

Ensuring the Delivery of Preventive Services for All:

The SPARC Action Guide

February 2011

The Healthy Aging Program at the Centers for Disease Control and Prevention (CDC) is pleased to share a “beta version” of a valuable resource, titled *Ensuring the Delivery of Preventive Services for All: The SPARC Action Guide*. To date, SPARC (which stands for Sickness Prevention Achieved through Regional Collaboration) has been successfully implemented in a few select communities. With this Action Guide, CDC expects to expand the SPARC network and extend the benefits of clinical preventive services to greater numbers of older adults. While this beta version is NOT the final version of the Action Guide, its early release is intended to promote expeditious testing so that its quality can be improved through real-life experiences.

Disclaimer: The findings and conclusions of this guide are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC)
Sickness Prevention Achieved through Regional Collaboration (SPARC)

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Dear Colleagues,

Thank you for your interest in developing a community-based infrastructure to increase the delivery of clinical preventive services. This work represents an important and achievable way to contribute to the health of older adults in your community. We offer this SPARC Action Guide as a foundation for building a program that broadens access to the most effective preventive services available, while taking advantage of delivery opportunities unique to your community. Clinical preventive services are a crucial set of interventions for promoting and maintaining health across the life span. Recommendations for persons aged 50 and older include vaccinations, cardiovascular screenings, and colorectal cancer screening. Additionally, recommendations for women include cervical and breast cancer screenings.

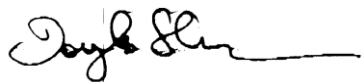
The SPARC model, developed by the non-profit organization Sickness Prevention Achieved through Regional Collaboration (SPARC), has been designed to respond to an important challenge. Despite coverage by Medicare and other insurance programs, no more than 45 percent of older adults are up-to-date with this set of services. In 2010, a *Healthy People 2020* objective was consequently established to increase the proportion of older adults “up-to-date” with these core services.

The SPARC Action Guide was prepared by the Centers for Disease Control and Prevention (CDC) in collaboration with SPARC. It builds on the experience of public health, aging services and healthcare leaders who have deployed the SPARC model in communities across the country. The Guide is intended to help you and your colleagues create a community-based prevention-oriented structure that can assure all persons easier access to and receipt of high-impact preventive measures.

We hope you will join us in this important work. The task of preventing disease and of helping older Americans lead longer healthier lives is the responsibility of both individuals and of communities. The SPARC Action Guide can help you establish an initiative that is convenient for the public and that encourages individuals to make healthy decisions.

We look forward to your participation and to your successes.

Sincerely,



Doug Shenson MD MPH
President, SPARC



Lynda Anderson PhD
Director, Healthy Aging Program, CDC

Executive Summary

Seven clinical preventive services are recommended for all adults: influenza and pneumococcal vaccination; screening for breast, cervical and colorectal cancer; and cholesterol and high blood pressure screening. Delivery of this core set of services has been shown to prevent much unnecessary illness and death and to significantly reduce healthcare costs. Yet, fewer than 25% of adults aged 50 to 64, and less than 40% of adults age 65 and older, are up to date with them.

An innovative approach called SPARC, or Sickness Prevention Achieved through Regional Collaboration, makes it possible to close this gap. Conceived in 1994 by two physicians in New York City, SPARC was originally implemented in four adjacent counties at the intersection of Massachusetts, Connecticut and New York and subsequently tested by nine counties in the Atlanta metropolitan area. After close scrutiny and evaluation, the SPARC model has proven successful in broadening the delivery of clinical preventive services and is now recommended by the Centers for Disease Control and Prevention (CDC) for other communities around the country seeking to improve and protect the health of their residents.

What makes SPARC unique and why is it effective?

SPARC creates stronger networks of existing healthcare providers. Rather than create a new system or structure for preventive service delivery, SPARC relies on the cadre of physicians, hospitals, medical practices, and other healthcare providers already actively delivering services in the community. SPARC creates alliances between and among these local providers and integrates them into an ongoing, cohesive and powerful network.

SPARC strengthens public-private sector connections. To support healthcare providers and bolster their “reach,” SPARC enlists a variety of community-based agencies: state and local health departments, mayors, community advocacy groups, faith-based organizations, visiting nurse and home health agencies, local election authorities, media, home-delivered meal programs, public housing authorities, schools, colleges and universities, area agencies on aging, quality improvement organizations, chambers of commerce, and businesses and employers. They may serve as hosts in sites where preventive services are provided, transport residents to service delivery sites, help with publicity, or advocate for increased financial support.

SPARC makes preventive services more accessible and convenient by bringing them out of traditional clinic settings into the community. Services are offered at new locations that are closer to residents’ homes, places of employment, or sites they might frequent in the course of their daily activities: churches, beauty salons, barbershops, worksites, polling places, public schools, community centers, low-income housing, etc. In addition, whenever feasible, multiple services are bundled for expedient “one-stop shopping.” As examples, mammogram appointments might be offered to women

receiving vaccinations at community-based flu clinics or pneumococcal and flu vaccinations provided at the same time outside a beauty salon or YMCA.

SPARCs are coordinated by an existing well-respected local “convener” agency. This agency is pivotal to SPARC’s success since it provides the leadership to facilitate and monitor preventive service delivery. It does not engage directly in the delivery of services; instead, it coordinates SPARC-related services delivered by other existing community providers. The convener serves as the “glue,” the objective party, the “air traffic controller,” the catalyst that energizes collaborating organizations and sustains an ongoing and continuous effort.

SPARC’s delivery strategies are designed by the very network of providers who will be responsible for providing them, thus ensuring that their needs and capacities are respected while also incorporating local knowledge about residents’ practices and preferences. By collecting and analyzing basic data, SPARC monitors results to improve its effectiveness.

SPARC’s purview is an entire community. SPARC assumes responsibility for delivering core preventive services to all residents of a community. While this community can vary in size and complexity, it is typically defined by geographic boundaries: a city or county, a region of several continuous counties, or an entire state.

To date, SPARC has been implemented in only a handful of communities. Imagine if all Americans routinely received effective clinical preventive services and were spared the burden of avoidable disease and death. Now further imagine you and your organization as catalysts in achieving this worthy vision. With this Action Guide, CDC hopes to expand the SPARC network and bring the benefits of clinical preventive services to communities all across America. The first two sections of this Guide offer a chance to learn more about the core preventive services and SPARC's potential for improving the health of your community. Subsequent sections guide you through the SPARC Roadmap (Figure 1) and outline a step-by-step process to help you and your organization embrace the SPARC approach and successfully implement a program that meets your unique needs and priorities.

“The time has come for major governmental health agencies at the state and federal levels to determine how best to replicate a SPARC-like program nationwide: spread the delivery of preventive services (immunizations and cancer screenings) to a vast population of people who are without them at present and therefore are at avoidably greater risk of developing potentially fatal diseases.”

Paul Brodeur

RWJ Anthology: To Improve Health and Health Care, Vol X, Chapter Seven. Ed: Stephen L. Isaacs and James R. Knickman, October 2006

Figure 1. The SPARC Roadmap



The Case for Preventive Services

Decades of research have yielded an array of effective clinical preventive services for children, adolescents and adults. Included among them are vaccinations to prevent diseases such as tetanus and influenza; and screenings to diagnose conditions such as cancer, heart disease and stroke in their early stages when treatment may be more effective.

What are the core preventive services and why are they important?

A core set of clinical preventive services is strongly recommended for all adults by national panels of scientific experts, namely, the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP). These services are listed in Table 1, along with their respective recommendations. Collectively, they represent a powerful force for improving health and quality of life.

Table 1. Recommended Preventive Services for Adults*

Preventive Service	Recommendation
Influenza vaccination**	All persons 6 months and older should receive one dose annually.
Pneumococcal vaccination	All persons age 65 and older should receive one dose of the pneumococcal vaccine, including previously unvaccinated persons and persons who have not received vaccine within 5 years (and were less than 65 years of age at the time of vaccination). All persons in this age category who have unknown vaccination status should receive one dose of vaccine. Adults aged 64 and younger who are at elevated risk should receive one dose.
Breast cancer screening	All women age 50 to 74 should have a mammogram every two years.
Cervical cancer screening	All women who have been sexually active should receive screening for cervical cancer (if they have a cervix). Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. Women older than age 65 do not need routine screening for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.
Colorectal cancer screening	All adults, beginning at age 50 years and continuing until age 75 years, should receive screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Evidence suggests a maximal benefit from screening every 10 years.
Cholesterol screening	All men aged 35 and older should be screened for lipid disorders. Men aged 20 to 35 should be screened if they are at increased risk for coronary heart disease. All women aged 20 and older should be screened for lipid disorders if they are at increased risk for coronary heart disease. A recommended screening interval is every 5 years, but shorter for people who have lipid levels close to those warranting therapy, and longer for those not at increased risk who have had repeatedly normal lipid levels.
High blood pressure screening	All adults aged 18 and older should have their blood pressure checked. A recommended screening interval is every 2 years in persons with blood pressure less than 120/80 mm Hg and every year with systolic blood pressure of 120-139 mm Hg or diastolic blood pressure of 80-89 mm Hg.

*Each of these clinical preventive services is rated at the A (highly recommended) or B (recommended) level by the USPSTF. For more information on USPSTF and ACIP, see Appendix A and the websites: <http://www.ahrq.gov/clinic/uspstfab.htm> and <http://www.cdc.gov/vaccines/recs/acip/#about>.

** Additional influenza vaccines, such as H1N1, may be recommended each year and should be considered. See <http://www.cdc.gov/vaccines> for more information.

These recommended vaccinations and screenings not only prevent unnecessary illness and death, but can also be extremely cost effective. A for examples:

- During 10 seasons, influenza vaccination was associated with significant reductions in the risk of hospitalization for pneumonia or influenza and in the risk of death among community-dwelling elderly persons.¹
- While mammography is not a perfect screening tool, a series of studies conducted in community settings has supported the conclusion that screening mammography saves lives. Overall, the evidence indicates that the availability of screening mammography reduces mortality from breast cancer by 20 to 30 percent.²
- Screening for colorectal cancer for adults ages 50 and older is rated as a highly recommended preventive service. Colorectal cancer screening is effective in reducing deaths by detecting the disease at earlier more curable stages.³

Despite the effectiveness of these potentially life-saving preventive services, their value is compromised by our failure to provide them universally to all adults. In 1997, 37.6% of men and 30.5% of women aged 50 to 64 were up to date on these services. With a new recommendation in 2000 that influenza vaccination be routinely delivered to adults in this age group, delivery rates fell dramatically to less than 25% of adults aged 50 to 64 (Figure 2).⁴ Sadly, these delivery rates have not shown any significant improvement in the last eight years. For adults over age 65, delivery rates have improved moderately but are still less than 40% (Figure 3).

