program aimed to promote psychological flexibility and thereby decrease aggression in participants.	*Program participants were referred to treatment by mental health professionals at clinics, community mental health centers, and private practices. The participants were seeking treatment for problems that may have included anxiety, depression, substance abuse, and life stressors (e.g., unemployment), as well as more pervasive interpersonal difficulties (e.g., borderline personality disorder). The program consisted of 12 weekly, 2-hour group sessions that emphasized emotional- and behavioral-skills enhancement techniques to decrease experiential avoidance. The modules focused on the development of each skill in a group context, skills generalization outside the group, and homework assignments. Throughout the treatment, clients completed daily monitoring forms on the emotional and relational consequences of their use of problematic interpersonal behaviors such as aggression. Participants also worked to identify emotional avoidance versus emotional acceptance and the consequences of each.* *More detail:* https://crimesolutions.gov/ProgramDetails.aspx?ID=592 *Zarling, Lawrence, and Marchman (2015) found that participants in Acceptance and Commitment Therapy (ACT) for aggressive behavior reported less physical aggression at pos ttreatment than the comparison group. This difference was statistically significant.*

Social Determinants of Health

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Built Environment	**Bike Shares and Shared Micromobility Programs** Shared micromobility programs encompass all shared-use fleets of small, fully, partially human powered vehicles (bikes, scooters, etc.). With over 207 million trips taken in the U.S. since 2010, bike share and shared micromobility have rapidly emerged as a new transportation option that can increase cycling and bolster public transit usage. As cities and towns around the country focus on sustainability, bike share and shared micromobility systems can play an important role in safety, livability, physical health, and environmental health.	*Two major studies analyzed the effects of bikeshare programs on mortality due to traffic injury, physical activity, and air pollution (https://www.lumina.com/case-studies/health-and-pharmaceuticals/city-bike-sharing/).* *Both studies estimate that bike share programs have produced net positive effects on health for riders of all ages, as well reduced CO_2 emissions. The London study found a net increase in health of 88 DALYs per year -- i.e. 88 healthy life years –which translates to 3.3 to 10.9 deaths averted annually per million users. The Barcelona study found a much larger effect of 69.2 deaths averted annually per million users.*

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Built Environment	**Access to Green Space** Urban green space interventions are defined as urban green space changes that significantly modify green space availability and features through: creating new green space, changing or improving green space characteristics, use and functions, or removing/replacing green space. The interventions can be implemented in publicly accessible green space, including school yards, private parks and similar settings if they are open to the public. The most promising intervention approaches are (1) park-based interventions combined with social promotion activities, and (2) greening interventions (such as street trees, greening vacant lots, green infrastructure for water management).	*This report by the World Health Organization is a review of impacts and effectiveness of several Urban Green Space interventions aimed at improving health:* https://www.cbd.int/health/who-euro-green-spaces-urbanhealth.pdf

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Built Environment	**Complete Streets/Safe Street Initiatives** Streetscape design improvements enable pedestrians, bicyclists, transit riders, and motorists to share and use the street, accommodating the needs of all users. Improvements to streetscape design can include increased street lighting, enhanced street landscaping and street furniture, increased sidewalk coverage and connectivity of pedestrian walkways, bicycling infrastructure, street crossing safety features, and traffic calming measures. Streetscape design improvement projects typically include elements from more than one of these categories; these projects can be implemented incrementally or comprehensively, and are often part of community-level Complete Streets policies (from County Health Rankings)	*The National Complete Streets Association, AARP, and Smart Growth America evaluation of complete streets projects:* https://www.smartgrowthamerica.org/app/legacy/documents/evaluating-complete-streets-projects.pdf

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Environmental Health	**Air and Noise Pollution** The literature consistently shows associations of adverse cardiovascular and pulmonary outcomes with residential proximity to highways and major roadways. Community-level tactics for reducing exposure include the following: 1) HEPA filtration; 2) Appropriate air-intake locations; 3) Sound proofing, insulation and other features; 4) Land-use buffers; 5) Vegetation or wall barriers; 6) Street-side trees, hedges and vegetation; 7) Decking over highways; 8) Urban design including placement of buildings; 9) Garden and park locations; and 10) Active travel locations, including bicycling and walking paths.	*The CAFEH study (CAFEH; http://sites.tufts.edu/cafeh/), the Community Assessment of Freeway Exposure and Health Study, serves as the larger umbrella for 5 related community-based participatory research (CBPR) air pollution studies. These projects have full participation of the community partners in all aspects of the science including: developing the proposal, leading the study, and collecting, analyzing and interpreting the data.* *The CAFEH partnership combines community and academic resources to advance scientific understanding of the health risks of highway pollution. We hope our findings will inform policymakers about the risks of siting new housing, schools or playgrounds next to highways and help to identify measures to reduce exposures.*

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Environmental Health	**Alternative Fuels Initiatives: Clean Diesel Technology** Clean diesel technology transition programs replace or retrofit government or privately operated diesel vehicles (e.g., buses) until the entire fleet operates with clean diesel technology. Vehicles are often replaced towards the end of their useful life. Diesel powered engines can be retrofitted with control devices such as diesel particulate filters (DPF), diesel oxidation catalysts (DOC), and closed crankcase ventilation systems (CCV). Diesel exhaust is carcinogenic, and contains numerous pollutants that negatively affect cardiovascular and respiratory health; estimates suggest exposure contributes to 27,000 heart attacks, 14,500 hospitalizations, and 2.4 million lost work days each year (CDC-Clean diesel).	*There is strong evidence that adopting clean diesel technology through diesel transition programs decreases environmental exhaust emissions (US EPA-Transportation 2006, Zhang 2011, Barone 2010, Sandhu 2015). Retrofitting diesel buses has also been shown to improve in-cabin air quality by decreasing particulate matter, organic carbon, and elemental carbon in some circumstances (Borak 2007, Trenbath 2009, Barone 2010).* *Decreases in emissions associated with retrofitted diesel buses appear to have positive effects on riders' health. A Washington-based study, for example, indicates reductions in bronchitis, asthma, and pneumonia among children in school districts with retrofitted buses (Beatty 2011), as well as improvements in lung function and reductions in absenteeism, especially among children with asthma (Adar 2015). Retrofitting may also decrease the costs associated with respiratory disease-related hospitalizations and treatment (Beatty 2011).*

BUILT ENVIRONMENT AND ENVIRONMENTAL HEALTH
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Environmental Health	**Integrated Pest Management** Integrated pest management (IPM) includes a broad range of methods to control pests that also minimize potential hazards to people, property, and the environment. IPM employs a four-tiered approach – setting action thresholds, monitoring and identifying pests, preventing pests from becoming a threat, and pest control as needed. IPM pest control begins with the least risky approaches (e.g., using pheromones or mechanical controls such as weeding or trapping) and moves to targeted pesticide application only if other measures are not successful. The IPM approach can be used in outdoor settings such as farms, home gardens, parks, or any other landscaped environment	*All 50 states have IPM programs. Regional IPM centers and federal IPM programs also support development of IPM practices (USDA-IPM in the US). The US Department of Agriculture's National Institute of Food and Agriculture (NIFA) is the primary agency connecting the federal government with the land-grant university system; it also administers and provides leadership for many IPM programs (USDA NIFA-IPMP).* *The US Environmental Protection Agency (EPA) administers the Pesticide Environmental Stewardship Program (PESP) that works with the pesticide-user community to promote IPM practices, and currently has over 200 participating member companies and organizations in 41 states and Washington DC (US EPA-PESP).*

FOOD INSECURITY
Sample Evidence-Based Strategies and Outcome Indicators

Strategies and evidence from County Health Rankings:
https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies?search_api_views_fulltext=food&items_per_page=10

Topic Area	Sample Strategies	Additional Information
Food insecurity	**Food Hubs** Support businesses or organizations that aggregate, distribute, and market local and regional food products (e.g., fresh fruits and vegetables, meat, dairy, grains, and prepared items)	*Food hubs are a suggested strategy to improve local and regional food systems, facilitate fruit and vegetable purchases by schools, hospitals, and small stores, and increase access to fresh fruits, vegetables, and other healthy foods in low income communities (CDC-State indicator 2013, Lerman 2012, USDA-Food hubs, Matson 2013, Schmit 2013, USDA-Matson 2013). Food hubs are also a suggested strategy to improve rural economies and increase the economic viability of small- to mid-size farms (Gaskin 2013, NGFN-Food hub, Lerman 2012, USDA-Food hubs, Schmit 2013). However, additional evidence is needed to confirm effects.* *Food hubs are associated with increased sales opportunities for farmers, increased access to fresh fruits and vegetables for consumers, and increased use of local foods by schools, businesses, and restaurants (Schmidt 2011, USDA-Matson 2013). By providing a single reliable point of purchase for high quality produce, food hubs can lower the cost of fresh fruits and vegetables for consumers and institutions such as schools, hospitals, and convenience stores (CDC-State indicator 2013).*

