INTEGRATION
More than just a buzzword...

Colorado Department of Public Health and Environment
Why integrate?

- Integration extends the reach of individual programs to address multiple issues across prevention continuum
- Reduces confusion and duplication—combines
- Maximizes limited resources
- Reduce the need for communities to “decide” which type of violence is most severe and in need of action
- Presents a more unified image of public health
Bold Steps Toward Child and Adolescent Health:
A Plan for Youth Violence Prevention in Colorado
THE SHARED RISK AND PROTECTIVE FACTORS

RISK FACTORS
- Substance use
- Early and persistent antisocial behavior
- View of problem behavior disapprovingly
- Positive social orientation
- History of treatment for emotional or mental problems
- Perceived sanctions for wrongdoing
- Previous involvement with violence
- Poor general health

PROTECTIVE FACTORS
- Self-identified religiosity
- Having delinquent peers
- Family who participate in socially acceptable activities
- Family connectedness and attachment
- Having friends who participate in socially acceptable activities
- Sharing in regular activities with parents
- High educational expectations from parents or guardians
- Family conflict and/or lack of parental control
- Gang involvement

INDIVIDUAL

RISK FACTORS
- Availability of alcohol, tobacco, and other drugs
- Availability of firearms
- Academic failure beginning in late elementary school
- Community disorganization
- Community norms and expectations
- Commitment and/or bonding to school
- Trust

PROTECTIVE FACTORS
- Bonding with caring adults
- High academic achievement
- Available resources and opportunities
- Healthy community norms and expectations

COMMUNITY

RISK FACTORS
- Poverty

PROTECTIVE FACTORS
- Respect for diversity and an emphasis on equality
- Adequate and affordable health care
- Access to health care services
- Health disparities

SOCIETY

RISK FACTORS

PROTECTIVE FACTORS

RELATIONSHIP

The bold steps outlined in this strategic plan are intended to highlight strategies that address these shared factors.
EMPOWER and RPE: Underlying Principles

- Anti-Oppression Framework
- Focus on communities with the fewest protective factors
  - Urban Communities of Color
  - Native American Communities
  - LGBTQ Communities
  - Youth
- Focus on culturally relevant primary prevention programs
- Community-based State Prevention Team, members from priority populations
- Risk and protective factors across the social ecology
- Empowerment Evaluation Approach
Teen Dating Violence

- Grounded in EMPOWER and RPE work
- Community-based
- Empowerment evaluation approach
- Integration with State Prevention Team
- Integration of Prevention System Capacity work
Integration with Other Injury and Violence Prevention Programs

- Unintentional Injury Prevention
  - Teen Motor Vehicle
  - Injury Prevention Strategic Plan

- Injury, Suicide and Violence Prevention Unit Projects
  - Integrated Curriculum
  - Share risk and protective factor grantees
  - Injury, Suicide and Violence Prevention Conference
  - Literature review about the connection between ISVP and Chronic Disease
# Cooperation Coordination Integration

## Definition
- Exchanging information, altering activities and sharing resources for mutual benefit.
- Exchanging information, altering activities and engaging in intentional efforts to enhance each other’s capacity for the mutual benefit of programs.
- Using commonalities to create a unified center of knowledge and programming that supports work in related content areas.

## Key Points

### Cooperation
- **Episodic**
- Does’t require shared mission, culture or processes.
- Not formalized

### Coordination
- **Long-term**
- Staff from different programs work together
- Joint commitment of resources
- Shared planning and responsibility for activities

### Integration
- Structurally sustained
- Shared mission and vision
- Composed of interdependent systems

## Programmatic Example:
**Providing Funding to Local Communities**
- Informs other programs of RFA release Increasing levels of trust, time, risk and dependence.
- Decreasing levels of trust, time, risk and dependence.
- Separate granting programs utilizing shared administrative processes and forms for application review and selection.
- Developing and utilizing shared priorities for funding effective prevention strategies. Funding pools may be combined.

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Increasing levels of trust, time, risk and dependence.
Injury & Violence Prevention and Chronic Disease Relationship

Root Causes/Modifiable Risk and Protective Factors

Intentional and Unintentional Injuries

Risk Factors Health Behaviors

Chronic Disease Health Outcomes

Social Determinants of Health + Youth Development

Adverse Childhood Experiences/Domestic Violence

Increased Rates of Smoking, Obesity, Decreased PA, Poor Diet

Higher rates of hypertension, asthma, diabetes, etc.
GOAL III: Ensure PSD operates more efficiently with integrated and coordinated strategies and systems so that we improve services to internal customers and external partners.

Goal Leaders: Shannon Breitzman, Rachel Hutson, Erik Aakko
Report to: Karen Trierweiler and Karen DeLeeuw;
Accountability steps: Core - when needed, PIIT - quarterly

<table>
<thead>
<tr>
<th>GOAL</th>
<th>Objective</th>
<th>Action Steps</th>
<th>Accountability</th>
<th>Deadline</th>
<th>Update 11.09</th>
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<tbody>
<tr>
<td>GOAL III</td>
<td>Ensure PSD operates more efficiently with integrated and coordinated strategies and systems so that we improve services to internal customers and external partners.</td>
<td>OBJECTIVE 1: By December, 31, 2010, create, coordinate and streamline at least two business practices that lead to efficiencies in reaching program goals within the Division</td>
<td>a. Identify existing efforts to coordinate business practices between Centers.</td>
<td>Work Group One Susan Brunhofer Rachel Hutson Laurie Freedle</td>
<td>8/1/09</td>
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<td>b. Identify external stakeholders shared by both Centers who are impacted by PSD business practices.</td>
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<td>c. Compile existing feedback from internal stakeholders regarding PSD business practices. If feedback doesn't exist or is insufficient, solicit additional feedback through surveys or focus groups.</td>
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<td>d. Prioritize needed changes to business practices based upon criteria such as amenability to change and potential benefit.</td>
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<td>e. Develop teams with representatives from both Centers and external stakeholders, as possible, to create and implement strategies to address the top two priorities.</td>
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<td>f. Create and implement strategies to address top two priorities</td>
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<td>g. Establish accountability measures for teams.</td>
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<td>h. Reward team members for success in achieving objectives.</td>
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An Explanatory Framework for Conceptualizing the Social Determinants of Health

NATIONAL INFLUENCES
GOVERNMENT POLICIES
CULTURES

SOCIAL DETERMINANTS OF HEALTH + INDIVIDUAL FACTORS = POPULATION HEALTH OUTCOMES

ECONOMIC OPPORTUNITY
- Adequate income
- Jobs
- Educational attainment

COMMUNITY ENVIRONMENT
- Quality housing
- Quality schools
- Access to recreational facilities
- Access to healthy foods
- Transportation resources
- Access to healthcare
- Clean and safe environment

SOCIAL FACTORS
- Participation
- Social network/social support
- Leadership
- Political influence
- Organizational networks
- Racism

BEHAVIORAL HEALTH
- Diet & nutrition
- Physical activity
- Smoking
- Alcohol consumption & addictive behaviors
- Preventive health care use
- Violence/ intentional injury
- Unintentional injury
- Parenting skills

MENTAL/PSYCHO-SOCIAL
- Self esteem
- Emotional state
- Coping
- Attachment
- Demand/ strain
- Sense of control
- Stress
- Perceptions
- Expectations
- Mental state

QUALITY OF LIFE
MORBIDITY
MORTALITY
LIFE EXPECTANCY

LIFE COURSE
EARLY CHILDHOOD
CHILDHOOD
ADOLESCENCE
ADULTHOOD