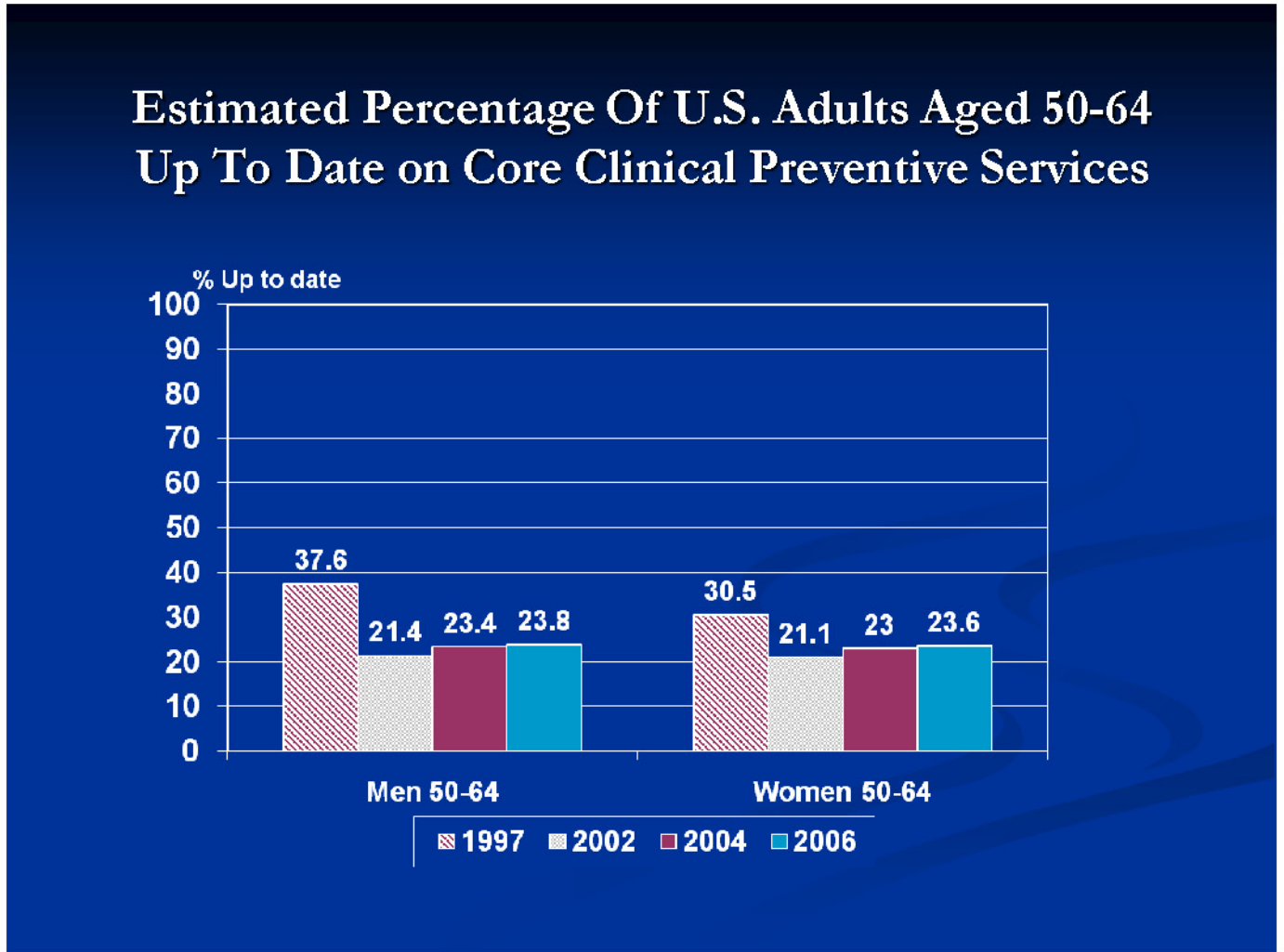
1. Nichol KL, Nordin JD, Nelson DB, Mullooly JP, Hak E. Effectiveness of influenza vaccine in the community-dwelling elderly. *N Engl J Med* 2007;357(14):1373-1381.

2. Saving Women's Lives: Strategies for Improving Breast Cancer Detection and Diagnosis, 2004. Institute of Medicine and National Research Council.

3. U.S. Preventive Services Task Force. *Ann Intern Med* 2007;146(5):361-364.

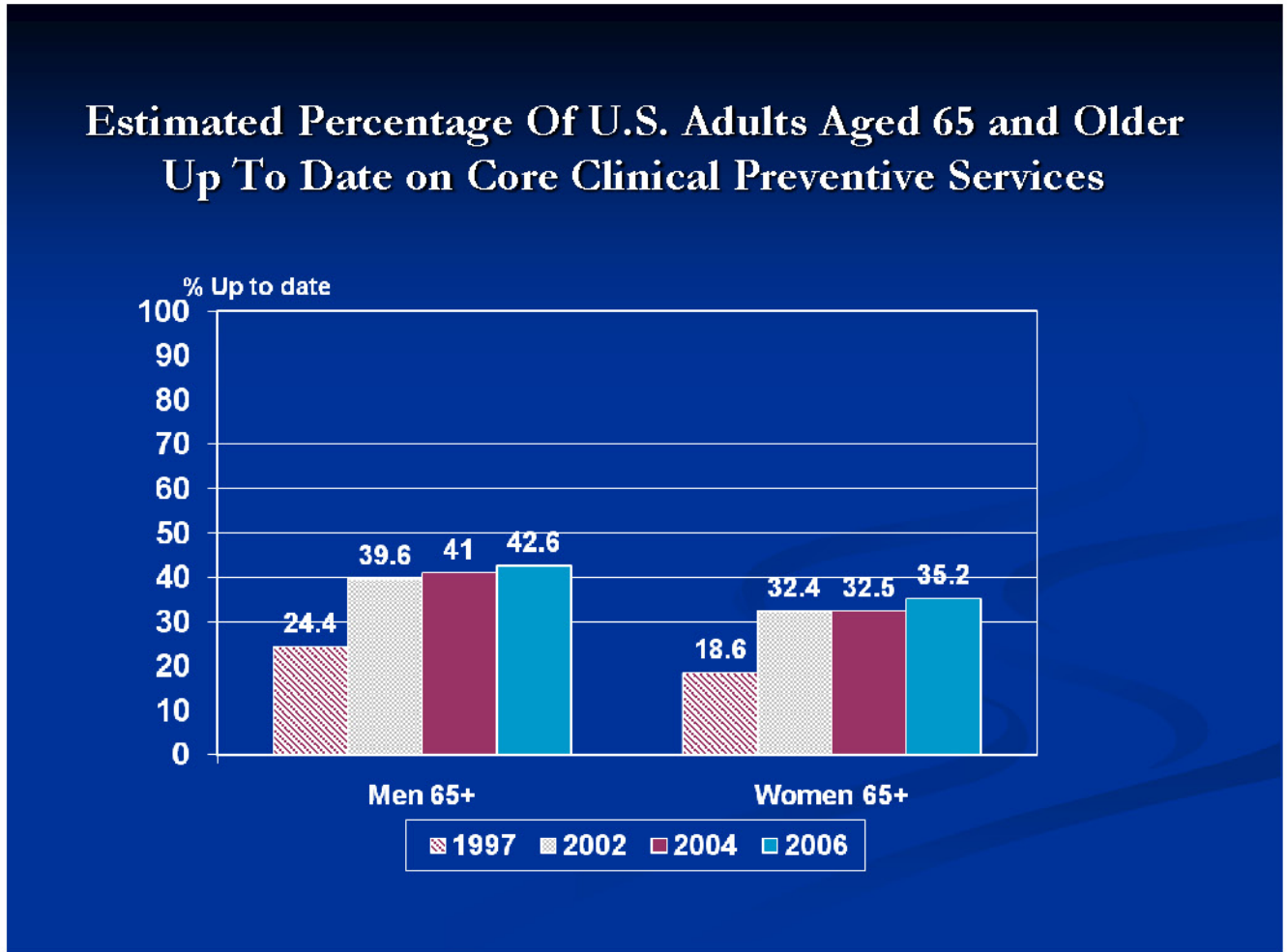
4. Shenson D, Bolen J, Adams M. Delivery of preventive services to adults aged 50-64: Monitoring performance using a composite measure, 1997-2004. *J Gen Intern Med* 2008;23(6):733-740.

Figure 2.



Source: Behavioral Risk Factor Surveillance System 1997, 2002, 2004, 2006

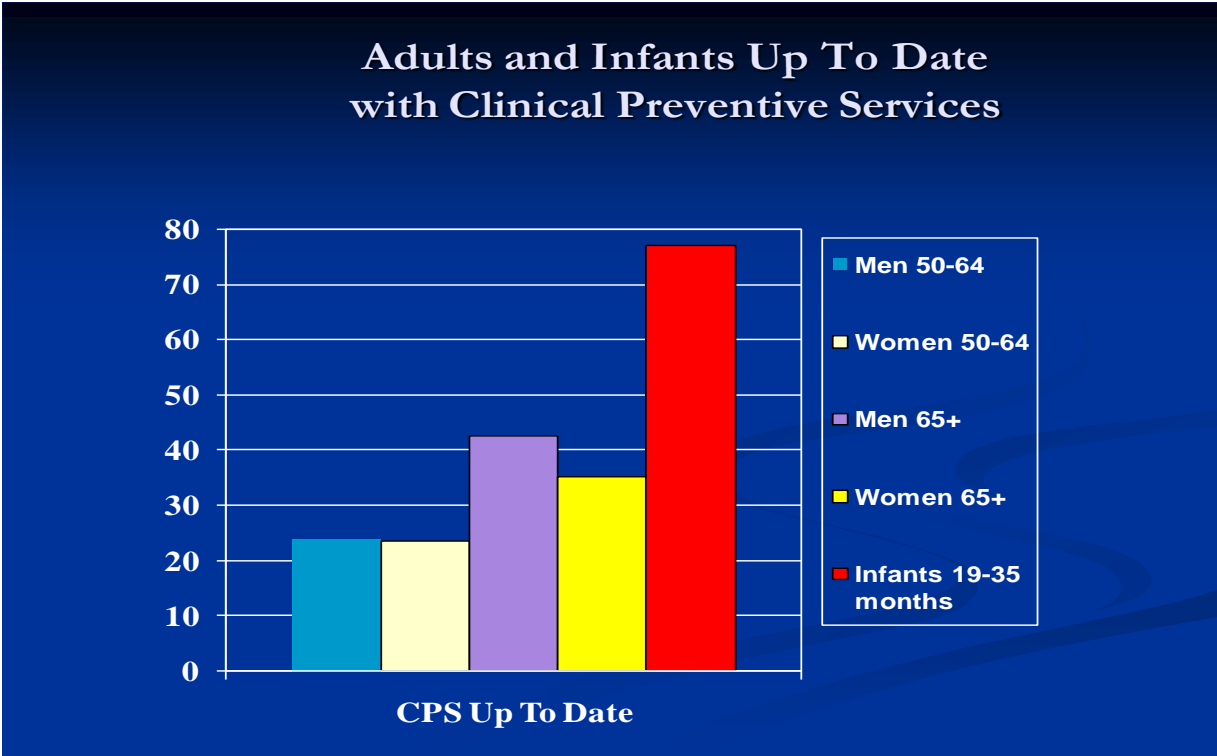
Figure 3.