FOOD INSECURITY
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Food insecurity	**Healthy Food Initiatives in Food Banks** Combine hunger relief efforts with nutrition information and healthy eating opportunities, often with on-site cooking demonstrations, recipe tastings, produce display stands, etc.	*There is some evidence that food banks and food pantries that use healthy food initiatives increase fruit and vegetable consumption, improve diet quality, and increase food security for clients more than traditional food banks and pantries (Martin 2012b, Flynn 2013). However, additional evidence is needed to confirm effects.* *Food bank initiatives that provide nutrition education and recipe demonstrations may improve the variety of fruits and vegetables clients consume, as well as their food knowledge and home cooking habits (Flynn 2013, Keller-Olaman 2005). In a Rhode Island-based study, food pantry clients participating in a plant-based cooking and nutrition education program and preparing these meatless recipes at home 2-3 meals per week, improved weight status and reduced total food costs (Flynn 2013).* *See more evidence on County Health Rankings site:* https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/healthy-food-initiatives-in-food-banks
Food insecurity	**Food Buying Clubs and Co-Ops** Support opportunities for group purchase and distribution of selected grocery items, generally at a reduced price	*USDA-affiliated experts indicate that buying clubs and co-ops can reduce food costs (Kantor 2001). A number of case studies also suggest that buying clubs and co-ops can have positive effects on food purchases (Little 2010, Carroll 2011, Shuman 2009). Buying clubs and co-ops may also increase healthy food access, choices, and food security for low income families (Morales 2014). Overall, however, additional evidence is needed to confirm effects.*

FOOD INSECURITY
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Food insecurity	**Mobile Markets** Mobile markets, mobile farmers markets, or fresh food carts travel to multiple neighborhoods to sell fresh fruits and vegetables, operating on a set schedule so residents know when they can shop. Mobile markets can be created from buses, trucks, vans, carts, or any other vehicle with space to display produce. Mobile markets often travel to areas without easy access to supermarkets or grocery stores (i.e., food deserts).	*Mobile markets that accept payments from SNAP and WIC nutrition assistance programs can have greater effects on access to fresh produce than markets that do not (The Network-Mobile vending). Locating mobile markets in neighborhoods with high concentrations of food insecure households may reduce food insecurity (Widener 2012, Algert 2006). Nutritional education, advertising and promotion, extended hours of operation, and variety of products may maximize mobile markets' effects (Zepeda 2014a).* *More evidence via County Health Rankings:* https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/mobile-markets
Healthy Food Choices	**Healthy Convenience Stores** Encourage convenience stores, corner stores, or gas station markets to carry fresh produce and other healthier food options	*There is some evidence that offering fresh produce and other healthy foods in convenience or corner stores increases access to and purchasing of healthy foods, especially in food deserts and low income urban and rural communities (Gittelsohn 2012, Paek 2014, Ayala 2013, AHA-Mozaffarian 2012). Establishing financial incentives for corner stores to increase availability and variety of healthy foods and beverages is a suggested strategy to prevent obesity (CDC MMWR-Khan 2009). However, additional evidence is needed to confirm effects, especially regarding consumption changes (Ayala 2013, AHA-Mozaffarian 2012).* *More evidence via County Health Rankings:* https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/healthy-food-in-convenience-stores

FOOD INSECURITY
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Healthy Food Choices	**Point of Purchase Prompts for Healthy Food** Place motivational signs on posters, front of package labels, or shelf labels near fruits, vegetables and other items that encourage individuals to purchase healthier food options	*Fruit and vegetable consumption and fat intake can be positively affected through environmental strategies such as point-of-decision prompts; effects are less consistent in grocery stores than in settings such as worksites and universities where fewer food choices are available (Story 2008, Seymour 2004). In a Boston-based study, point-of-purchase traffic light food labels in hospital cafeterias led to healthier choices (Sonnenburg 2013). Point-of-purchase signage can also influence children's food selections (CDC MMWR-School health guidelines 2011) and has been shown to positively affect food choices among university students (Buscher 2001, Freedman 2010, Reed 2011). As part of a multi-component worksite intervention, point-of-decision prompts may lower saturated fat and dietary cholesterol intake (Brehm 2011).* *More evidence via County Health Rankings:* https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/point-of-purchase-prompts-for-healthy-foods

TRANSPORTATION
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Transportation	**Bike Shares and Shared Micromobility Programs** Shared micromobility programs encompass all shared-use fleets of small, fully, partially human powered vehicles (bikes, scooters, etc.). With over 207 million trips taken in the U.S. since 2010, bike share and shared micromobility have rapidly emerged as a new transportation option that can increase cycling and bolster public transit usage. As cities and towns around the country focus on sustainability, bike share and shared micromobility systems can play an important role in safety, livability, physical health, and environmental health.	*Two major studies analyzed the effects of bikeshare programs on mortality due to traffic injury, physical activity, and air pollution (https://www.lumina.com/case-studies/health-and-pharmaceuticals/city-bike-sharing/).* *Both studies estimate that bike share programs have produced net positive effects on health for riders of all ages, as well reduced CO_2 emissions. The London study found a net increase in health of 88 DALYs per year -- i.e. 88 healthy life years –which translates to 3.3 to 10.9 deaths averted annually per million users. The Barcelona study found a much larger effect of 69.2 deaths averted annually per million users.*
Transportation	**Carpool and Rideshare Programs** Help commuters share transportation through informal arrangements between individuals, formally arranged dynamic ridesharing programs, or other ride-matching services (from County Health Rankings)	*From County Health Rankings:* *Carpool and rideshare programs are suggested strategies to reduce traffic congestion, decrease emissions, and reduce vehicle miles traveled (VMT) (UC Davis-Yura 2006, ICF Consulting 2006, RAND-Sorenson 2008). Studies suggest that these programs can be cost-effective (ICF Consulting 2006, RAND-Sorenson 2008, Gallivan 2011), especially for longer commutes (Silva-Send 2013); programs may also improve mobility and quality of life for seniors (Silvis 2009) and reduce stress for commuters (Robbins 2015). Overall, transit incentives can increase use of alternative transportation; however, additional evidence is needed to confirm effects and costs of carpool and rideshare programs specifically (Graham-Rowe 2011).*

TRANSPORTATION
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Transportation	**Alternative Fuels** Alternative fuels initiatives support transition from traditional motor fuel sources (i.e., gasoline and diesel) to alternative sources such as biodiesel, ethanol, compressed natural gas, partial electric, hydrogen fuel cells, or liquid petroleum gas. Such initiatives support the supply, distribution, and production of alternative fuels and vehicles through various combinations of financial incentives (e.g., tax benefits, loans, grants, or rebates), mandates or rules (e.g., consumption targets or renewable fuel standards), direct purchases of alternative fuel vehicles for use in state or municipal fleets, and investments in research and development to improve technology and to evaluate and improve the infrastructure for alternative fuel vehicles. Initiatives are underway in many areas around the country to reduce potential barriers to the adoption of alternative fuels, such as high costs and a lack of supporting infrastructure (from County Health Rankings)	*From County Health Rankings:* *Alternative fuels initiatives are a suggested strategy to reduce emissions (US DOE-AFAVDC, US EPA-Alternative fuels, NGA-Green vehicle guide 2008, Rahm 2006, Lutsey 2008). Available evidence suggests that using alternative fuels decreases emissions of greenhouse gases and volatile organic compounds (VOCs) (Hill 2006, CTR-Wang 1998, US DOT-Alternative fuels strategies, US DOE-AFAVDC), and that alternative fuel sources such as compressed natural gas, methanol, ethanol, or electricity produce significantly less air toxics emissions than conventional gasoline (CTR-Winebrake 2000).* *Pollutant levels and emissions reductions vary for each type of alternative fuel (US DOE-AFV Emissions) and geographic regions have varying exposure levels to emissions and particulate matter (US EPA-Air toxics). Understanding local context can support decisions about the most appropriate alternative fuels initiatives; there is not a one-size-fits-all approach for these initiatives or incentives (NGA-Escobar 2010). Additional evidence is needed to determine the costs and effects of various initiatives promoting each alternative fuel.*

TRANSPORTATION
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Transportation	**Individual Incentives for Public Transportation** Incentives such as free or discounted bus, rail, or transit passes reimbursements, partial payments (Bueno 2017), or pre-tax payroll deductions (NCTR-Commuter benefits) decrease consumers' cost to use public transportation. Incentives are typically offered by employers as a commuter benefit and can be part of transportation subsidy programs, deep discounting, or transit pass incentive programs (Bueno 2017). (From County Health Rankings)	*From County Health Rankings (more evidence at the source):* *There is some evidence that offering individual incentives for public transit increases public transit use (VTPI-Litman 2017a, Graham-Rowe 2011, Zhou 2014a, Bueno 2017, Dong 2016a, Yang 2015b). Such incentives can also increase physical activity for individuals who use non-motorized travel to and from transit stops (Saelens 2014, MacDonald 2010, Martin 2012, Webb 2012, Hipp 2017, Freeland 2013). However, additional evidence is needed to confirm effects.* *Transit users have higher levels of physical activity than non-transit users (Saelens 2014, Lachapelle 2009, Wener 2007). Incentives for public transit use have been shown to increase active travel options such as walking and cycling (Martin 2012, Coronini-Cronberg 2012), which may reduce the likelihood of becoming obese (MacDonald 2010, Webb 2012).*

