LEAVITT PARTNERS | BRIGHT SPOT INITIATIVE | NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Centering Health Equity and Collective Impact in the Bright Spot Initiative

In the context of type 2 diabetes prevention, state health departments in the Bright Spot Initiative (BSI) applied the principles of collective impact and health equity toward increasing enrollment into the National Diabetes Prevention Program (National DPP) lifestyle change program. They built health equity into their collective impact approach by implementing the following five strategies throughout their and their partners' activities in ways that aligned with the needs and populations in their state, as described below:

Ground the work in data and context, and target solutions.
Used data to identify underserved communities and help states create tailored geographic approaches.

Focus on systems change, in addition to programs and services.
Established and leveraged existing partnerships with organizations that mirror the populations they serve to create opportunities for increasing awareness among priority populations and recruiting new lifestyle coaches.

Shift power within the collaborative.
Actively incorporated community leaders or champions into decision-making roles to further health equity.

Listen to and act with the community.
Created and customized culturally relevant material that resonated with priority populations and made the National DPP lifestyle change program more accessible.

Build equity leadership and accountability.
Conducted health equity trainings to assist in creating a shared understanding of health equity and to actualize it throughout multiple aspects of the partner network approach.

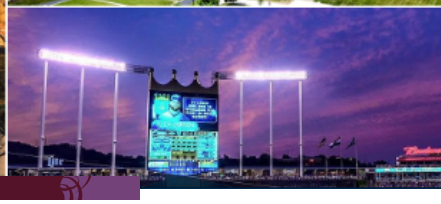
For more information on the Bright Spot Initiative, please visit the Partner Networks page on the Coverage Toolkit.

Collective Impact

Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. Equity can be achieved using collective impact through the partner network via shared learnings and integrated actions to achieve population and systems-level change.

Health equity is built into collective impact Partners leverage each other's expertise and reach to maximize their capacity and capabilities toward their common goal or vision. CDC defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Health equity implies that everyone has a fair opportunity to achieve their full health potential, and achieving health equity would mean the removal of "avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification."

Kansas



Promising Practices . . .

Five states participated in the two-year BSI program: Kansas, Michigan, Missouri, Utah, and Wisconsin. Each state's health department carried out several activities to pursue collective impact to center health equity throughout the BSI. Below are examples of some of those activities.

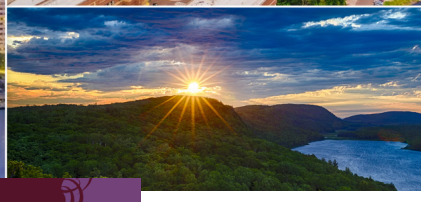
The Kansas Department of Health and Environment (KDHE) utilized a comprehensive data approach to inform which populations should be engaged across the state. KDHE mapped age-adjusted diabetes prevalence data from the Population Level Analysis and Community Estimates (PLACES) dataset and overlaid it with National DPP suppliers across in 105 counties in the state.

KDHE is incorporating results from a prediabetes question in their 2022 Behavioral Risk Factor Surveillance System (BRFSS) survey to stratify prevalence data by different variables. This multifaceted approach is being used to develop the Kansas Diabetes State Report, which will analyze race, ethnicity, gender, and other demographics against the prevalence of prediabetes, and diabetes. KDHE will present the report to a Kansas state legislature committee and other KDHE diabetes programs.

STRATEGY	OUTCOME
Ground the work in data and context, and target solutions.	KDHE leveraged the data and identified disparities in rates of prediabetes and diabetes among persons that were Hispanic and Latino, Black or African American, rural and frontier, and low-income populations across Kansas. As part of their BSI work, they chose to engage those populations.