Source: Behavioral Risk Factor Surveillance System 1997, 2002, 2004; Am J Prev Med 2007;32(1).

Thanks to national immunization requirements for school entry, we have done a better job in providing recommended clinical preventive services to our youth than to adults: more than 75% of children aged 19 to 35 months have received all their vaccinations (Figure 4).

Figure 4.



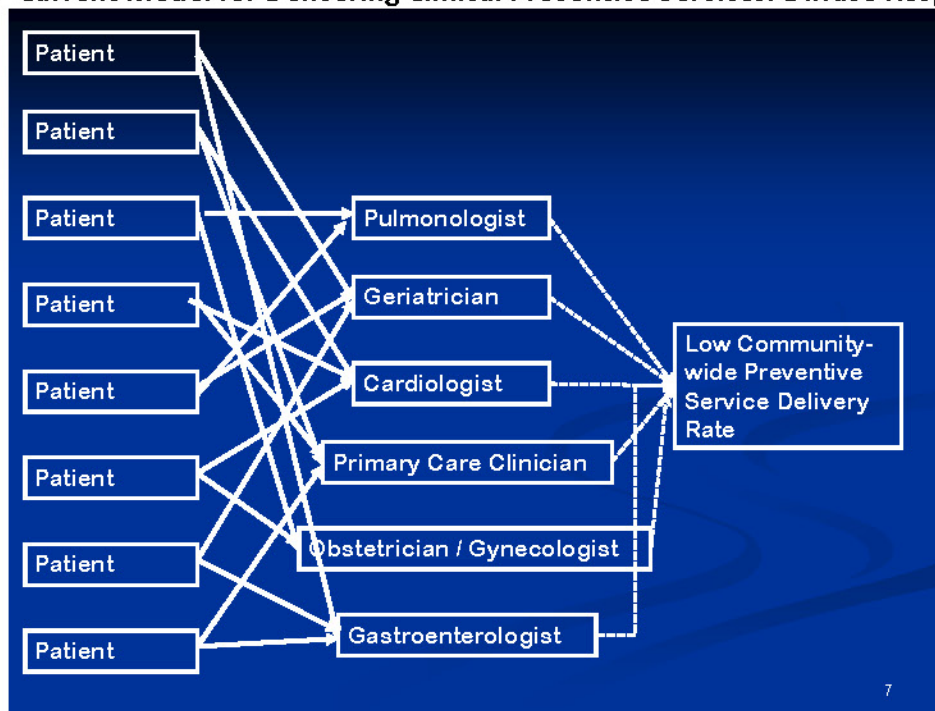
Source: BRFSS 2006

Why are these services not widely delivered?

If these core preventive services are highly effective, why are delivery rates so low—particularly among adults? A few fundamental reasons stand out.

First, most adults who receive a preventive service do so in a physician's office or some other clinical setting. Often, they must visit several physicians to secure the full array of services recommended for their age and gender: a primary care clinician for the flu vaccination; a gynecologist for a Pap test; and a gastroenterologist for colorectal cancer screening (see Figure 5). The inconvenience and burden of scheduling and attending all of these visits, plus time away from work or family, may discourage even those adults who are motivated and aware of the potential health benefits. This complex situation also complicates referrals, follow-up and coordination of care.

Figure 5. Current Model for Delivering Clinical Preventive Services: Diffuse Responsibility



Second, insurance coverage plays an influential role. Nearly all insurance plans, including Medicare and Medicaid, cover the core preventive services. Fortunately, with the recent enactment of healthcare reform legislation, insurance companies will no longer be able to charge out-of-pocket costs for preventive services such as screenings and recommended immunizations. Furthermore, those who have been uninsured and have a pre-existing condition will be able to get insurance that must cover these core preventive services. Yet, one

of every four adults aged 50 to 64 is currently uninsured or has inadequate insurance coverage.⁵

Physicians and other healthcare providers also bear some responsibility. They may not be current on recommended guidelines for clinical preventive services or may have poor office reminder systems to bring their patients in for annual or routine exams. Amidst all of the challenges of providing quality healthcare, physicians may place disease prevention at a lower priority than the treatment of more pressing acute and chronic conditions.^{6,7}

Lastly, there is a looming shortage of generalist physicians, with expected deficits of 35,000 to 44,000 physicians for adult care by 2025.⁸ Adults frequently seek healthcare only when they have specific medical concerns (frequently in a hospital emergency room or “doc-in-a-box”) and often do not receive regular medical checkups, exams or services. Denial, fear and other common emotions also can play a role in discouraging routine clinical visits.

In summary, the responsibility for ensuring that adults receive recommended clinical preventive services is diffuse. No one local organization has the mandate to oversee and coordinate delivery of preventive services to all residents in their community. What we need is an agency that is truly committed to mobilizing the healthcare providers in a community and developing the capacity to guarantee the routine, ongoing delivery of core clinical preventive services.

5. Smolka G, Purvis L, Figueiredo C. FYI: Characteristics of uninsured and underinsured 50- to 60-year-olds. AARP Web site. Available at: http://assets.aarp.org/rgcenter/health/m_4_uninsured.pdf.

6. Cabana MD, Rand CS, Powe NR, Wu AW, Wilson MH, Abboud PC, Rubin HR. Why don't physicians follow clinical practice guidelines? A framework for improvement. *JAMA* 1999;282(15):1458-1465.

7. Yarnall KSH, Pollak KI, Østbye T, Krause KM, Michener JL. Primary care: Is there enough time for prevention? *American Journal of Public Health* April 2003; 93(4):635-641.

8. Colwill JM, Cultice, JM, Kruse RL. Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs* 2008;27(3): w232-w241 (Published online 29 April 2008) doi:10.1377/hlthaff.27.3.w232.

Introducing SPARC

Sickness Prevention Achieved through Regional Collaboration (or SPARC) was created to ensure the delivery of core clinical preventive services recommended for all community residents. To achieve that end, SPARC builds strong networks of healthcare providers and community organizations that offer ongoing service delivery in accessible and convenient community sites.

What preventive services are delivered?

The priority for SPARC – and for this Action Guide – is the core set of preventive services recommended for all women and men aged 50 years and older (see Table 1):

- Influenza and pneumococcal vaccination
- Screening for breast, cervical and colorectal cancer
- Cholesterol and high blood pressure screening.

This is not to say that these are the only valuable preventive services, nor the only important age group. Some communities may want to serve younger age groups or offer additional preventive services. Indeed, many other preventive services are recommended by the USPSTF and ACIP for persons who are at higher risk of disease due to their behaviors or clinical symptoms. These services might include counseling to reduce unhealthy behaviors (e.g., smoking or physical inactivity) associated with coronary heart disease, stroke, diabetes and cancer; and treatments (e.g., aspirin use) to address clinical symptoms that increase the risk for a heart attack or stroke.

However, because SPARC is uniquely focused on entire communities, our priority is to assure delivery of the core set of preventive services common to all residents 50 years of age and older. SPARC maintains a deliberately tight mission by focusing exclusively on those preventive services that are recommended universally.

Who is served?

A “SPARC community” is defined by its geographical boundaries: a city or county, a region comprised of several contiguous counties, or an entire state. These boundaries must be within the geographic purview of the agency coordinating the SPARC Program (known as the “convener” and discussed in detail later in this Introduction).

Some SPARC Programs take on the responsibility of assuring services to an entire community from their inception; others begin by targeting certain subsections of the defined community with high concentrations of residents who have traditionally had low preventive service rates. No two SPARC Programs should exist or overlap in the same “community.”

Who provides the services?

The beauty of SPARC is that it does not demand establishment of a new agency to deliver services. Instead, SPARC works with and relies on healthcare providers already actively delivering preventive services in the community and link them into a more cohesive and effective network with other community collaborators.

SPARC creates alliances between and among local healthcare providers and engages them in helping to design a delivery strategy that respects the unique needs and capacities of each community.

To support these healthcare providers and bolster their “reach,” SPARC enlists community-based agencies that span public and private sectors: state and local health departments, hospitals, mayors, community advocacy groups, faith-based organizations, visiting nurse and home health agencies, local election authorities, media, home-delivered meal programs, public housing authorities, schools, area agencies on aging, quality improvement organizations, chambers of commerce, and businesses and employers.

Common SPARC Collaborators

- Area Agencies on Aging
- Regional hospitals
- Academic medical centers
- Employers
- Public health departments
- Churches or synagogues
- Housing authorities
- AARP offices
- YMCAs and YWCAs
- County or local government
- Nonprofit multi-service community organizations
- Community or private foundations

Some of these organizations serve as hosts for SPARC “events” where preventive services are provided (such as employers, churches, or public housing). Others transport residents to the event site from a senior center or private residence, for example (nonprofit transportation services). Still others help publicize the events (local media) or advocate for increased financial support (mayors and chambers of commerce). Collectively, they are SPARC’s infantry, the agencies and organizations “on the ground” that ensure delivery of preventive services to those who may not otherwise receive them.

How and where are services delivered?