Financial Mobility

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Education	**Alternative high schools for at-risk students** Provide educational and social services in an alternative setting for students at-risk of dropping out of traditional high schools	*Alternative high schools provide educational opportunities for students whose needs are not met by a traditional school model, often, students who have quit, been expelled, or are at increased risk of dropping out. Alternative schools generally offer services such as childcare or support groups, have a flexible structure, supportive environments, and small classes, and emphasize interactions between teachers and students. Such schools are frequently established in low income communities and housed outside of traditional schools. Alternative high schools are distinct from community-based alternative education programs for at-risk students that supplement traditional high school learning (CG-TFR Education).*
Education	**Attendance interventions for chronically absent students** Support interventions that provide chronically absent students with resources to improve self-esteem, social skills, etc. and address familial and school-related factors that can contribute to poor attendance	*Attendance interventions for chronically absent students provide support and resources to address individual factors that contribute to absences such as low self-esteem, school anxiety, social skills, or medical conditions; familial factors such as discipline, parental support, or poverty; and school factors such as attendance policies, teacher/student relationships, and bullying. Such programs can be implemented by schools, community organizations, courts, police agencies, or multi-sector collaborations (Campbell-Maynard 2012). In 2013-2014, 1 in 8 students were chronically absent, missing three weeks or more of school via excused or unexcused absences (US ED-Chronic absenteeism).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Career & technical education for high school graduation** Provide career and technical education (CTE) as an integrated part of an academic curriculum for students at risk of dropping out of high school; also called vocational training	*Career and technical education (CTE) or vocational training programs teach high school students, especially those at risk of dropping out, job skills needed for specific occupations as they complete their academic coursework. CTE programs often include internships or job shadowing outside of school settings. Some programs also include support services such as childcare, transportation, or job placement assistance, along with remedial coursework and life skills training (CG-TFR Education). CTE programs can prepare students for careers in fields such as information technology, health services, hospitality and tourism, communications, advanced manufacturing, or science, technology, engineering and mathematics (STEM). Many of these careers require additional education such as professional certification or associate degrees at 2- or 4-year colleges (Dougherty 2016, ACTE-CTE).*
Education	**Career Academies** Establish small learning communities in high schools focused on fields such as health care, finance, technology, communications, or public service	*Career Academies are small learning communities within high schools that focus on specific vocational fields such as health care, finance, technology, communications, or public service. Career Academies organize academic, college preparatory, and technical education around a career theme, apply academic skills to real world problems, and offer exploratory field trips and work experience through partnerships with local employers (CCASN).*
Education	**Chicago Child-Parent Centers** Provide preschool education and comprehensive support to low income families, including small classes, student meals, and home visits with referrals for social service support as needed	*Chicago Child-Parent Centers (CPC) provide preschool education and comprehensive family support to children from low income families. Classes are small, allowing teachers to use a child-centered, individualized approach. Children also receive free breakfast and lunch daily, and vision and hearing screening upon enrollment. Parents are required to participate at least half a day per week. Staff conduct home visits and refer families to social service agencies as needed. CPC uses Title I funds and operates through the Chicago Public School system (CPS-CPC, PPN). The program started in 1967 at four sites. As of 2016, CPC programs operate in 24 centers; 13 of those centers offer the primary-grade program from 1st-3rd grade in addition to the preschool program (UMN-CPC).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**College access programs** Help underrepresented students prepare academically for college, complete applications, and enroll, especially first generation applicants and students from low income families	*College access programs help underrepresented students, often high or low performing, low income, and first generation high school students, prepare academically for higher education and complete the college entry process (IES WWC-Tierney 2009). Programs may include whole school reforms or supplementary student services, and may include counseling, social enrichment, academic enrichment, mentoring, parental involvement, or scholarships. Programs that support college access can be funded by federal, state, local, and non-profit funds (US ED-Harvill 2012).*
Education	**Dropout prevention programs** Provide supports such as mentoring, counseling, or vocational training, or undertake school environment changes to help students complete high school	*Dropout prevention programs provide at-risk students with specific supports such as mentoring, counseling, vocational or social-emotional skills training, college preparation, supplemental academic services, or case management. Such programs are frequently multi-service interventions and may include attendance monitoring, sometimes with financial rewards or sanctions. Dropout prevention programs can undertake comprehensive changes to high school environments such as restructuring schools into smaller learning communities, or offering alternative schools. Such programs can be delivered in school or community settings and can focus on individual at-risk students or on entire schools with low graduation rates (CG-TFR Education, IES WWC-Dynarski 2008). As of 2014, 9% of 25- to 29-year-old Americans did not graduate from high school (US Census-Education 2014).*
Education	**Dropout prevention programs for teen mothers** Provide teen mothers with services such as remedial education, vocational training, case management, health care, child care, and transportation assistance to support high school completion	*Dropout prevention programs for teenage mothers typically offer multiple services such as remedial education, vocational training, case management, health care, transportation assistance, and child care. Some dropout prevention programs focus on attendance monitoring interventions, which can include contingencies or financial incentives for mothers to attend school, for example, making welfare receipt contingent on school attendance. Dropout prevention programs for teenage mothers are usually comprehensive and intense and last about a year. Such programs are also usually conducted in multiple community settings rather than exclusively at school (Campbell-Wilson 2011). In 2014, there were 24.2 births for every 1000 women between the ages of 15 and 19. Nationwide, half of all teenage mothers do not graduate from high school (CDC-Teen Pregnancy).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Early Head Start (EHS)** Provide child care, parent education, physical health and mental health services, and other family supports to pregnant women and parents with low incomes and children aged 0 to 3	*Early Head Start (EHS) is a federally funded program for low income pregnant women, parents, and children aged 0 to 3. The program's comprehensive approach includes child care, parent education, health and mental health services, and family support. EHS programs can be home-based, center-based, or offer a mix of home and center services (ECLKC-EHS).*
Education	**Families and Schools Together** Convene small groups of families for facilitated weekly meetings that include a family meal, structured activities, parent support time, and parent-child play therapy	*Families and Schools Together (FAST) is a group-based family intervention program for at-risk children. Groups of 9-12 families gather for 8 facilitated 2.5 hour weekly meetings that include a family meal, structured activities, parent support time, and parent-child play therapy. Meetings are facilitated by a trained team of 4 to 8 people, including parents, teachers, school representatives, and community-based workers such as social workers or counselors. FAST teams are representative of the ethnic or cultural background of participating families. Families then run monthly follow-up meetings for 2 years (YG-FAST). The FAST model has been expanded to include Baby FAST, Pre-K FAST, Kids FAST, Middle School FAST, and Teen FAST (FAST).*
Education	**Full-day kindergarten** Offer kindergarten programs for 4 to 6-year-old children, five days per week for at least five hours per day	*Schools that offer kindergarten educate children aged 4 to 6 through a formal program conducted in the year prior to first grade. Full-day kindergarten programs run 5 days per week and last at least 5 hours per day (CG-TFR Education). In 28 states, full-day kindergarten days have the same duration as first grade days (ECS-Parker 2016a).*
Education	**Health career recruitment for minority students** Recruit and train minority students for careers in health fields via information about health careers, classes, practicum experiences, advising about college or medical school admissions, etc.	*Programs to recruit and train racial and ethnic minority students for careers in health fields generally include academic support and professional experiences for high school, college, or post-baccalaureate students, and may also offer financial support (US DHHS-Diversity programs 2009). Programs serve American students or foreign nationals who worked as health professionals before immigrating to the United States (Fernandez-Pena 2011). Programs can include information about health careers, classes, practicum experiences, advising about college or medical school admissions (Winkleby 2007), educational case management, or health-focused English as a second language (ESL) training (Fernandez-Pena 2011). Minorities comprise more than a quarter of Americans, but only 10% of health professionals (Noonan 2013).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Incredible Years** Support young children who exhibit or are at risk for behavioral problems with interpersonal relationship training and parents and teachers who are trained to meet their needs	*Incredible Years offers parent, teacher, and child training, teaching parents how to parent more effectively and warmly, teachers how to manage classrooms more effectively, and children how to better manage their interpersonal relationships. The program focuses on children up to 12 years old that exhibit or are at risk for behavioral problems (Blueprints).*
Education	**Knowledge is Power Program (KIPP) in middle schools** Emphasize high expectations for all students, parent and student commitment, empowered principals, and regular student assessments that inform continuous improvement in a lengthened school-year and school-day	*The Knowledge is Power Program (KIPP) is a nonprofit network of public charter schools that emphasize high expectations for all students, parent and student commitment, empowered principals with flexibility in budgeting and personnel, and regular student assessments that inform continuous improvement. KIPP schools require approximately 9 hours per day, 192 days per year, including one Saturday per school month; traditional public schools (TPS) require an average of 6.6 hours per day and 180 days per school year (Mathematica-Tuttle 2013). KIPP schools serve primarily low income students. Larger proportions of KIPP students are black, Latino, or low income than students in nearby TPS and smaller proportions of KIPP students have limited English proficiency or special needs (Mathematica-Tuttle 2013, Miron 2011). When enrollment requests exceed school capacity, student admission is based on a lottery system. KIPP started as a middle school program and began expanding into elementary and high schools in 2004 (Mathematica-Tuttle 2015).*
Education	**Mentoring programs for high school graduation** Establish programs that connect at-risk students with trained adult volunteers who provide ongoing guidance for academic and personal challenges	*Mentoring programs pair adult mentors with at-risk students to provide guidance through academic and personal challenges (Campbell-Wilson 2011). Trained mentors meet regularly with students, establishing a personal relationship and helping the student overcome obstacles in and out of school. Mentors also model positive behavior and decision-making skills (IES WWC-Dynarski 2008).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