Hiawatha, Kansas

Michigan



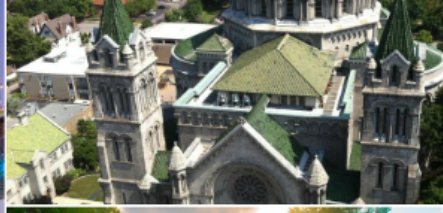
The Michigan Public Health Institute (MPHI) collaborates with the Michigan Department of Health and Human Services (DHHS) and the Southeast Michigan Hospital Collaborative (SEMIHC). Within this collaborative effort, four hospitals and a community based organization—Henry Ford Health, Corewell Health East, Trinity Health, Ascension Southeast Michigan Community Health, and the National Kidney Foundation of Michigan—engage with five community champions representing the Black or African American population at highest risk for developing type 2 diabetes. MPHI selected the community champions based on their experience with the National DPP lifestyle change program as lifestyle coaches.

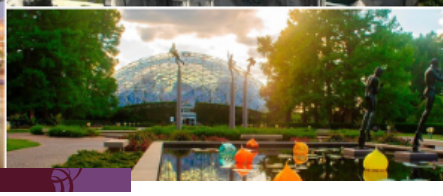
Through Advancing Justice Together Health Equity and Social Justice Training (ADJUST), MPHI works with community champions to build their capacity and strengthen their skills. Using a health equity lens, ADJUST incorporates real-life scenarios to illustrate how community champions may improve their interactions with National DPP lifestyle change program participants. The community champions are members of SEMIHC's National DPP lifestyle change program Community Champion Workgroup, and initiate health-related conversations in faith-based settings within the Black or African American community. The community champions receive a stipend for their commitment.

STRATEGY	OUTCOME
Build equity leadership and accountability	Four community champions participated in the ADJUST training to incorporate health equity into their work. After the training the participants gained knowledge and tools to implement social justice and health equity practices in their workplace.
Shift power within the collaborative **Listen to and act with the community**	The Community Champion Workgroup solicited surveys from community members where they identified several barriers to participation in the National DPP lifestyle change program and are working with SEMIHC to address those barriers. Barriers included the need for more in-person cohorts, the need for a variety of time options for the working population, a simpler enrollment process and a shorter program. Community champions worked to address some of those barriers by sharing classes with one another in hopes of providing cohorts that fit the need of the participant.

Detroit, Michigan

Missouri





Missouri Department of Health and Senior Services (DHSS) partnered with Operation Food Search, the second-largest food distribution center in St. Louis, to run the MetroMarket program in 2023. The program involved a traveling mobile grocery store that made daily stops at different National DPP supplier community locations in the St. Louis region. The scheduled stops allowed interested individuals to participate in National DPP lifestyle change program screening assessments in return for a $10 food voucher redeemable that same day on the MetroMarket bus.

The program was a success—results from the two-month program showed that screenings made onsite at supplier locations led to increased referrals compared to the previous two months. Due to the success, Missouri DHHS purchased several hundred food vouchers for the program to run again in May 2024. The state health department partnered with its Bureau of Community Health and Wellness to use CDC State Physical Activity and Nutrition (SPAN) funding to support more stops.

STRATEGY	OUTCOME
Focus on systems change, in addition to programs and services	The mobile grocery store food voucher incentive program, MetroMarket, increased prediabetes screenings and referrals to the National DPP lifestyle change program. 154 referrals were made (151% increase) in July 2023, compared to an average of 61 referrals over each of the previous three months.
	The mobile grocery store increased access to and affordability of nutritious foods around the St. Louis region.

St. Louis, Missouri

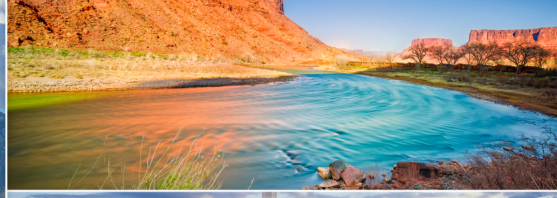
Wisconsin

The Wisconsin Department of Health Services (DHS) conducted county-wide population analyses for each of their nine National DPP supplier partners. The analyses included looking at prediabetes prevalence in addition to age, race, culture, and other sociodemographic characteristics. The state health department used this information to identify populations with the highest risk of prediabetes and type 2 diabetes specific to each supplier and the unique areas they operated. Wisconsin DHS, empowered their supplier partners to develop their programs and extended support with funding, strategic guidance, and technical assistance. The support helped National DPP supplier partners to effectively focus on building partnerships with community-based organizations that had established and trusted relationships with the populations of focus.