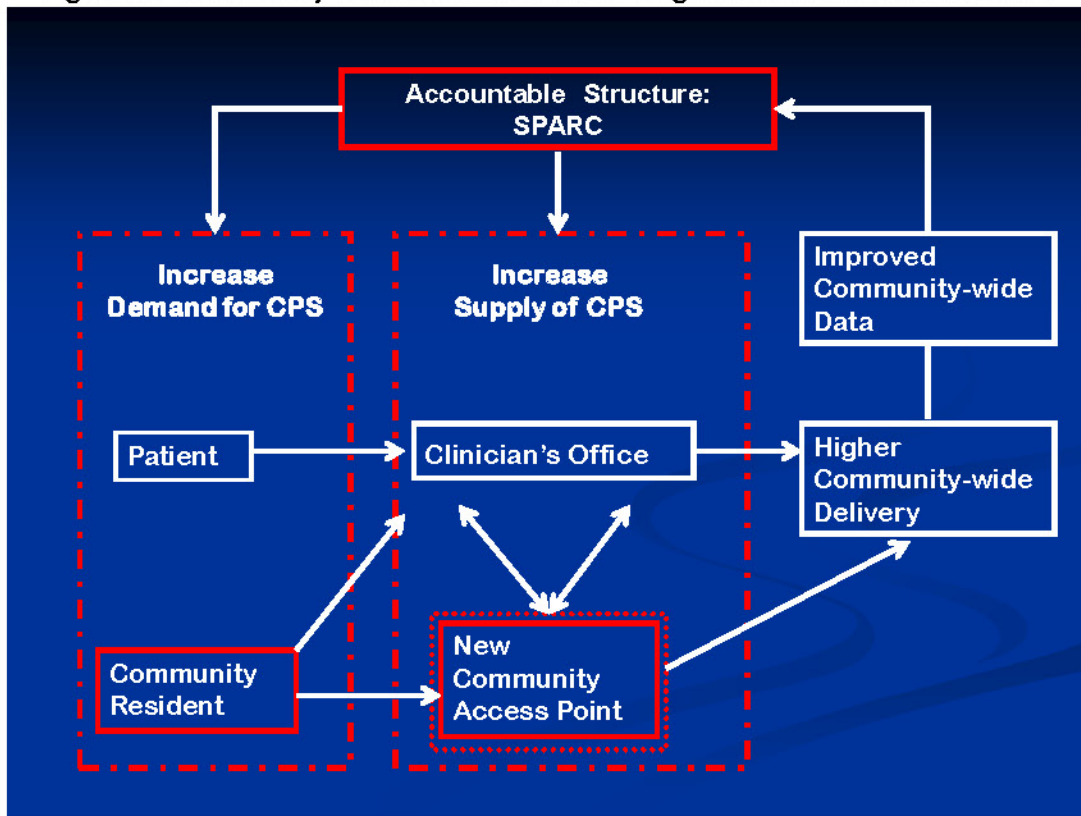
SPARC makes it as easy as possible for community residents to access and benefit from preventive services — and to do so at regular intervals. Two key strategies are employed: linking and bundling.

Linking: SPARC extends preventive services beyond traditional clinical settings into the community, linking services to “fresh” community sites. SPARC chooses an array of delivery settings that community residents can reach easily—convenient and comfortable locations close to their homes, places of employment, or sites they might frequent in the course of their daily lives: churches, hair salons, barbershops, worksites, polling places, public schools, community centers, physician practices, and low-income housing. Flu shots might be offered at polling sites, for example, or by employers during the work day.

Bundling: SPARC Programs often bundle two or more preventive services for one-stop delivery to further enhance accessibility and convenience. Mammogram appointments might be offered to women receiving vaccinations at community-based flu clinics, or pneumococcal and flu vaccinations might be provided at the same time at a beauty salon or local YMCA.

The key is to make it easy for residents to get the core preventive services appropriate for their age or gender in one place, at one time—and to avoid the need for multiple trips to multiple providers (see Figure 6). While some community residents will visit a clinician’s office for preventive care, many others will have the opportunity to get preventive services from a new community access point. Ensuring that multiple, or “bundled,” preventive services are made available at convenient, non-clinical locations helps individuals begin to consider getting these services as just another routine activity of life. As getting “bundled” services becomes the norm, overall delivery rates increase.

Figure 6. Community-Wide Model for Delivering Clinical Preventive Services



How is delivery coordinated?

SPARC relies on the leadership of a neutral “convener” agency to coordinate, facilitate and monitor community-wide delivery of preventive services. This agency is the “glue” that binds the network of partnering community service and healthcare agencies. It is the catalyst that energizes collaborating organizations and sustains an ongoing and continuous effort. It is the organizer and manager for SPARC events. It is the “air traffic controller” that is ever vigilant to:

- Who is doing what
- With what results
- What more can be done.

Among the potential SPARC conveners are area agencies on aging, medical societies, and local public health departments. Often, the convener is the specific unit within the agency responsible for promoting health and wellness among its constituents. This unit does not take part in delivering preventive services. Instead, by valuing and building on the community’s capable network of providers, the convener remains “neutral” and objective, better able to shape and structure an effective delivery strategy.

The success of a SPARC program directly correlates with strong leadership of a neutral convener. You and your organization may be perfectly suited for this challenging but highly rewarding role.

“SPARC represents a particularly noteworthy catalyst for enabling an effective community based response to a national priority.”

James S. Marks, MD, MPH

Former Director

National Center for Chronic Disease Prevention and Health Promotion

Centers for Disease Control and Prevention

Currently Senior Vice President and Director, Health Group

Robert Wood Johnson Foundation

What impact can SPARC have?

A community that implements a SPARC program can expect to reap meaningful benefits:⁹

Integration of multiple community assets

- People from different perspectives come to a common “table” and embrace a shared mission.
- Diverse talents and resources are mobilized.
- A central locus of accountability is formed for ensuring delivery of preventive services.
- An efficient and effective vehicle is established for ongoing communication and exchange of knowledge, ideas, strategies and tactics.
- Community agencies and sectors gain a greater sense of trust and mutual understanding.

Innovation and extension into diverse and underserved communities

- Access to routine preventive services in community settings expands.
- Collaborators gain greater access to skills and expertise not available in their own organizations.
- “Missed opportunities” to receive clinical preventive services are diminished.

Economies of scale

- Communities share a wider pool of resources that would otherwise be unaffordable or beyond their reach (such as vaccine supplies and a mobile mammography van).
- Duplication of effort is minimized and resources are used more efficiently (e.g., standardized posters and marketing material designed for all SPARC events).

Cost savings

- Service delivery rates improve.
- Healthcare costs decline due to lower rates of hospitalization to treat diseases that have been prevented.

Force for community health

- SPARC provides an ongoing forum for key and varied players to jointly address critical issues and challenges.

Why Be a SPARC Collaborator?

Participation in a SPARC program can help a collaborating agency:

- Enhance your ability to fulfill your organization’s mission
- Engage and serve more clients
- Increase the visibility of your agency
- Save money by creating a common marketing strategy with your colleagues.

9. Butterfoss, Kegler. The Community Coalition Action Theory. Submitted for publication 2010.

- Collaborators have a louder “voice” for medical and healthcare issues with almost unlimited potential to tackle priority community needs.
- The infrastructure for addressing unanticipated health threats and emergencies is primed for a rapid and effective response.
- Highly functioning networks of community organizations wield greater weight when competing for funding.

All of these benefits ultimately lead to a more prepared, healthy, productive community.

Tracing SPARC's Evolution

1994: The genesis of SPARC lies with two physicians who were convinced of the untapped potential of clinical preventive services. According to Michael Alderman, chairman of the Department of Epidemiology and Social Medicine at the Montefiore Medical Center/Albert Einstein College of Medicine in the Bronx, and Douglas Shenson, an internist and assistant professor in the department made their case in *The New York Times*:

We need radical new ways to make sure everyone gets the handful of services proved to prevent disease and extend life. Too few people get the vaccinations that prevent infections and the mammograms, Pap smears and examinations that can detect cervical, breast and colon cancers while they are still curable. Nor do most people with high blood pressure or elevated cholesterol receive effective treatment that can prevent strokes and heart attacks. These cancers and cardiovascular diseases together account for half of all deaths in the United States.¹⁰

They persuaded Virgil Stucker, director of the Berkshire Taconic Community Foundation based in Lakeville, Connecticut, to convene several meetings of community leaders—among them local hospital officials, physicians, visiting nurses, and directors of rotary clubs and senior centers—to explore ways to increase preventive service delivery to their area's residents. Six months later, SPARC—Sickness Prevention Achieved through Regional Collaboration—was born.

1995–2005: SPARC staff and community agencies spent the first years developing projects to carry out SPARC's mission, establishing an independent governance structure, raising funds for operating costs, and establishing half a dozen steering committees to assume responsibility for delivering services in their own localities.¹¹ Initially, the area covered by SPARC included parts of Berkshire (Massachusetts) and Dutchess (New York) counties. Ultimately, SPARC was implemented in all four adjacent counties at the intersection of Massachusetts, Connecticut and New York.

Fundamental to all programs was the conviction that clinical preventive services should not only be delivered in primary care physicians' offices but also out in the community at convenient, highly frequented sites. In addition, multiple services should be provided whenever possible. With funding from the Centers for Disease Control and Prevention (CDC), community foundations, nongovernmental organizations, private philanthropy, and key support from the

10. Alderman M, Shenson D. A ton of cure. *New York Times* op-ed page, April 24, 1994.

11. Brodeur P. SPARC—Sickness Prevention Achieved through Regional Collaboration. In: Isaacs SL, Knickman JR., eds. *To Improve Health and Health Care*, Vol. X. The Robert Wood Johnson Anthology. San Francisco: Jossey-Bass; 2006:145-167.

Robert Wood Johnson Foundation's (RWJF) Local Initiatives program, several projects were designed and tested over the next five years.

- In 1997, SPARC led a broad project to ensure the delivery of pneumococcal vaccination at all community flu shot clinics in Berkshire¹² and Dutchess¹³ counties—and **doubled** the annual delivery of pneumococcal vaccine to Medicare recipients.
- In 2001, SPARC provided mammography appointments at flu shot clinics for women who were behind schedule for breast cancer screening. This innovation doubled mammography rates among women attending the clinics, due in large part to proactive efforts in scheduling appointments, reserving blocks of time on hospital mammography schedules, and providing free transportation to and from mammograms.¹⁴
- In 2002, SPARC redistributed flu vaccine among mass immunizers (public health clinics, drug stores, and grocery stores that administer vaccines to the public) and physician practices to ensure immunization of high-risk patients.¹⁵

2006: To explore the replicability of the SPARC model, CDC facilitated a partnership between SPARC and the Aging Services division of the Atlanta Regional Commission, Area Agency on Aging. After an initial meeting of approximately 20 key health and social service leaders from this Georgia region, two counties—Fulton and Fayette—agreed to develop and implement local strategies consistent with the SPARC approach. Coalitions were established in each county comprised of local public health departments, local hospitals, social service agencies, visiting nurse agencies, and advocacy organizations. The county offices on aging served as coalition facilitators.¹⁶

- Fulton County offered preventive services in the lobbies of three senior housing apartment buildings, a local fire station, and a middle school. Women aged 50 and over attending the clinics were offered the opportunity to receive a phone call from a radiology facility of their choice to schedule a mammogram. An estimated 62% of adults receiving a flu vaccination at these clinics had not received one in the previous year.

12. CDC. Local data for local decision-making - Selected Counties, Connecticut, Massachusetts, and New York, 1997. *MMWR* 1998;47:809-813.

13. Shenson D, Quinley J, DiMartino D, Stumpf P, Caldwell M, Lee T. Pneumococcal immunizations at flu clinics: The impact of community-wide outreach. *J Community Health*. 2001;26(3)191-201.

14. Shenson D, Cassarino L, DiMartino D, Marantz P, Bolen J, Good B, Alderman M. Improving Access to Mammography Through Community-Based Influenza Clinics: A Quasi-Experimental Study. *Am J Prev Med*. 2001;20(2):97-102.