	No Excuses charter school model Focus heavily on reading and math achievement, enforce high behavioral expectations through a formal discipline system, lengthen instructional time, and increase feedback on teacher performance	*No Excuses charter schools focus heavily on reading and math achievement, enforce high behavioral expectations through a formal discipline system, and substantially increase instruction time relative to traditional public schools (TPS) (Angrist 2013, Dobbie 2013). Teachers receive more feedback about their teaching than peers in other schools and regularly use data from student assessments to modify instruction; school days and school years are often longer than those in TPS (Dobbie 2013). No Excuses schools often offer intense tutoring, especially for students with remedial needs (Dobbie 2013, Fryer 2014). As with other charter schools, No Excuses schools use public finances and are not subject to many of the regulations that govern TPS such as staffing, curriculum, and budgeting requirements (Mathematica-Clark 2011).*
Education	**Preschool education programs** Provide center-based programs that support cognitive and social-emotional growth among children who are not old enough to enter formal schooling	*Preschool education programs are center-based interventions that foster children's cognitive and social-emotional development. Programs usually focus on children who are at least three years old but not yet old enough to enter formal schooling (Burger 2010). Children from low income families are less likely to be enrolled in preschool than children from higher income families. African-American children and children from low income families are also the most likely to attend low quality preschool programs (US ED-Preschool 2015).*
Education	**Preschool programs with family support services** Provide center-based programs that support cognitive and social-emotional growth among young children from low income families, with supports such as home visiting or parental skills training	*Preschool programs with family support services are center-based programs that support the cognitive and social development of low income children prior to kindergarten. These intensive programs usually include a combination of high quality preschool, parental education, and additional services such as home visiting, health, and family services. Examples of such programs include: Chicago Child-Parent Centers, HighScope Perry Preschool, and the Carolina Abecedarian Project.*
Education	**Reach Out and Read** Partner with doctors, nurse practitioners, and other medical professionals to incorporate literacy support into regular well-child visits, especially in lower income communities	*The Reach Out and Read program partners with doctors, nurse practitioners, and other medical professionals to incorporate literacy support into regular well-child visits. From the 6-month checkup through age five, medical providers give children developmentally appropriate books and give parents guidance and encouragement on reading with their children. The program focuses on children in low income communities (ROR).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**School breakfast programs** Support programs to provide students with a nutritious breakfast in the cafeteria, from grab and go carts in hallways, or in classrooms	*School breakfast programs offer students a nutritious breakfast, often incorporating a variety of healthy and culturally relevant choices. Breakfast can be served in the cafeteria before school starts, from grab and go carts in hallways, or in classrooms as the school day begins. Some schools offer breakfast during a morning break, called second chance breakfast or school brunch (NKH CBP-School breakfast). Schools that participate in the federal School Breakfast Program receive subsidies for each breakfast served. Students from families with incomes at or below 130 percent of the federal poverty level (FPL) are eligible for free breakfast and children from families with incomes between 130 and 185 percent FPL qualify for reduced-cost breakfast; schools are reimbursed at higher rates for free and reduced-cost breakfasts (FRAC-SBP). School participation in the federal program varies by state and region (Bartfeld 2010). Some participating schools offer free breakfast to all students, others only to qualifying students (FRAC-Woo 2015).*
Education	**School-based health centers** Provide health care services on school premises to attending elementary, middle, and high school students; services provided by teams of nurses, nurse practitioners, and physicians	*School-based health centers (SBHCs) provide elementary, middle, and high school students a variety of health care services on school premises or at offsite centers linked to schools. Teams of nurses, nurse practitioners, and physicians often provide primary and preventive care and mental health care; reproductive health services may be offered in middle and high schools, as allowed by district policy and state law. Providers at SBHCs often manage chronic illnesses such as asthma, mental health conditions, and obesity. Most patients treated at SBHCs are children insured by Medicaid or children without insurance (CG-SBHC, Keeton 2012). SBHCs are most common in urban areas and may be funded at the federal, state, or local level (SBHA-SBHC).*
Education	**School-based social and emotional instruction** Implement focused efforts to help children recognize and manage emotions, set and reach goals, appreciate others' perspectives, and maintain relationships; also called social and emotional learning (SEL)	*School-based social and emotional instruction focuses on five core competency areas: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (Corcoran 2017). Such instruction typically includes efforts to develop skills such as recognizing and managing emotions, setting and reaching goals, appreciating others' perspectives, establishing and maintaining relationships, and handling interpersonal situations constructively. Skills may be modeled, practiced, and then applied throughout the school day (Durlak 2011). Social and emotional learning (SEL) can also be called emotional literacy, emotional intelligence, mental health, resilience, life skills, or character education (Weare 2011).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**School-based violence & bullying prevention programs** Address students' disruptive and antisocial behavior by teaching self-awareness, emotional self-control, self-esteem, social problem solving, conflict resolution, team work, social skills, etc.	*School-based violence prevention programs address disruptive and antisocial behavior by teaching self-awareness, emotional self-control, self-esteem, social skills, social problem solving, conflict resolution, or team work. Such programs address general violent behavior or specific violence such as dating or bullying violence (CG-Violence). School-based bullying programs may focus on bullies, victims, peers, teachers, or the entire school. Most programs seek to reduce both bullying and victimization (being bullied) (Campbell-Farrington 2009).*
Education	**School-wide Positive Behavioral Interventions and Supports (Tier 1)** Teach positively stated behavior expectations to all students, often reinforced with prizes or privileges and supported with coaching and data; SWPBIS is tier one of Positive Behavioral Interventions and Supports (PBIS)	*School-wide Positive Behavioral Interventions and Supports (SWPBIS) is the first tier of the three tier Positive Behavioral Interventions and Supports (PBIS) school-wide behavioral system. In schools using SWPBIS, staff teams establish three to five positively stated behavior expectations. These expectations are taught to all students and staff and reinforced through verbal praise and student rewards such as prizes or privileges. SWPBIS teams receive external coaching and support, and use school-level behavior data to monitor implementation and identify students who would benefit from further intervention; some schools then use more intensive PBIS interventions to support these students. Positive Behavioral Interventions and Supports is often considered an alternative to zero tolerance policies (Bradshaw 2013).*
Education	**Summer learning programs** Provide academic instruction to students during the summer, often along with enrichment activities such as art or outdoor activities	*Summer learning programs provide academic instruction to students during the summer, often along with enrichment activities such as art, music, theater, sports, or outdoor activities. Programs typically spend one to two hours for each academic subject covered, and operate four to eight hours per day, four or five days per week, for four to eight weeks. Programs can also facilitate home-based reading, often with teacher-selected books and encouragement. Programs can be offered by school districts, national providers, or local community organizations. Programs often serve low-performing students, but may also serve all students. On average, students who do not participate in summer learning programs lose about a month of academic gains during the summer (RAND-McCombs 2017, RAND-McCombs 2011).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Technology-enhanced classroom instruction** Incorporate technology into classroom instruction via computer-assisted instruction programs, computer-managed learning programs, use of interactive white boards, etc.	*Technology such as computers, mobile devices, internet access, and interactive white boards can be incorporated into instruction to help educators deliver learning materials and support learning in traditional classrooms (Cheung 2012). Computer-assisted instruction programs, for example, deliver instruction at each student's assessed level, supplementing teacher instruction but relying primarily on computer/student interaction. Computer-managed learning programs assess students, assign materials, score tests, and chart progress. Comprehensive models combine computer-assisted instruction with non-computer activities.*
Education	**Universal pre-kindergarten** Provide pre-kindergarten (pre-K) education to all 4-year-olds, regardless of family income	*Universal pre-kindergarten (pre-K) is offered through a state to all 4-year-olds regardless of family income (Gormley 2005). Universal pre-K typically includes strong state standards and enrolls a wider variety of students than targeted interventions like Head Start (Fitzpatrick 2008). Oklahoma's program, for example, offers voluntary, free, school-based pre-K to all 4-year-old students in participating school districts. The program limits class size to 20 students and sets child-teacher ratios at 10-to-1. Oklahoma's Pre-K teachers are required to hold a bachelor's degree as well as early childhood certification (NIEER-Barnett 2013).*
Education	**Bridge programs for hard-to-employ adults** Provide basic skills (e.g., reading, math, writing, English language, or soft skills) and industry-specific training with other supports; also called occupationally contextualized basic education programs	*Bridge programs for low-skilled, unemployed adults are basic education and training programs that teach fundamental skills (e.g., reading, math, writing, English language, or soft skills) with industry-specific training. Bridge programs can include hands-on courses closely tied to in-demand jobs and may provide additional supports for low income and at-risk students. Programs can be implemented on their own but are most often included as the first step in career pathways programs or as an early component of sector-based workforce initiatives aimed at increasing participants' skill levels enough to continue progressing in a career pathway (Couch 2018, Upjohn-King 2015). Programs are also called occupationally contextualized basic education programs.*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Child development accounts** Establish dedicated child development accounts (CDAs) to build assets over time with contributions from family, friends, and sometimes, supporting organizations; also called children's savings accounts (CSAs)	*Child development accounts (CDAs), also called children's development accounts or children's savings accounts (CSAs), are accounts designated for a specific child to build assets over time through contributions from governments, society, family, friends, or the child. Accounts are generally started with an initial contribution, or seed money, from a sponsoring organization such as a government agency, nonprofit, or philanthropic foundation. Sponsoring organizations may also provide ongoing savings incentives (e.g., matching contributions) for participants from low income families, along with age-appropriate financial education for the family and child. CDAs are often available through school-based initiatives, citywide public-private partnerships, or statewide efforts. Current statewide initiatives invest in state 529 college savings plans (PN-CSAs).*
Education	**DARE to be You** Provide education and training sessions with parent-child activities and family meals for youth, parents, and care providers	*DARE to be You (DTBY) is a multi-component program that provides educational workshops and training sessions for children, parents, and community members such as child-care providers, social service agency workers, and community volunteers working with at-risk families. DTBY programs are typically comprised of 10 to 12 weekly sessions incorporating parent-child activities, two hour workshops, family meals, and optional follow up support groups and booster workshops after program completion. DTBY offers a variety of programs for youth of all ages and their families, including the Preschool Families Program, Bridges Program for Families with Teachers, and Care to Wait (Families with Middle School Youth). DARE is an acronym for key program concepts: Decision-making, Assertiveness, Responsibility, and Esteem. DTBY is not affiliated with the D.A.R.E. (Drug Abuse Resistance Education) program (YG-DTBY).*