STRATEGY	OUTCOME
Focus on systems change, in addition to programs and services	Each of the nine National DPP supplier partners secured partnerships with organizations that are representative of their selected populations with prediabetes and high risk for type 2 diabetes.
Listen to and act with the community	One of Wisconsin's partners, Green Lake County DHHS, employs a lifestyle coach who has started four different National DPP lifestyle change program cohorts while maintaining 100% retention. With two months to go, they have enrolled 29 of their 44 participant goal for this year. However, only three were men of the goal of 14 male participants. Female participants are encouraged to bring their spouses with intent of having male participants feel more comfortable participating in the National DPP lifestyle change program cohort.

Burlington, Wisconsin

Utah



The Healthy Environments Active Living (HEAL) program at the Utah Department of Health and Human Services (DHHS) is a part of the Office of Health Promotion and Prevention (OHPP). In 2022, OHPP worked with the Public Health Alliance of Southern California to create the Utah Healthy Places Index (Utah HPI)—a powerful data and policy platform created to advance health equity through open and accessible data. The evidence-based and peer-reviewed tool helps support efforts across the state to prioritize equitable community investments and develop critical programs and policies. Utah HPI maps health indicators that are positively associated with life expectancy at birth like education and job opportunities. This data is pulled from multiple data sources, including but not limited to the Census (American Community Survey), Utah Behavioral Risk Factor Surveillance Survey (BRFSS), and CDC PLACES.

HEAL leveraged Utah HPI, in addition to a healthcare access survey, to understand how persons with prediabetes or at high risk for type 2 diabetes and community members with chronic conditions were accessing services. The tool and survey were important for the state health department in better understanding how to engage with their priority populations and work toward eliminating barriers to accessing services.

STRATEGY	OUTCOME
Ground the work in data and context, and target solutions.	HEAL identified Medicaid beneficiaries with prediabetes as their population of focus and partnered with Utah Medicaid to analyze data to identify individuals covered by Medicaid who were residing in the same ZIP code as a National DPP supplier location.

Blanding, Utah

Lessons Learned and Considerations for Future Partner Networks

Successful health equity activities begin with state health departments grounding their work in data.
States and their partners identified priority populations to engage with through data analyses. National- and state-level datasets are useful for understanding populations that may be experiencing prediabetes and diabetes at higher rates compared to other parts of the state.

Offering health equity trainings to community partners can bolster their ability to affect change.
Community health workers were able to participate in health equity training. State health departments are uniquely positioned to either plan, host, or work with a partner organization to facilitate trainings that advance health equity.

State health departments shifted power within the collaborative.
Developing a robust partner network with a commitment to collaboration allows for partners to excel in many areas, magnifying the impact of National DPP lifestyle change program promotion and enrollment efforts. State health departments do not need to master every area of diabetes prevention. Instead, they can develop partner networks that include partners with different strengths. States strategically shift the power to community-based organizations and local health departments who are subject matter experts in their communities resulting in larger outcomes and impact.

Partnerships can be leveraged to address social determinants of health barriers for potential participants. State health departments worked with partner organizations through the BSI and identified and addressed barriers to participating in the National DPP lifestyle change program. Leveraging partnerships with organizations that can offer transportation, improve access to affordable nutritious foods, or offer support for program participation can help increase enrollment.

Centering health equity and collective impact should be strategically embedded into every activity.
State health departments used a collective impact approach to advancing diabetes prevention and integrating health equity. Incorporating health equity into project activities early in the planning process fosters the ability to measure early wins and track the impact that BSI is having on the engaged communities.