15. DiMartino D, Cassarino L, Boy A, Shenson D. Redistribution of influenza vaccine between mass immunizers and physician practices to assure immunization of high-risk patients. Abstract and presentation at the 35th Annual National Immunization Conference. Atlanta GA. May, 2001.

16. Shenson D, Benson W, Harris AC. Expanding the delivery of clinical preventive services through community collaboration: The SPARC model. *Prev Chronic Dis* 2008;5(1). <http://www.cdc.gov/pcd/issues/2008/>.

- Fayette County adopted Vote and Vax and delivered flu vaccinations to 634 voters near 10 polling places—27% of whom had not received a flu vaccination in the past year.
- In 2006, SPARC piloted a multi-state “Vote and Vax” to evaluate the feasibility of delivering flu shots near polling places in many kinds of community.¹⁷

2008: Nine metropolitan Atlanta counties joined the SPARC initiative and have established their own coalitions, used local knowledge and a network of collaborators to develop innovative, community-tailored interventions. The SPARC model’s success in broadening the delivery of critical preventive services is well documented in these communities and recommended by CDC for other communities around the country seeking to improve and protect the health of their residents.

- With RWJF support, SPARC expanded this program and, in 2008, delivered on Election Day more than 21,434 influenza vaccinations at 331 polling places in 42 states and the District of Columbia.¹⁸



Is your organization interested in applying to be the “convener” for a SPARC community?

If so, consult with the National SPARC Center to be sure there is not another SPARC already designated for your area. The SPARC program can be reached by emailing Dr. Doug Shenson at dshenson@sparc-health.org or by phone at 617-796-7966. Then proceed to Step 1.

17. Shenson D, Adams M. The Vote and Vax Program: Public health at polling places. *Journal of Public Health Management and Practice* July/August 2008.

18. Shenson D, Adams M, Benson W, Clough J. Vote & Vax: Delivering vaccinations at polling places. Poster Presentation. 44th National Immunization Conference. Atlanta GA. April 20,2010.

Step 1: Commit to Being the SPARC Convener

Are you and your organization interested in starting a SPARC in your community? If so, your first step is to be sure that SPARC is a good “fit” with your agency’s mission, role and future direction. Three pivotal questions can help determine your agency’s potential for serving as an effective convener and guide your decision making.

Is SPARC’s mission compatible with the mission of your agency?

Does your agency’s mission encompass disease prevention or health and wellness? Does SPARC fit with what you are already doing? Are clinical preventive services in your purview, or do you believe they should be?

Can your agency be “neutral?”

Ideally, the convening agency should not be a direct provider of clinical preventive services. Does your agency currently deliver any preventive services? Are you willing to be the facilitator, convener, catalyst, and enabler for clinical preventive service delivery—and not a direct provider of those services? Are you perceived by other providers and community-based organizations as a neutral player? Does your agency have any incentives (e.g., financial, competitive or structural interests) that would lead you to favor one collaborator over another?

Can your organization commit to coordinating a SPARC Program for at least three years?

Successful SPARCs take time to evolve. Typically, they start small and focused, with a modest investment of staff time and resources. However, as achievements accrue, the demand for services to be delivered in more sites and to more residents will grow. Does the leadership of your organization find the accomplishments and results of other SPARC programs compelling? How likely are your agency’s leaders to stay invested in the program for the next few years?

What else should you consider?

If the answer to all three questions is “yes,” you may indeed be an ideal SPARC convener. Before taking the next step, however, we urge you to consider two more factors.¹⁹

To what extent can your agency bring people and organizations to the table?

Do you have a history of successful community-based collaborations focused on prevention? Have you done any collaborative work in the past with nontraditional partners beyond your “silo” or specialty area? Are you able to involve all sectors of the local healthcare delivery system, such as hospitals, public health organizations, and medical practices? Have you reached beyond the health sector into the business community? What is your relationship with the local media, faith-based organizations, the housing authority, nearby universities?

To what extent can your agency provide strong leadership?

Successful partnerships and coalitions require strong and effective leadership.²⁰ Do you have a staff member who can lead and manage a SPARC program? Does he or she have the requisite skills and experience to be a Program Coordinator (see Table 2)? Are you willing to support his or her salary? This is likely to be at least a half-time job depending on the scale of your program. As noted earlier, focusing on a small geographic area initially and expanding over time is highly recommended. Similarly, it may be prudent to start with a part-time Program Coordinator.

“When selecting leadership, look for a person with some health experience in the community. SPARC coordinators have to believe in it wholeheartedly. They have to have goose pimples about what they do and can accomplish.”

Regine Denis, LMSW
Aging Services Program Manager
Fulton County Human Services Department
Atlanta, Georgia

15. Shenson, Benson, Harris. Expanding the Delivery of Clinical Preventive Services Through Community Collaboration: The SPARC Model. 2008.

16. Ansari, Oskrochi, Phillips. Engagement and Action for Health: The Contribution of Leaders’ Collaborative Skills to Partnership Success. 2009.

Table 2: Qualities of an Effective SPARC Program Coordinator

Job Functions

- Has a focus on and commitment to health and wellness as part of his/her assigned job duties
- Has a background in aging services, social work, public health or similar field
- Has sufficient time to dedicate to SPARC

Skills

- Is an energetic and inspiring leader
- Is an innovative yet concrete thinker
- Is personable and open to suggestions and partnerships
- Has excellent communication and organizational skills
- Is a good facilitator and collaborator, with no hidden agendas
- Is willing to follow up and be persistent (has “staying power”)

Experience

- Has credibility with the healthcare community
- Is comfortable being out in the community and sensitive to residents’ needs
- Has had success working with other community organizations, e.g., a good track record in getting things done with and through others



Are you and your agency ready to commit to being a SPARC convener?

If so, contact the National SPARC Center to work out the details. Then formally designate a Program Coordinator and proceed to Step 2.

Step 2: Form SPARC Steering Committee

Your first formative step as a new SPARC is to establish your Steering Committee. Unlike similar committees for other programs, the SPARC Steering Committee is comprised of the individuals, organizations and businesses involved in preventive service delivery to residents of your community. They are the “collaborators” discussed in the Introduction: hospitals, medical groups, aging services, governmental agencies, housing authorities, nonprofit organizations, advocacy organizations, faith-based groups, organizations representing ethnic, racial or cultural communities, fire and police services, mayor’s offices, businesses and employers, chambers of commerce, and local media. By participating in SPARC, these organizations play an active role in deciding what preventive services will be delivered, to whom, how, when and where.

Specifically, the Steering Committee shares responsibility for:

- Determining the communities in which SPARC will focus
- Identifying the specific set of preventive services to be offered
- Designing local strategies for increasing access to services
- Selecting delivery sites that are convenient for residents
- Designing promotion approaches and incentives for participation
- Providing local knowledge about opportunities and challenges to market and deliver preventive services
- Connecting to additional local resources for service delivery, transportation, publicity and marketing, advocacy and financial support
- Helping to monitor delivery rates and program outcomes.

Depending on the scope of your SPARC, you may have more than one Steering Committee. For example, if your SPARC program spans three counties, each of those counties may have its own Steering Committee. The geographic areas covered by your Steering Committees should not overlap. However, some agencies may be represented on more than one Steering Committee if they serve several communities.

Identify core collaborators

Several organizations are essential to involve as collaborators because they are integral to the delivery of clinical preventive services in your area.

- A community hospital can apply advanced technology and draw on its skilled staff in providing screening, e.g., mammograms, Pap tests, and colonoscopies.
- A public health department can ensure that vaccinations and screening services can be offered for free or on a sliding scale.
- An agency that serves adults 60 years of age and older—an area agency on aging, a senior center, or YMCA/YWCA—can connect with residents in need of services.

- Other community-based organizations can serve as host sites, provide transportation, recruit volunteers, and publicize events—all key components of effective service delivery.

Think about the community served by your agency. Which organizations are most likely to have an interest in increasing preventive services and improving community health? Consider the full range of healthcare and social service organizations: home health providers, senior services, medical practices, visiting nurse agencies, faith-based organizations, housing authorities, employers and businesses, recent immigrant advocacy associations, local news organizations, etc.

They do not need to be new partners; in fact, it is easier to start with agencies that you have worked with before in another capacity or are currently working with on another issue. Which of these agencies are most likely to be enthusiastic and participate in a SPARC? Is a relevant coalition already in place (for example, a flu coalition or a health and wellness consortium) that you can tap? Are there individuals who know about funding resources in your community, support services, and entities serving people without health insurance coverage?

Strive to identify organizational leaders who are creative, willing to think “outside the box,” well-respected in the community, and serve the age group you expect to target. Keep your initial group small (8–12 individuals) and manageable. The composition and size of your Steering Committee will undoubtedly change and grow as your SPARC evolves.

“SPARC offers a way to change the way we do business. It’s is easy to implement if you follow the model. All you need is the opportunity and the structure to do it in.”

Cathie Berger
Director

Atlanta Area Agency on Aging

Explain SPARC and its potential

Meet separately with potential collaborators to describe the uniqueness of the SPARC approach, their role, and the potential benefit to their organizations. Explain SPARC’s mission and approach, and your agency’s role as convener and facilitator. Ask questions to become more familiar with the collaborating agency’s mission, target population, current priorities and activities, and anticipated future directions. Discuss what you believe the agency can contribute—its unique role and added value (see Table 3). Clearly explain the benefits of SPARC; be explicit that you are not treading on their turf but attempting to extend their “reach” to those in the community who are not likely to benefit from their services otherwise.

Anticipate such questions as:

- How does SPARC fit with my mission?
- What does my agency stand to gain?
- How will SPARC impact my staff workload and time commitment?
- What will this cost my agency?

Answer these and other questions as best you can and enlist their help in identifying other community agencies that might be pivotal to delivering preventive services.

Table 3. Potential Roles for Collaborators

Agency	Potential Roles
Health departments and visiting nurse agencies	May provide core clinical preventive services in community settings - usually adult vaccinations and cardiovascular screenings with appropriate follow up. May provide a mobile unit for Pap tests, mammograms, and other recommended screenings. May oversee appointment links to hospital-based disease screening.
Hospitals	May provide screenings using high-technology/skills: mammograms, Pap tests, and colonoscopy.
Medical practice groups and volunteer clinics	May accept referrals for screening and screening follow-up; may provide venues for community clinics outside of office hours.
Local Breast and Cervical Cancer Early Detection Programs (NBCCEDP)	May provide screening coverage for women without health insurance.
Housing authority, fire departments, election authorities, mayor's office, senior centers, etc.	May provide venues for delivery of clinical preventive services.
Faith-based organizations	May provide venues, volunteers and transportation for community-based events.
Colleges and universities	May provide students nurses for SPARC events.
Senior service agencies	May provide venues and volunteers for community-based events.
Community and ethnic advocacy organizations	May provide translations of health education materials and may promote disease prevention events with their constituencies.
Cultural, communications, and media groups	May develop and distribute outreach materials and help create and organize "draws" for disease prevention events.