Financial Security & Mobility - Education
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Education	**Financial Literacy Programs** Financial literacy is essential to long-term financial well-being. Evidence shows that very young children can learn economic, and financial concepts and a growing consensus believe that financial education should be a requirement in K-12 education. Programs include Junior Achieve programs, Financial Fitness for Life, High School Financial Planning Program, Banking on Our Future, etc.	*Authors from the Frances McClelland Institute of Children, Youth, and Families reviewed over 300 documents and over 200 youth financial literacy programs with the goal of identifying effective delivery methods and evidence-based curricula and programs. See table here for results: https://www.bostonfed.org/-/media/Documents/events/conf/2015/leveraging-financial-education/Evidence-Based-Financial-Literacy-Poster-NCFR-2013.pdf*

Financial Security & Mobility – Employment
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Employment	**Adult vocational training** Support acquisition of job-specific skills through education, certification programs, or on-the-job training, often with personal development resources and other supports	*Vocational training for adults supports acquisition of job-specific skills through education and certification programs, also called career and technical education, or on-the-job training. Programs may include job search assistance, personal development resources, and other comprehensive support services (e.g., child care) during training. Some programs provide participants with financial compensation for the duration of their participation. Vocational training programs in the United States usually serve individuals with little job experience or education, individuals who are unemployed, or dislocated workers.*
Employment	**Flexible scheduling** Offer employees control over an aspect of their schedule through arrangements such as flex time, flex hours, compressed work weeks, or self-scheduled shift work	*Flexible scheduling allows employees to control some aspect of their schedule. This can include flex time, where workers set their own start and end times around a core schedule; flex hours, which allows banking of accumulated hours for future time off; compressed work weeks, such as working 10 hours per day for four days rather than five 8-hour shifts; and self-scheduling of shift work, sometimes used in nursing and manufacturing positions. Voluntary reductions in work weeks, such as temporary transitions to part-time or partial retirement for older workers, are also approaches to flexible scheduling (Golden 2018, Cochrane-Joyce 2010).*
Employment	**Paid family leave** Provide employees with paid time off for circumstances such as a recent birth or adoption, a parent or spouse with a serious medical condition, or a sick child	*Paid family leave (PFL) provides employees with paid time off for circumstances such as a recent birth or adoption, a parent or spouse with a serious medical condition, or a sick child. Some employers allow the use of other paid time off, such as sick leave, for these purposes rather than designating family leave; some employers also offer maternity and paternity leave. PFL may be provided by employers or via state-level programs. State programs vary in the amount of benefit and maximum length of leave provided, and whether leave is job protected (Urban-Isaacs 2017). PFL is distinct from the federal Family and Medical Leave Act (FMLA), which provides eligible employees with at least 12 work weeks of job-protected leave without pay (US DOL-FMLA).*

Financial Security & Mobility – Employment
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Employment	**Transitional jobs** Establish time-limited, subsidized, paid job opportunities to provide a bridge to unsubsidized employment	*Transitional jobs are time-limited, subsidized, paid jobs intended to provide a bridge to unsubsidized employment. These positions are generally available to hard–to-employ individuals, such as those with limited or no job history, Temporary Assistance for Needy Families (TANF) recipients, or individuals with criminal records. Transitional jobs can be in government, non-profit, or for profit organizations, and may be combined with training and services to help participants overcome barriers to employment and build work-related skills.*
Employment	**Bridge programs for hard-to-employ adults** Provide basic skills (e.g., reading, math, writing, English language, or soft skills) and industry-specific training with other supports; also called occupationally contextualized basic education programs	*Bridge programs for low-skilled, unemployed adults are basic education and training programs that teach fundamental skills (e.g., reading, math, writing, English language, or soft skills) with industry-specific training. Bridge programs can include hands-on courses closely tied to in-demand jobs and may provide additional supports for low income and at-risk students. Programs can be implemented on their own but are most often included as the first step in career pathways programs or as an early component of sector-based workforce initiatives aimed at increasing participants' skill levels enough to continue progressing in a career pathway (Couch 2018, Upjohn-King 2015). Programs are also called occupationally contextualized basic education programs.*
Employment	**Career pathways programs** Provide occupation-specific training for low-skilled individuals in high-growth industries, with education and supports, usually with stackable credentials and work experience opportunities	*Career pathways programs offer occupation-specific training to low-skilled individuals for higher-skilled positions in high growth industries such as health care, advanced manufacturing, or information technology (King 2016, MDRC-Hossain 2015, Mathematica-Gash 2010). Such programs combine academic and technical education with supportive services; many also incorporate work experience and bridge programs. Career pathways are designed to allow individuals to participate in sequenced training courses of increasingly advanced skills and credentials with multiple entry and exit points, allowing participants to enter the labor force with marketable skills and credentials and return to education later, with credits allowing them to move towards a degree (Upjohn-King 2015). For example, a health care career ladder program can train hospital food service workers to become Certified Nursing Assistants (CNAs), and CNAs to become Certified Medical Assistants (CMAs) or Licensed Practical Nurses (LPNs) (Mathematica-Gash 2010). Programs may offer training at the basic skills-level, entry-level, and/or offer upgrade training and education. Career pathways are often aimed at meeting regional workforce needs and may be components of sector-focused workforce initiatives (King 2016, Upjohn-King 2015).*

Financial Security & Mobility – Employment
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Employment	**Certificates of employability** Issue certificates of employability to individuals with criminal convictions who have met pre-specified standards of rehabilitation; also called certificates of relief, reentry, good conduct, rehabilitation, recovery, etc.	*Certificates of employability are issued by state courts to people with criminal convictions who have met certain standards to help employers and landlords make better-informed decisions about applicants with criminal records (Vera-Subramanian 2014). Courts and, sometimes, parole boards can tailor certificates based on an individual's history and circumstances, and may relieve or mitigate some or all consequences of criminal conviction, such as statute-imposed penalties which restrict occupational or business licensing and employment. Certificates may be issued after a set waiting period based on proof of behavior and employment history, or may be awarded during sentencing to support reentry. Several states' certificates create an enforceable presumption of rehabilitation, and some limit employers' liability in negligent hiring actions. Some certificates may be available only to individuals convicted of less serious offenses, though several jurisdictions award them to individuals convicted of felony-level offenses (CCRC-Love 2018). Names of certificates vary by state; examples include certificates of relief, certificates of reentry, certificates of good conduct, certificates of rehabilitation, certificates of qualification for employment, and certificates of recovery. Unlike a pardon or expungement, a certificate does not remove a conviction from a person's record or relieve a job applicant of the obligation to acknowledge the conviction if asked.*
Employment	**Youth apprenticeship initiatives** Provide participating high school students with professional opportunities that combine academic and on-the-job training or mentorship	*Youth apprenticeship programs provide high school students with professional opportunities that combine academic and on-the-job training and mentorship. Apprenticeships include classroom-based vocational education in a high school or technical college setting that is related to paid on-the-job work and connects participants to instructors who also act as mentors. Youth apprenticeships are offered in a variety of fields. Training requirements and applicable government or industry-recognized standards vary by field (Bulanda 2015, Abell-Lerman 2015). Most formalized apprenticeships in the United States serve adults who have graduated from high school, often through Registered Apprenticeship programs (Eichorst 2015).*