Trust from community agencies often must be earned. You can invite them to the table, but until it becomes clear that you are not treading on their turf, they may remain “on guard.”

Convene additional collaborators

Host a meeting of interested organizations to jointly explore how SPARC can benefit your community and gain their commitment to initiate a SPARC program. You may also want to invite staff from the National SPARC Center and/or CDC's Healthy Aging Program to this pivotal meeting. They can help prepare a strong presentation, answer questions during the meeting, and provide handouts, materials, and resources to help you make a persuasive case.

"SPARC coordinators are great leaders with the ability to make you believe."

Pat Stumpf
Former Assistant to Director
Poughkeepsie/Dutchess County
Health Department

Suggested agenda items for this meeting are:

- *The problem: Low delivery rates for preventive services*
Present data on delivery rates and related disease and death rates
- *The causes*
Discuss the *opportunities and* challenges for the delivery of preventive services and the need for community-wide responsibility
- *The SPARC program*
Present SPARC's mission and approach, examples of how other communities are implementing it, and program outcomes
- *The local commitment*
Explore opportunities for using the SPARC approach to meet local needs
- *The next steps*
Field questions then determine as a group if you wish to proceed with SPARC development. Ask for suggestions of other organizations and agencies that should be approached to join in implementing SPARC and agree to reconvene soon.



Use language and tone to convey a true sense of partnership. If you bring people in as partners, they must actually be partners. Avoid being directive or authoritative; collaboration and true buy-in from everyone at the table is key. Prospective partners will need to understand clearly that this will be an ongoing, active collaboration.

Figure 7. Potential Members of SPARC Steering Committee

SPARC convener
Aging service provider
American Cancer Society affiliate
American Diabetes Association affiliate
American Heart Association affiliate
Area agency on aging
Breast and Cervical Cancer Early Detection Program
College or university
Community advocacy groups
Employer or business
Faith-based organization
Fire departments
Home health agencies
Home-delivered meal programs
Hospital
Local election authorities
Mayor and county commissioner
Medical practice groups
Medical society
Parks and recreation programs
Public health agency
Public housing authority
Public relations/marketing firm
Senior centers
Transportation agency
Visiting nurse agency
Volunteer clinics
YMCAs and YWCAs





Have you convened potential SPARC collaborators? Have these agencies made a commitment to serve on the SPARC Steering Committee and take responsibility for delivering clinical preventive services to your community?

If so, schedule your first official meeting of the Steering Committee when you will jointly design your community's SPARC. Then proceed to Step 3.

Step 3: Design a SPARC for Your Community

Each Steering Committee should address six key program design questions:

1. What community will be served by your SPARC Program?
2. Where will you target your efforts?
3. What clinical preventive services will you offer?
4. What delivery strategies will you use?
5. What sites are best?
6. What incentives will draw residents?

The answers to these questions will help shape Step 4: Plan SPARC Evaluation; in fact, both of these design steps are interdependent and must be completed before launching program activities.

Define initial SPARC community

The Steering Committee establishes the geographic boundaries of the community your SPARC program will serve. The area could be as small as a neighborhood or census tract, or as large as the entire state. Whatever you choose, stick with boundaries that exist naturally and avoid creating artificial lines and borders. Start with an area that you can handle with available staff and resources, knowing that you can expand as you gain experience and confidence.

Determine where to target efforts

Your next decision is whether you will serve everyone in the community or focus on certain underserved populations. Will it be all adults, those aged 50 to 64, those 65 and older? Will it be just residents who live or work in a certain neighborhood? Are there areas of your community where service delivery has historically been very low?

“We feel successful if we’ve served people who haven’t been to the doctor.”
Jessica Gill
Health and Wellness Coordinator
Atlanta Area Agency on Aging

Are there ongoing programs or recent policy initiatives that have goals similar to SPARC, perhaps in such areas as health and wellness, healthy aging, lifelong communities, transportation and housing, physical activity and

nutrition? If so, is there a way that SPARC can dovetail or coordinate with them?

Select clinical preventive services to deliver

Review the list of core clinical preventive services recommended at the A (highly recommended) or B (recommended) level by the USPSTF for all men and women aged 50 years and older (see Table 1):

Influenza and pneumococcal vaccination
Screening for breast, cervical and colorectal cancer
Cholesterol and high blood pressure screening.

Select those that you wish to focus on in your targeted community. The services you pick will depend on the age group you are targeting, available data on rates of service delivery to that group, and the services that your collaborators on the Steering Committee can provide.

In addition, plan ahead to ensure that everyone who comes to get these services will be able to take advantage of them and that no one will be turned away because of financial considerations. Consider the full range of payment and reimbursement options available to your collaborators and the residents to be served: Medicare, private insurance, fee for service, sliding scales, or free of charge.

Again, start small; strive for what is most doable, knowing that you can add more services later after your program is more established.



As the convener, remember that your role is to facilitate, provide direction, and gain consensus among Steering Committee members. What can and can't be done? Who is best situated to provide what service? How do providers work together for smooth and seamless delivery?

It will be challenging to keep collaborators aligned with the SPARC model and focused on recommended clinical preventive services. Do your best but remain flexible. Additional services may be needed to keep partners engaged and supportive (e.g., screening for bone density, osteoporosis, vision and hearing loss).

Be prepared for changes of heart and conflicting priorities, and adjust accordingly. Don't assume that every partner will step forward just as you anticipated.

Design delivery strategies

Once you agree on the services to be offered, select the best strategy for delivering them. Which community settings will you use to make these services as easy as possible for your

intended population to access and use them (linkage)? Will you offer more than one service at the same time (bundling)?

Examples of delivery strategies that have proven effective in bringing the benefits of clinical preventive services to all community residents follow.

Linking cancer screening to community-based adult immunization clinics

SPARC has shown that annual influenza clinics represent a feasible and efficient setting in which to promote breast cancer screening among older women. Because economic barriers to receiving flu shots are minimal (influenza vaccinations are usually given free or at low cost), flu clinics typically attract women across a broad racial, ethnic and socioeconomic range. Combining these two clinical preventive services creates an opportunity to boost the use of a service with lower utilization rates (mammograms) through its link with a service with higher rates (flu shots).²¹

- ✓ Interested SPARCs should visit the website, www.sparc-health.org, and download the *SPARC Implementation Guide for Offering Access to Breast Cancer Screening from Community Flu Shot Clinics*.

Immunization outreach campaigns to expand delivery of flu shots and pneumococcal vaccinations

More than 10 years of experience with adult immunization campaigns that deliver flu shots and pneumococcal polysaccharide vaccine (PPV) to high-risk adults has demonstrated that multifaceted organizational campaigns are effective if adapted to local healthcare delivery environments. Moreover, jointly offering these vaccinations has proven to be highly cost effective, to lead to substantial health benefits, and to reduce mortality from all causes in persons age 65 and older. SPARC has been among those agencies in the forefront of evaluation efforts to document the practicality of these efforts.²²

“Because of the regional approach, we were able to facilitate movement of influenza vaccine. Some providers ran short; we knew who had excess. SPARC could connect the haves with the have not’s.”

Virgil Stucker
President

Berkshire County Community Foundation

Delivery of Fecal Occult Blood Tests (FOBT) at flu shot clinics²³

In a recent study in San Francisco, a random sample of residents attending flu shot clinics were offered FOBT kits by nonphysician staff and encouraged to use them within [time

18. Shenson D, Cassarino L, DiMartino L, et al. Improving access to mammography through community-based influenza clinics: a quasi-experimental study. *Am J Prev Med* 2001;20(2):97-102.

19. Shenson D. Putting prevention in its place: the shift from clinic to community. *Health Aff (Millwood)* 2006;25(4):1012-1015.

20. Potter, Phengrasamy, Hudes, McPhee, Walsh. Offering Annual Fecal Occult Blood Tests at Annual Flu Shot Clinics Increases Colorectal Cancer Screening Rates. 2009.

frame?]. Results showed that those offered FOBT kits had higher colorectal cancer screening rates than those flu clinic attendees who did not receive such kits. Annual flu shot activities thus represent an ideal opportunity to increase rates of a second preventive service—colorectal cancer screening.

Vote & Vax

Each fall, millions of Americans vote at local polling places. The majority of them are 50 years of age or older, a key population for whom the influenza vaccination is recommended. In 2008, the Robert Wood Johnson Foundation funded the first nationwide Vote & Vax effort to deliver flu shots at polling places. With SPARC technical assistance, 21,434 voters were vaccinated at 331 polling places in 42 states and the District of Columbia. Almost 70% of vaccine recipients were in priority groups (e.g., uninsured, African American, and Hispanic adults) and almost half were “new” flu shot recipients.²⁴

- ✓ Interested SPARCs should visit the website, www.voteandvax.org, and download the program resource guide, *Vote & Vax: Setting Up a Successful Clinic in Your Community*.

Do any of these strategies resonate with your Steering Committee? Discuss additional options and come to agreement. Then think about additional partners to engage in the SPARC effort.

What agencies, besides those represented on the Steering Committee, could help to provide these services to your target group?

The program is well thought out and grounded in science. I tried strategies – successfully, I might add – that I never would have tried without SPARC. And we can tweak the program as needed to fit our community’s particular needs.

Pat Stumpf

Former Assistant to Director
Poughkeepsie/Dutchess County Health Department

Choose sites for delivery

As for ideal community settings in which to deliver services, the sky’s the limit. Your goal is to pick settings that your targeted residents can access easily, as part of their routine of daily living. Where do people congregate? Where do they go during the course of an average day? What social activities do they engage in? What sites are most convenient for them? Is parking available or can they easily use public transportation to get there?

Brainstorm with your Steering Committee, considering such sites as: churches and synagogues, food pantries, firehouses, schools, public housing, worksites, community centers, senior centers, beauty salons and barber shops, post offices, farmers markets, polling places, and grocery stores. Decide which services will be offered at which sites, and determine the timing so they are scheduled evenly throughout the year. Plan transportation for older residents or

17. Shenson D, Adams M, Benson W, Clough J. Delivering Vaccinations at Polling Places. Abstract No. 2284. 44th National Immunization Conference (NIC), Atlanta GA. April 20, 2010.

persons with disabilities; ensure medical referrals or follow up are available for people with positive screening results.

Agree on marketing and promotional strategies

For some adults, the inherent value of preventive services (staying well to enjoy a longer, healthier life) is enough of a “draw” to motivate them to get these services on a regular basis. If this were the case for all adults, rates of delivery would be closer to 100%. To attract residents to SPARC events, consider additional incentives such as:

- A farmers market offering fresh fruits and vegetables
- A free foot massage from a local podiatry program or massage therapist
- A drawing for movie tickets, sports event, gift certificate, or cooking class
- Haircuts for free or at reduced cost.

Then develop a communication plan to get the word out and encourage community residents to participate. Draw on your Steering Committee’s experience and expertise; organize those members who are most interested into an Outreach Subcommittee to take responsibility for this critically important component of your SPARC program. Print pamphlets, flyers, and posters and include the names and logos of all your collaborators. Distribute them strategically to attract the attention of your target audience; have leaders in the community, people that residents recognize and respect, hand them out.



As a newcomer, it is tough getting into neighborhoods and churches and earning people’s trust. Sometimes you need to find community “insiders” who are willing to volunteer to pass out flyers and help with recruitment.

The farmer’s market (or the foot massages, haircuts, etc.) may be the big draw for some, while mammograms and flu shots may motivate others. Vary your advertising and promotions to have wide appeal.

Often one organization on your Steering Committee will volunteer to take care of a particular task, e.g., developing posters to promote SPARC events. Encourage collaborators to do what they do best. You might also want to formalize the outreach effort by establishing a subcommittee of the Steering Committee.

“Energy comes from the camaraderie of partners and the flow of community folk . . . from the student interns who are learning as they help . . . from the local farmer giving out fruits and vegetables as people leave. . . .”

Regine Denis
Aging Services Program Manager
Fulton County Human Services Department
Atlanta, Georgia



Have you mapped your community and designed your SPARC strategies?

If so, identify any additional organizations that you need to engage in your SPARC program and plan your first event. Proceed to Step 4.

SPARC vs. Health Fair

When SPARC events are in full swing, they often resemble traditional health fairs. Rectangular tables line the walls of a large room; folding chairs are set up on one side for healthcare providers and on the other for residents receiving vaccinations or signing up for mammograms and other screenings. Additional chairs are grouped in the center of the room for those waiting their turn to be served. Large posters near each table identify the services being offered, ranging from a handful to a wide array that encompasses screenings for chronic diseases; counseling for nutrition, obesity, depression, and smoking; and vaccinations for current strains of influenza.

However, this is where the similarity ends.

Participants in a health fair are random; SPARC participants are targeted purposefully to attract adults who might not otherwise receive preventive services. Health fairs rely primarily on walk-ins, people who have heard about the health fair and choose to attend. In contrast, SPARC identifies the target group, chooses a time and place convenient and easily accessible for them, and uses its network of collaborating community-based agencies to get them there.

Providers in a health fair are independent and changeable; in SPARC, they are consistent and coordinated. Health fair providers staff their respective tables but are not connected to one another in any formal way. They may show up for one health fair but not the next. In contrast, SPARC providers are part of a larger, ongoing community-wide effort and are invested in a common purpose.

Leadership in a health fair is provided by a single agency that hosts and organizes the event; in SPARC, a neutral “convening” agency provides leadership and coordination. This agency does not actually deliver preventive services but instead serves as the overall manager, organizer, catalyst and facilitator to ensure service delivery by others. In addition, a SPARC is guided by its Steering Committee, comprised all participating providers who are engaged and invested in the planning, operation and monitoring of the SPARC.

Coordinated network of activities is not a feature of a health fair, since services are usually isolated offerings; in SPARC, services come with the promise of follow up and connections to the participant’s medical home. Health fair providers offer their services at a point in time, with no commitment to helping the resident secure needed diagnostic or treatment care. In contrast, SPARC is committed to ongoing service delivery, constantly seeking new convenient places to offer services. In addition, when SPARC services are provided to an adult who has an established relationship with a healthcare provider, a description of those services and screening results are sent confidentially to that provider so that appropriate follow-up action can be taken within the context of the “medical home.” Adults without a medical home are referred to available community resources for follow up.

Data collected in a health fair are minimal; in SPARC, they are more substantial and help to assess numbers served and referrals completed. Health fair organizers typically track attendance and pamphlets or brochures distributed. In contrast, SPARC conveners monitor the volume of services delivered, to whom, and with what result. In addition, they share these data with their collaborators and jointly use them to evaluate success, make adjustments in strategy, and plan future events.

Step 4: Plan SPARC Evaluation

One of SPARC’s strengths is its ability to get into an action mode quickly. Very little data collection is needed up front and, with only a modest investment of time, you can track progress delivering services to your community. Giving some thought to evaluation early on will put you in a better position to examine your efforts.

Select initial evaluation questions

When first beginning your SPARC, keep your evaluation simple and uncomplicated. Focus initially on how many services you delivered and to whom, and on any barriers you may have encountered – in other words, process evaluation. Ultimately, your SPARC evaluation should also address outcomes (to what extent have we improved service delivery?), but this type of evaluation is more complicated and can wait until your program is well underway.

The RE-AIM framework (Figure 8) focuses attention and critical thinking on essential program elements that can improve the sustainable adoption and implementation of effective, evidence-based programs and policies (Green & Glasgow, 2006).

Reach: the extent to which a program attracts its intended audience.

Effectiveness: the extent to which program outcomes are achieved.

Adoption: the extent to which intended settings (such as community-based organizations and clinics) are involved in a program.

Implementation: the extent to which different components of a program or policy are delivered as intended. It also includes the time and cost of program delivery and is sometimes referred to as intervention fidelity.

Maintenance: the extent to which the program continues to be effective over time for participants, and is continued or modified by adopting new settings.

“We began by envisioning what we could accomplish and making sure there was enough energy in the room.”

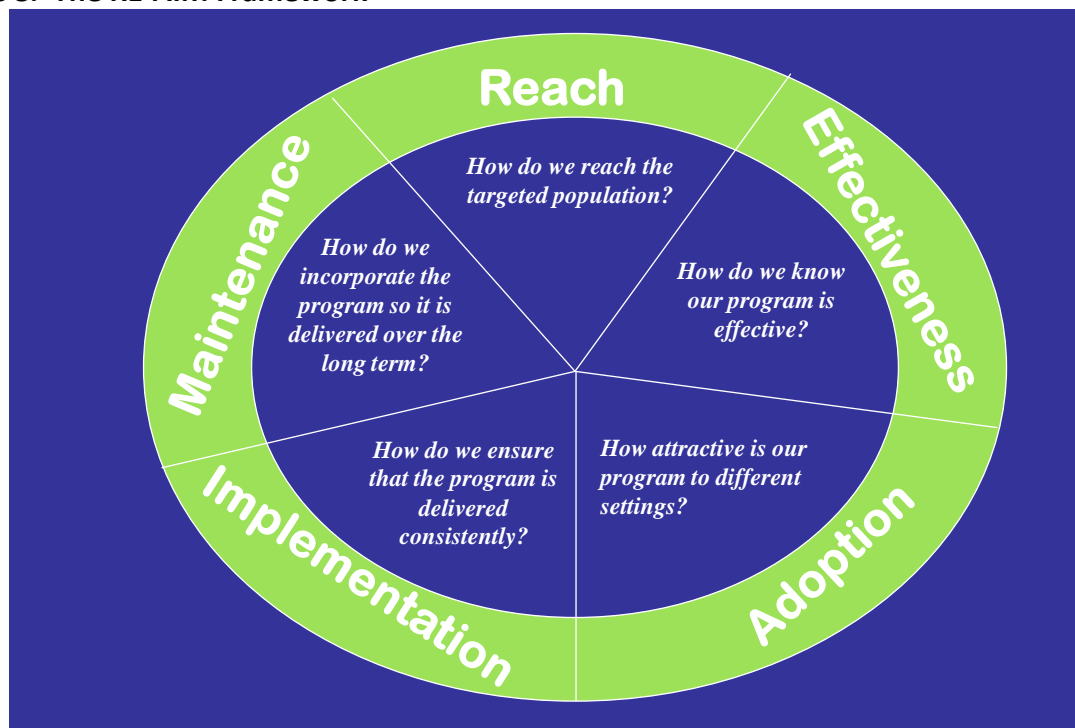
Virgil Stucker
President

Berkshire County Community Foundation

For each of five core elements—*Reach*, *Effectiveness*, *Adoption*, *Implementation*, and *Maintenance*—RE-AIM offers critical questions to help program planners, evaluators, and policy makers maximize their chances for successful translation of evidence-based interventions (see Table 4). Work with your Steering Committee to review the RE-AIM questions and select those that you most want to track. Keep your list short and manageable, knowing that you can add more questions as your SPARC evolves. Involving them in this process will help gain their support for needed data collection, provide cohesion among them, and boost their ability to re-engage when results are available. Usually, several members with a particular interest in

evaluation will be willing to form a small evaluation subcommittee to take responsibility for investigating further options and connecting with other organizations that may have access to relevant data.

Figure 8. The RE-AIM Framework



Plan to collect and analyze SPARC data

For each evaluation question you've selected, identify the data you will need to answer it and how you will collect it. One of the simplest methods is a survey of participants in a SPARC event. On one page, and in just a few minutes, you can collect information from participants on gender, age, race/ethnicity, health conditions, insurance coverage, reasons for attending the clinic, services received, etc.). You can also use surveys to collect information from your collaborators on their experience, including barriers and suggestions for improvements.

Again, involve your Steering Committee or the Evaluation Subcommittee in this task. Limit the data collection to only the essential items, those that you will actually use to answer your key questions.

Decide what comparisons you want to be able to make, for example:

- Over time: How many more services have you provided this season or year than last year?
- With another area: How many flu vaccinations have you provided compared with a neighboring county or city, the state, the nation?

- Between SPARC events: How many mammogram screening appointments were scheduled at the church-sponsored SPARC compared with the SPARC at the low-income housing project?

Begin to gather available state and local data

To assess the impact of your SPARC program, you want to know what percentage of your community's residents is receiving preventive services – and how that percentage improves over time. For this, you need rates of delivery, for example, the number of flu vaccinations provided to residents 50 years of age and older divided by the total number of residents in this age group. If your community is a large city, Metropolitan/Micropolitan Statistical Area (MMSA), an entire state, or the District of Columbia, there are several resources that can help you determine actual rates of service delivery (see Appendix B). These include:

- *CDC's State of Aging and Health in America*
<http://apps.nccd.cdc.gov/SAHA/Default/Default.aspx>
- *Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships*
http://www.cdc.gov/aging/pdf/promoting_report_tables.pdf
- *The Behavioral Risk Factor Surveillance System (BRFSS)*
<http://apps.nccd.cdc.gov/BRFSS/>
- *The Selected Metropolitan/Micropolitan Area Risk Trends (SMART)*
<http://apps.nccd.cdc.gov/brfss-smart/index.asp>

However, for many communities, particularly those at the county or smaller city level, accurate population figures (the denominators) are not yet available. Consequently, you must rely on absolute numbers of delivered services to assess your impact. Strive to get local numbers that are easily accessible and let them serve as your best estimate for now. Some examples include:

- Number of colonoscopies performed in local hospitals in the past year
- Number of flu shots delivered last season by local physicians and healthcare providers
- Number of Medicare claims for mammograms

Over time, you will be able to refine these numbers and work towards population-based rates.