Financial Security & Mobility – Employment
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Employment/Business	**Microfinancing** Safe and affordable access to financial services is a chief force behind economic mobility, empowering people to save, borrow, and invest. Unfortunately, financial services are not readily available for a large swatch of the population, often women in the lowest income brackets. Microfinance, also called microcredit, is a type of banking service that is provided to unemployed or low-income individuals or groups who otherwise would have no other access to financial services. Ultimately, the goal of microfinance is to give impoverished people an opportunity to become self-sufficient.	*Study of 1500 recipients in Northern New Jersey:* https://philanthropynewsdigest.org/news/microfinance-provides-benefits-for-u.s.-recipients-study-finds According to the study, more than 94 percent of program participants reported that their current financial situation improved from the previous year, a 13 percentage-point increase compared to the control group of women who were not eligible to receive a Grameen loan. In addition, the program produced a twenty-two point increase in the attainment of a credit score at seven to twelve months after participants enrolled in the study and a six-point increase in the attainment of a prime credit score. More than 95 percent of Grameen America members reported owning a business within six months of joining the program, an increase of 11 percentage points over the control group.

Financial Security & Mobility - Income
Sample Evidence-Based Strategies and Outcome Indicators

Sample Strategies and Policies from the County Health Rankings and Roadmaps, What Works for Health
http://www.countyhealthrankings.org/what-works-for-health

Topic Area	Sample Strategies	Additional Information
Income	**Child Care subsidies** Provide financial assistance to working parents, or parents attending school, to pay for center-based or certified in-home child care	*Child care subsidy programs provide financial assistance to working parents or, in some cases, parents attending school, to cover the costs of certified in-home or center-based child care. Child care subsidies are usually available to low income families; eligibility criteria vary by state.*
Income	**Earned Income Tax Credit (EITC)** Expand refundable earned income tax credits for low to moderate income working individuals and families	*The Earned Income Tax Credit (EITC) is a refundable income tax credit for low to moderate income working individuals and families. EITCs are offered by the federal government and many state governments. Federal earned income limits vary based on family size. The value of the EITC changes yearly; for the 2017 tax year, an individual with no custodial children who earns less than $15,010 can receive up to $510, while a married couple with three or more children making less than $53,930 qualify to receive up to $6,318. States that offer EITCs have various eligibility rules; similar to the federal EITC, refund amounts vary by income (NCSL-EITC).*
Income	**Child tax credit expansion** Expand federal or state child tax credits by increasing credit amounts, making credits refundable, decreasing or eliminating the earnings threshold, or creating a fully refundable supplement	*Child tax credits (CTC) are offered to eligible families with children under 17 years of age. The federal CTC varies in amount based on income and number of children and is partially refundable if the credit is higher than the taxes owed; the refundable portion is called the additional child tax credit. In 2018, the federal CTC for children under 17 is $2,000 and up to $1,400 can be received as a refund. It is limited to 15% of income above $2,500, so families that earn less than $2,500 are not eligible. There is also a nonrefundable $500 CTC available for other qualifying dependents. In 2018, an estimated 29 million children from low income working families will not receive the full value of the CTC (TPC-Maag 2018). Some state governments also offer CTCs. Similar to the federal CTC, state eligibility and refund amounts vary by income and number of children (TCWF-State tax credits). The CTC could be expanded by increasing the credit amount, making the credit fully refundable, decreasing or eliminating the earnings threshold, or creating a fully refundable supplement for families with young children.*

Financial Security & Mobility - Income
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Income	**Refundable child and dependent care tax credit** Offer a refundable tax credit to working families with qualifying children or other dependents that receive care outside the home (e.g., a spouse with disabilities)	*The child and dependent care tax credit (CDCC) provides eligible working families with qualifying children or other dependents (e.g., a spouse with disabilities) that receive care outside the home with a tax credit intended to partially offset the cost of that care. The federal government and some state governments offer CDCCs. To receive the federal CDCC, parents report care expenses, up to $3,000 per qualifying dependent or $6,000 per family, and receive a tax credit of 20-35% of that amount, depending on income (Urban-Maag 2011). The federal credit is nonrefundable; some state CDCCs are partially or fully refundable. Federal and state credit amounts vary by income and number of dependents in care. Eligibility rules also vary by state (TCWF-State tax credits).*
Income	**Full child support pass-through and disregard** Adopt policies that allow custodial parents who receive Temporary Assistance for Needy Families (TANF) to collect all child support paid by the non-custodial parent; no portion is retained by the state	*Families eligible for Temporary Assistance for Needy Families (TANF) are required to assign their rights to child support to the state in order to receive TANF benefits. States may retain child support payments collected on behalf of TANF families to offset the cost of welfare payments or may pass some or all collected funds to the custodial parent. States may also disregard some or all of a pass-through amount when determining TANF participants' benefits so that portion of the child support is not considered in benefit calculations. Full pass-through policies allow the custodial parent, usually the mother, to receive all child support paid; no portion is retained by the state.*
Income	**Child development accounts** Establish dedicated child development accounts (CDAs) to build assets over time with contributions from family, friends, and sometimes, supporting organizations; also called children's savings accounts (CSAs)	*Child development accounts (CDAs), also called children's development accounts or children's savings accounts (CSAs), are accounts designated for a specific child to build assets over time through contributions from governments, society, family, friends, or the child. Accounts are generally started with an initial contribution, or seed money, from a sponsoring organization such as a government agency, nonprofit, or philanthropic foundation. Sponsoring organizations may also provide ongoing savings incentives (e.g., matching contributions) for participants from low income families, along with age-appropriate financial education for the family and child. CDAs are often available through school-based initiatives, citywide public-private partnerships, or statewide efforts. Current statewide initiatives invest in state 529 college savings plans (PN-CSAs).*

Financial Security & Mobility - Income
Sample Evidence-Based Strategies and Outcome Indicators

Topic Area	Sample Strategies	Additional Information
Income	**Supplemental Security Income (SSI) benefits** Explore ways to increase Supplemental Security Income (SSI) program benefit amounts for aged, blind, or disabled individuals, including children, with little or no income	*The federal Supplemental Security Income (SSI) program provides monthly payments to people who are blind, disabled, or age 65 or older with limited income and resources who meet eligibility criteria; blind or disabled children may also qualify. Federal benefits can be supplemented with state contributions; benefits vary by state and by recipient. Federal benefit maximums change yearly. In 2018 federal monthly maximums were $750 for an individual and $1,125 for a couple (SSA-SSI), with average benefits of $662 for children, $577 for adults, and $447 for elderly beneficiaries (SSA-Snapshot 2018). SSI incentivizes work by disregarding $1 out of every $2 earned over $65 for benefit calculation. Personal assets help determine eligibility; individuals cannot have countable resources above $2,000, and couples are limited to $3,000. Child recipients are assessed at age 18 to determine eligibility under adult standards (SSA-SSI). In most states, individuals eligible for SSI are eligible for Medicaid, and in 32 states and Washington DC Medicaid is automatically conferred (SSA-Medicaid).*

Public Comments

Updated 7/18/19

Asian Community Development Corporation
亞美社區發展協會
BUILDING HOMES. EMPOWERING FAMILIES. STRENGTHENING COMMUNITIES.
同心建設實惠住房. 賦權家庭自主. 強壯社區.

July 2, 2019

RE: Beth Israel Deaconess Medical Center Community-Based Health Initiative

To Whom It May Concern:

I am writing on behalf of the Asian Community Development Corporation ("ACDC") to comment publicly on Beth Israel Deaconess Medical Center's Community-Based Health Initiative in connection with its new inpatient building project.

I serve as the Executive Director of ACDC, a 32-year-old nonprofit that creates affordable housing and provides housing and financial counseling in Boston's Chinatown. Through our work, we understand first-hand the housing crisis facing Asian immigrant families in Chinatown. We provide homes for 1,200 residents in Chinatown, and we have assisted over 2,000 households through first-time homebuyer education and financial literacy. Although over the years we have built close to 400 affordable homes in Chinatown, it simply has not been enough. Boston's Chinatown and the City of Boston are experiencing housing shortage that has not been seen before.

I was pleased to learn at the most recent BIDMC's Community Advisory Committee meeting that housing is one of the top priorities identified both through the series of community meetings and by the Committee. I do want to take this opportunity to share more about the particular housing challenges faced by our community, recognizing that although the housing crisis has left no Boston neighborhood untouched, its impact varies from one community to the next.

The majority of Asian households in Chinatown have limited English proficiency, and rely on both formal and informal social networks of neighborhood service providers, nonprofits, friends and relatives to access jobs, services, and translation assistance. When these immigrant families get displaced by rising rents and eviction, the luckier ones move to places like Quincy and Malden where there are growing Asian communities that can provide some support, although these two places have become more expensive to live as well. The unlucky ones have to move out to neighborhoods where this support is nonexistent, and not only is it very isolating, these families find it difficult to access jobs and services. This is why residents will put up with a lot of things to stay in Chinatown, such as several families and individuals sharing an apartment; paying more than half of their income toward rent; and living with substandard housing conditions. For families who live in affordable housing, they don't have to worry about skyrocketing rent or gratuitous eviction. They have stability to plan for the future, such as saving for homeownership, or sending their children to college, and getting more involved in their community. Unfortunately, the affordable housing waitlists are extremely long, and we regularly hear of families waiting for 10 years or more.

Because the median income in Chinatown is quite low ($21,773 in 2017), only a small portion of the population is ready for or can qualify for homeownership. Based on our extensive experience in providing first-time homebuyer education and counseling (we are the only organization in Massachusetts providing this HUD- and CHAPA-certified course in Mandarin and Cantonese) and our experience of two affordable homeownership projects in Chinatown, we believe that increasing

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affordable rental housing is more urgent and more accessible to Chinatown residents than affordable homeownership opportunity. We do not disagree that the community should have some affordable homeownership developments so that there is a diversity of residents, but the fact remains that homeownership – even affordable homeownership – is inaccessible to many in Chinatown, due to mortgage underwriting requirements.

Many Chinatowns across the U.S. are grappling with shrinking footprint and population due to gentrification, and Boston's Chinatown is no exception. Affordable housing is critical in ensuring that there will still be immigrant families living and working here in the future, that residents and workers who work in the restaurants and shops do not get pushed out, leaving Chinatown to become a Disney-fied tourist destination with few actual residents. We need more affordable housing, and housing that is actually affordable to the Chinatown residents. As pointed out earlier, the median income is quite low in Chinatown, so what is considered "affordable" or "workforce" housing is often out of reach for most Chinatown residents.

We look forward to continuing our participation in the dialogue with BIDMC and the Community Advisory Committee as this process unfolds.

Sincerely,

Angie Liou
Executive Director

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Nancy,

Thank you and Jamie for taking the time to meet with the folks here at CCBA last week and explaining BIDMC's process for the allocation of its $22.5m community benefits package, and thank you for providing us with the advisory committee list. We of course hope that BIDMC's advisory committee allocates Chinatown a sizable share of the fund for community programs and services in this area.

I know Jamie took detailed notes during our meeting, but I'd like to take this opportunity to reiterate and summarize some of the issues in the Chinatown community which we discussed (listed in no particular order):

1. Gambling Addiction. Casinos such as Mohegan Sun and Foxwoods already heavily target the Chinatown community (especially the elderly and low wage workers) through advertising and discounted bus fares, but with the recently opened Encore now just a short train ride away, I predict the gambling rates in Chinatown will increase significantly. Chinatown has historically had a gambling addiction problem which started out with illegal gambling dens decades ago, but those parlors have now been replaced with the casinos and the state lottery. Personally, I know of families which have broken up over gambling addiction. I refer you to a recently published article which discusses gambling addiction in the Asian community (https://www.wnpr.org/post/lure-luck-how-gambling-can-turn-addictive-southeast-asian-refugees).

2. Language Access. As an immigrant community with many members who speak limited English, language access remains a significant issue that affects all facets of life, from being able to get a decent job to being able to communicate with health care providers to being able to access healthcare (insurance). This issue likely needs to be addressed through a combination of ESL education, provision of more translators, bilingual forms, and more services to assist people in the community.

3. Smoking, Respiratory Health. Smoking and respiratory health is a major issue in the community. The Chinatown community has high rates of cigarette smoking, especially in the male population, and this affects the smokers themselves as well as those around them through second-hand smoke. With the legalization of recreational marijuana now, there is the added impact of marijuana smoking and second hand smoke. Then there's vaping as well. Chinatown also has air quality issues associated with its location next to the highway, local traffic congestion in the streets, and lack of trees. I spoke with Councilor Flynn over the weekend, and he told me that students who attend the Josiah Quincy Elementary School in Chinatown have some of the highest asthma rates in the city.

4. Affordable Housing. Chinatown is continually advocating for more affordable housing. One solution is to build more housing, but as feasible sites diminish, another solution is perhaps through job training and education to lift up people's economic situations.

5. Elder Care and Services.

6. Used drug needles being found throughout the community, including in public parks and school grounds.

7. Finally, there are a number of health conditions that the Chinese community seems to be more susceptible to, such as hypertension and strokes, diabetes, and cancer.

Thanks again for meeting with us and for your attention to this matter. Please do add me to your email distribution list for BIDMC's Community-based Health Initiative.

Best regards,

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Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

New Inpatient Building (NIB) Community Advisory Committee (CAC)
Meeting Minutes
Tuesday, July 23, 2019, 5:00 PM – 7:00 PM
BIDMC East Campus
Leventhal Conference Room, Shapiro Building

Present: Elizabeth (Liz) Browne (by telephone conference), Lauren Gabovitch, Richard Giordano, Jamie Goldfarb, Sarah Hamilton, Nancy Kasen, Barry Keppard, Patricia (Tish) McMullin, Holly Oh, MD, Joanne Pokaski, Jane Powers, Luis Prado, Edna Rivera-Carrasco, Richard Rouse, Jerry Rubin, LaShonda Walker-Robinson, and Fred Wang

Absent: Tina Chery, Phillomin Laptiste, Theresa Lee, Alex Oliver-Davila

Guests: Alec McKinney, John Snow Inc. (JSI), Senior Project Director; Madison MacLean, JSI, Facilitator

Public: Several community members attended.

Welcome

Nancy Kasen, Director of Community Benefits, Beth Israel Deaconess Medical Center (BIDMC), welcomed everyone to the meeting and asked for a volunteer to share why they are involved in the Community Advisory Committee (Advisory Committee).

Richard Giordano, Director of Policy and Community Planning, Fenway Community Development Corporation, shared that he is passionate about improving housing in Boston. He recently heard Megan Sandel speak about Boston Medical Center's housing initiative. He hopes that BIDMC will follow suit.

Next, the minutes from the June 25th Advisory Committee meeting were reviewed and accepted.

Public Comment Period

Nancy entered into record two written public comments that were given to the Advisory Committee five business days prior to the meeting. Comments were received from Susan Chu, Executive Director, Chinese Consolidated Benevolent Association of New England (CCBA) and Angie Liou, Executive Director, Asian Community Development Corporation.

Nancy then introduced the oral public comment period. She reminded everyone that the Advisory Committee allotted a total of fifteen minutes per meeting (maximum of three minutes per individual) for individuals from the community to share their thoughts with the

Advisory Committee. Individuals sign up to speak at the meeting. Slots were allocated on a first come, first served basis. Nancy shared that if time runs out before the individual finishes, or there are no more spots available for oral comments, the Advisory Committee welcomes written public comments. All written comments will be shared with the Advisory Committee prior to the next meeting if received at least five business days before the next Advisory Committee meeting.

Dr. Kahris White-McLaughlin, a lifelong resident of Roxbury, shared comments with the Advisory Committee. She was present at the Roxbury/Mission Hill community meeting and the June 25th Advisory Committee meeting and felt as though education should be prioritized by the Advisory Committee. Dr. White-McLaughlin explained that access to education gave her an opportunity to develop professionally and led her to serve as President of the Metropolitan Council for Educational Opportunity, Inc. (METCO) Board. She explained that education is the least expensive way to help residents. Dr. White-McLaughlin mentioned a Boston Globe article that shared stories of 15 racially and ethnically diverse valedictorians from Boston Public High Schools. The story highlighted that graduates did not feel ready for life after high school. She explained that the Boston Public School system needs to create a new process for educating students. She believes there are many ways BIDMC can help improve education in Boston.

Radiology

Alec introduced Kelly Hart, a member of BIDMC's Radiology team, who was presenting on a new Computed Tomography (CT) scanner for BIDMC's West Campus. There are three CT scanners on BIDMC's West Campus; one for emergency visits, one for inpatient and outpatient use, and one for procedures. Currently, all three CT scanners are at capacity, creating multiple challenges. This leads to long wait time for patients; on average procedures for cancer diagnoses are scheduled up to 10 days in advance, with cancer treatments scheduled up to 6 weeks in advance. Outpatient visits are diverted to other campuses, requiring sick patients to travel between doctors' offices and the CT scanner. Additionally, if a scanner goes down it can take a few hours or a few days to be repaired, causing services to be delay/canceled. Adding a new scanner will reduce wait time for inpatients and create more availability for outpatients, leading to faster diagnoses and treatments. Additionally, if there are equipment issues, services would not have to be suspended. One committee member asked what happens if the new machine has equipment issues. Kelly explained that if this happens, there would be fewer delays since there would be three other machines.