Collaborators have an important role in sharing data and must be willing to provide data from systems within their control. For example, the visiting nurse agency or health department might share numbers of flu vaccinations provided last year, or the area agency on aging may know how many adults over age 60 live in your community.

Table 4. Core Elements of the RE-AIM Framework and Suggested Questions

Core Element	Possible Questions
<p>Reach is the extent to which a program attracts its intended audience.</p>	<ul style="list-style-type: none"> • What are the characteristics of those residents who participated versus those who did not? • Did those who received services have to overcome any barriers? If so, what were they? • What were the most common barriers preventing local residents from participating and how might they be addressed? • What percentage of the targeted population (those who are intended to benefit from the program) actually participated?
<p>Effectiveness is the extent to which program outcomes are achieved.</p>	<ul style="list-style-type: none"> • Are you achieving the outcomes that you set? • Is your program equally effective for racial and ethnic minorities? • Are there any adverse consequences from implementing SPARC? • What characteristics of collaborators are enhancing or detracting from effective implementation?
<p>Adoption is the extent to which intended settings (such as community-based organizations and clinics) are involved in a program.</p>	<ul style="list-style-type: none"> • How many collaborators have participated in SPARC? • What percentage of appropriate settings participated in your programs? • How have you developed organizational support (funding and in-kind contributions) for service delivery? • What are the specific characteristics of the settings that participated in the SPARC? • What are the benefits to the chosen settings of participating in your program? • What characteristics of the settings constitute minimal requirements for delivering the program successfully? • Are there any reasons that settings choose not to participate? • What are the reasons that some settings are more successful than others? • Is SPARC perceived as a benefit to participating organizations?
<p>Implementation, sometimes referred to as intervention fidelity, is the extent to which different components of a program or policy are delivered as intended. It also includes the time and cost of program delivery.</p>	<ul style="list-style-type: none"> • Which SPARC strategies are most challenging to deliver as intended? • Can staff with different sets of expertise implement SPARC strategies so that they are delivered consistently? • What parts of the program can be omitted or adapted without compromising program success (and which cannot)? • What is the cost to deliver SPARC events?

Maintenance is the extent to which the program: 1) continues to be effective over time for participants; and 2) is continued or modified by adopting new settings.

- What is the cost to maintain the SPARC program?
- How many collaborating agencies continue to support SPARC after the first year?
- What were the characteristics of those agencies that continued and those that did not?
- How can SPARC be sustained over time?



Have you selected initial evaluation questions and planned to collect data to answer them?

If so, it's time to implement your planned SPARC events. Proceed to Step 5.

Step 5: Manage SPARC Implementation

Once your plans are in place, you are ready to get out in the community and begin delivering preventive services. The keys to a successful, ongoing SPARC program are: coordinating and monitoring planned activities, nurturing partnerships, securing needed resources, and sustaining and expanding impact.

Coordinate planned activities

Get to SPARC event sites early and greet all collaborators as they arrive. Make sure everything is in order, sufficient numbers of tables and chairs are arranged properly, all needed supplies are available, and all collaborators are doing what they have committed to do.

Handle any issues that arise during the event and keep things moving smoothly. Then, at the end of the event, wrap up by thanking everyone, cleaning up, and collecting any paperwork for referrals and evaluation.



If there is a relevant SPARC manual for your selected program, refer to it often.

Some examples:

- *Vote & Vax: Setting Up a Successful Clinic in Your Community.*
- *SPARC Implementation Guide for Offering Access to Breast Cancer Screening from Community Flu Shot Clinics.*

Nurture partnerships

As you are aware, sustaining strong relationships is critical for a cooperative effort such as SPARC, not only with your collaborators but also with the medical community at large and internally within your own agency.

- Schedule Steering Committee meetings on a routine basis, with subcommittees meeting more often if necessary to accomplish their specific tasks. Communicate in between meetings with phone calls and emails.
- Recognize collaborators' contributions publicly and thank them often; give credit where credit is due. Share progress and successes in local publications, and involve collaborators in presentations throughout the community.
- Reach out to physicians and healthcare providers in your community and keep them informed about SPARC plans and events. Continue to build a strong relationship with your local medical society. They may perceive you as competitors, so listen carefully to their

“SPARC frees us to take care of sick patients.”
A local physician

concerns and reinforce their vital role as the “medical home” where SPARC patients will be referred for further diagnosis and treatment of disease. Share data on current service delivery numbers and rates to make the point that there is enough work in the prevention business for everyone.

- Know who your constituency and supporters are—and stay connected to them. The benefits of preventive services are invisible, so you need to draw attention to your successes and give credit to those collaborators who earn it.



Since SPARC requires you to spend much of your time and energy outside of your organization, you may discover that your greatest “uphill battle” is within your own organizational walls. Keeping your agency’s leadership informed about and engaged in SPARC activities is essential.

Not every project will have relevance to all Steering Committee members. They will naturally align and coalesce around the services, locations and target groups that fit their mission and interests.

Be patient. It may take 9-12 months to bring the partners together and build trust. Plan regular meetings of the Steering Committee, as needed, to iron out program details. Supplement meetings with communication through emails and phone calls to reinforce shared understanding and direction.

Secure needed resources

As your SPARC matures, you will undoubtedly identify gaps and needs that hamper your ability to continue SPARC events on an ongoing, routine basis, and expand into new areas of your community. Your agency may wish to seek public and private funding from donors, foundations, and other potential sources to bolster SPARC activities. The SPARC program can best be sustained over time if it has dedicated staff and funding.

If your budget allows, an able part-time assistant to the Program Coordinator would make a significant difference in planning day-to-day logistics and program activities. This individual should be detail-oriented, highly organized and persistent while also being comfortable working with a wide variety of community agencies and healthcare providers.

Sustain and expand impact

Your ultimate goal is to institutionalize SPARC throughout your community, weave it into the fiber of your organization’s mission and philosophy, and make it a routine method for delivering preventive services. Your job is to be ever vigilant to new opportunities to expand preventive services: new venues, new collaborators, new communities, new sites, new services, and new strategies. Consider monitoring expansion by posting a large map of your community on your office wall, then marking sites where vaccinations and screenings occur.

Some additional ideas for expanding your SPARC’s impact are to:

- Identify local data sources with potential for tracking service delivery rates on a population basis
- Explore ways to use current and emerging medical records and other e-technology to send annual reminders for recommended vaccinations and screenings
- Adding new services as they are recommended by the USPSTF and ACIP for all residents of a certain age and gender
- Conducting research to expand our knowledge base on SPARC and identify new and improved ways of delivering preventive services to all.

SPARC keeps us focused on preventive strategies in the midst of so many competing priorities. An individual agency couldn’t do it alone. We are not competing. We are all working together. SPARC is invisible but essential in getting our work done.

Pat Stumpf
Former Assistant to Director
Poughkeepsie/Dutchess County Health Department



Plan for staff turnover: Cross train one or two staff to fill in when the Program Coordinator or other key staff are sick, on vacation, or no longer working with SPARC.

Although it draws on innovative strategies, anticipate burn out: SPARC’s success relies on regular, consistent offerings of the same set of services in the same settings at the same time of year. Because of this repetitiveness, you (and some of your collaborators) may need more variety. Consider rotating responsibilities so that others have a chance to contribute.

Beware of mission creep: Similarly, your success with the core set of preventive services may tempt you to consider offering additional services recommended for certain specific high-risk groups. Staying focused on the core recommended services will be the best way to substantially increase coverage in your community.



Are you interested in sharing strategies, lessons learned, and outcomes with other SPARCs?

If so, visit the website, www.sparc.org, to join post your insights and learn what other SPARCs are doing across the country. Welcome to the national SPARC initiative!

Appendix A: National Expert Panels

The U.S. Preventive Services Task Force (USPSTF), first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the Agency for Healthcare Research and Quality (AHRQ), is the leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Its recommendations are considered the "gold standard" for clinical preventive services.

The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for clinical preventive care. The Task Force grades the strength of the evidence for delivery in clinical settings from A, strongly recommended, to I, insufficient evidence to recommend. Each of the core clinical prevention services included in the SPARC program are rated at the A or B level. For more information, visit <http://www.ahrq.gov/clinic/uspstfab.htm>.

The Advisory Committee on Immunization Practices (ACIP) consists of 15 experts in fields associated with immunization, who have been selected by the Secretary of the U. S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control and Prevention (CDC) on the control of vaccine-preventable diseases. In addition to the 15 voting members, ACIP includes 8 *ex officio* members who represent other federal agencies with responsibility for immunization programs in the United States, and 26 non-voting representatives of liaison organizations that bring related immunization expertise.

The role of the ACIP is to provide advice that will lead to a reduction in the incidence of vaccine preventable diseases in the United States, and an increase in the safe use of vaccines and related biological products. The Committee develops written recommendations for the routine administration of vaccines to children and adults in the civilian population; recommendations include age for vaccine administration, number of doses and dosing interval, and precautions and contraindications. The ACIP is the only entity in the federal government that makes such recommendations. For more information, visit <http://www.cdc.gov/vaccines/recs/acip/#about>.

Appendix B: Data Sources

- ✓ *CDC's State of Aging and Health in America* report assesses the health status and health behaviors of U.S. adults aged 65 years and older and makes recommendations to improve the mental and physical health of all Americans in their later years. The report includes national- and state-based report cards that examine 15 key indicators of older adult health. Data can be viewed by region, state or MMSA.
Visit <http://apps.nccd.cdc.gov/SAHA/Default/Default.aspx> to obtain data on the 15 indicators and compare older adult health for the nation, your state, the District of Columbia, a region or an MMSA.
- ✓ *Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships* highlights data and opportunities to broaden the use of clinical preventive services among adults aged 50 to 64 years in the United States.
Visit <http://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf> and http://www.cdc.gov/aging/pdf/promoting_report_tables.pdf to obtain data on state by state percentages for key indicators.
- ✓ *The Behavioral Risk Factor Surveillance System (BRFSS)* is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors.
Visit <http://apps.nccd.cdc.gov/BRFSS/> to obtain data on prevalence and trend by state, year, and health problem or risk factor.
- ✓ *The Selected Metropolitan/Micropolitan Area Risk Trends (SMART)* project uses the BRFSS to analyze the data of 143 metropolitan and micropolitan statistical areas (MMSAs) with 500 or more respondents.
Visit <http://apps.nccd.cdc.gov/brfss-smart/index.asp> to access local area health risk data for an MMSA by year and category; generate reports that compare your statistics to a different MMSA; and view local area quick-view charts that show state, MMSA, and county data for a limited set of health risk factors, including smoking, obesity, and diabetes.
- ✓ *The Older Americans 2008: Key Indicators of Well-Being* report provides the latest data on the 38 key indicators selected by the Forum to portray aspects of the lives of older Americans and their families. It is divided into five subject areas: population, economics, health status, health risks and behaviors, and health care.
Visit http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/Data_2008.aspx.