Kelly and her colleague Dr. Bettina Siewert asked if there were any questions. One committee member asked if other hospitals were having this problem. Kelly and Dr. Siewert said that other local hospitals are having this problem, and have invested in new CT machines. One member asked how much a CT scanner cost. Kelly explained that it cost approximately $2.2 million, but the money for the new machines has already been allocated. Nancy explained that the new CT scanner would result in BIDMC having to complete a new Determination of Need (DoN) and the required 5% of the Total Capital Expenditure (TCE) would ideally be combined with the current Community-based Health Initiative funding for the New Inpatient Building.

Alec thanked Kelly and Dr. Siewert for sharing information on the new CT scanner.

NIB CHI Priorities and Sub-Priorities

Alec explained to the Advisory Committee that during this meeting, they would work to reach consensus on the health priorities and narrow the sub-priorities down to two or three per priority area. Alec reminded the Advisory Committee that at the June 25th meeting there was a preliminary vote to accept housing, jobs and financial security, and behavioral health (mental health and substance use) as priorities, with a fourth topic pending discussion at the July 23rd meeting.

Alec summarized that at the last meeting, the Advisory Committee wanted to find a way to incorporate access to care, other social determinants of health, and violence prevention into the priority areas. Alec and Nancy proposed a category called healthy neighborhoods. They explained that this is a suggestion, and there should be a discussion among the Advisory Committee. This priority would allow for the seven communities (Allston/Brighton, Bowdoin/Geneva, Chelsea, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury) to have their own community-driven/led prioritization process. The Advisory Committee would set parameters and criteria on how the funds could be used. Questions came up regarding the subtopics proposed for healthy neighborhoods. Nancy explained that since needs were different based on the demographics and geography, the subtopics represented the potential areas that could be prioritized by the individual neighborhoods based on the needs identified through the Boston CHNA/CHIP Collaborative's work and BIDMC's community meetings. Many Advisory Committee members felt this category encompassed what was discussed at the June 25th meeting. A few concerns were raised regarding this priority including that it could be difficult to achieve; if the investment is not substantial enough, it would not make significant positive change in addressing the identified needs, potentially, creating more harm than good. Additionally, the Advisory Committee thought that this method could be reinventing the wheel and would take time to get it started. Another Advisory Committee member felt that healthy neighborhoods was the most important priority area from a Public Health perspective, adding that this priority moves beyond organizations and creates social cohesion among the community. A motion was made to accept housing, jobs and financial security, behavioral health (mental health and substance use) and healthy neighborhoods as priorities. The motion was seconded. Of the eleven voting members present, ten voting members voted in favor of the priorities passing, and one voting member abstained. The motion passed.

The Advisory Committee then moved into narrowing down the sub-priorities for each priority area. Alec informed the committee that the recommended sub-priorities and strategies are not an exhaustive list, and were based on the Advisory Committee's requests to provide and synthesize evidence-based strategies found through a literature review. Many of the sub-priorities and strategies were identified and/or included in the Boston CHNA/CHIP Collaborative prioritization and planning processes. He reminded the Advisory Committee that the evidence-based strategies were sent out in the Advisory Committee meeting packet one week prior to the meeting. Nancy reminded the committee that all strategies selected for CHI funds will need to be evidence-based or evidence-informed.

Housing

Four housing sub-priorities were recommended to the Advisory Committee; affordability, homelessness, home ownership, and gentrification/displacement

The Advisory Committee did not feel they had the capacity to create change in housing gentrification and displacement; rather this change is rooted in government policy. One member recommended removing this topic. The Advisory Committee was in agreement and removed gentrification and displacement as a sub-priority for housing.

One Advisory Committee member mentioned that many of the evidence-based strategies given to the committee prior to the meeting were mainly focused on housing individuals with substance use disorders. Though important, this individual emphasized there needs to be discussion and strategies related to affordable housing for all individuals. There was discussion around the overlapping nature of the three sub-priorities; affordability, homelessness, and home ownership. The Advisory Committee questioned what impact for these sub-priorities would look like and how much of an investment would need to made to have an impact.

After discussion among the Advisory Committee, polling technology was used to see if there was a consensus on the selection of sub-priorities. Preliminary polling results showed that affordability was the top priority, with homelessness and home ownership ranked second to affordability, and equally important to one another. After further discussion, it was recommended to fold home ownership and homelessness into affordability, making "affordability, with home ownership, and homelessness as subtopics" the sub-priorities. A motion was made to accept "affordability, with home ownership, and homelessness as subtopics" the sub-priorities. The motion was seconded and all members were in favor. The motion passed.

Jobs and Financial Security

Three jobs and financial security sub-priorities were recommended to the Advisory Committee; education/workforce training, employment opportunities, and income/financial supports.

One member recommended changing the term workforce training to workforce development because it encompasses a broader range of workforce opportunities. The Advisory Committee agreed with this change. A few members asked about the difference between employment opportunities and bridge programs, a potential strategy under education and workforce development. An Advisory Committee member who works in career development explained that employment opportunities are about creating jobs and subsidizing jobs for those who may have difficulty finding them. Bridge programs help individuals with low skills grow into higher level positions. The Advisory Committee then began discussing income/financial supports. Some members were uncertain if the potential strategies were relevant to the work they want to accomplish and that some tactics such as micro-finance programs were a risky investment.

After discussion among the Advisory Committee, polling technology was used to see if there was a consensus on high versus low sub-priorities. Preliminary polling results showed that education/workforce development was the top priority, with employment opportunities and income/financial support ranked second to education and workforce development and equally important to one another. A motion was made to accept all three priority areas; education/workforce development, employment opportunities, and income/financial support. The motion was seconded. Ten voting Advisory Committee members were in favor of the sub-priorities passing, and one voting member abstained. The motion passed.

Behavioral Health

Three behavioral health sub-priorities were recommended to the Advisory Committee; mental health, substance use, and access to services.

The Advisory Committee members requested clarification on the definition of access to services. Alec explained that access to services, as recommended, is improving the availability of services and increasing the amount of providers in the workforce. Multiple members suggested that access to care can be a strategy under both mental health and substance use.

After discussion, a motion was made to accept mental health and substance use as sub-priorities with the caveat that potential strategies must include increasing access to services, including increasing workforce. The motion was seconded, and all voting members were in favor. The motion passed.

Healthy Neighborhoods

Alec discussed that healthy neighborhoods encompassed health priorities that varied based on neighborhood needs. Examples include topics such as access to care, social determinants of health, and violence.

Rather than determine sub-priorities, the Advisory Committee is tasked with creating a set of criteria that the community must meet to determine priorities and allocation. Alec and Nancy will draft an outline of criteria, and present it to the Advisory Committee for discussion at the next Advisory Committee meeting.

Allocation

Alec introduced the conversation for allocation of the priorities and sub-priorities. He explained that this will be voted on at the next Advisory Committee meeting. Given the Advisory Committee's request at the April 9th meeting to be given proposals to which they can react, Nancy and Alec provided a straw-model for the potential allocation discussion. The straw-model included 35% jobs and financial security, 15% housing, 20% behavioral health, and 30% healthy neighborhoods. Both Nancy and Alec emphasized that this was just a starting point for discussion. She explained that jobs and financial security and behavioral health both influence housing opportunities, which is why these priorities have a larger distribution of funds compared to housing. Likewise, she explained the significant desire and requirement for achieving impact and the belief that employment and financial stability/security and building wealth are key opportunities for impact.

A few members felt that more money should be allocated for housing. One recommendation was to give 60% of funds to housing, 20% to healthy neighborhoods, 10% to jobs and financial security, and 10% to behavioral health. There was also discussion about raising housing from 15% but less than 60%. Other members advocated for allocating more money to jobs and financial security because without a stable income, even if there is subsidized housing, people would not be able to afford it. Another recommendation was to have an even split of 25% per priority area.

Prior to the meeting ending, Alec reminded everyone that they will be voting on the allocation plan at the next Advisory Committee meeting.

Adjourn

Alec thanked the public for joining and for sharing their thoughts with the Advisory Committee. He stated that after the meeting, the Community Benefits team will resend the data collected by the Collaborative. Alec thanked the committee for their dedication and he reminded everyone that the next Advisory Committee meeting will be held on September 24th.

Advisory Committee Members	2019				
	April 9th	May 21st	June 25th	July 23rd	September 24th
Elizabeth Browne	X	X	Ph	Ph	
Tina Chery	X	A	A	A	
Richard Giordano	X	X	X	X	
Sarah Hamilton	X	X	X	X	
Barry Keppard	X	X	A	X	
Phillomin Laptiste	X	X	X	A	
Theresa Lee	X	A	X	A	
Holly Oh	X	X	A	X	
Alex Oliver-Davila	Ph	X	A	A	
Luis Prado	A	X	A	X	
Jane Powers	A	X	X	X	
Edna Rivera-Carrasco	X	X	X	X	
Richard Rouse	X	X	X	X	
Jerry Rubin	X	A	A	X	
Fred Wang	X	X	X	X	
BIDMC Staff - Ex Officio					
Lauren Gabovitch	X	A	A	X	
Nancy Kasen	X	X	X	X	
Tish McMullin	A	X	X	X	
Joanne Pokaski	X	A	A	X	
LaShonda Walker-Robinson	X	X	Ph	X	

Key	
X	Participated
A	Absent
Ph	Participated by Phone