Public Health Institute Webinar

Dialogue4Health Web Forum:

A New Road Forward: How Hospital, Public Health and Stakeholder Collaboration has Changed the Community Health Landscape

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>> Hello and welcome to A New Road Forward: How Hospitals, Public Health and Stakeholder Collaboration has Changed the Community Health Landscape. My name is Holly Calhoun, and I'll be running today's web forum along with my colleague Joanna. Closed captioning will be available throughout the forum. Nicole from Home Team Captions will be providing realtime captioning. The closed captioning text will be available in the media viewer panel. The panel can be accessed by clicking on an icon that looks like a small circle with a filmstrip running through it. On a PC this can be found in the top right hand corner of the screen and on a MAC in the bottom of the screen. In the bottom right hand corner, you'll see the show hide header text. Click on this in order to see more of the live captioning. During the web forum, another window may cause the panel to collapse. Don't worry, you can reopen the window by clicking on the icon that looks like a small circumstance well a filmstrip running through it. If you experience technical difficulties dial 866-229-3239 for assistance. Take a moment to write that number down for future reference. The audio he portion of the web forum can be heard through computer speakers on a headset plugged into your computer. If you have having technical difficulties regarding audio please sent a question in the panel and we'll respond to you. Please take a moment to complete the evaluation at the end as we need your feedback to improve our web forum. The recording will be posted on the web site at Dialogue4Health.org. We're encouraging you to ask questions. Simply click the

Q mark icon, type your question in and hit send. Please send questions to all panelists. We'll be addressing questions both throughout and at the end of the presentation. We'll be using the polling feature to get your feedback during the event. The first poll is an screen now. Select your answer and click the submit button. I'm attending individually. In a group of 2-5 people N a group of 6-10 people N a group of more than 10 people. Once you've completed it, please click submit. When you are done click on the media viewer icon to bring back closed captioning. Now it's my pleasure to introduce the moderator for today Matthew Marsom as Vice President for public policy and programs for the public health Institute he works to advance and support the public policy goals of organization's domestic and global health problems. He is -- programs. He is responsible for designing and implementing strategy for monitoring and influencing public policy, legislation and regulations affecting PHI projects and public health policy. Matthew, please go ahead.
>> Thank you very much, holly. Welcome to the Dialogue4Health web forum. We're thrilled today to have a truly stellar panel for us providing an credibly rich conversation. We're going to in a moment provide an opportunity to introduce our panel but first I want to thank the sponsors for today who are able to bring this web forum to you. The American public health association, prevention Institute, the public health Institute and trust America's health. We're thrilled today have a series of cosponsors able to join us today and help increase the risk today. I'm thrilled to Americas essential hospitals, the association of community health improve, alliance of community health plans, children's hospital association, Medicaid health plans of America, national Institute for health care management, soldier health and thank you to the cosponsors for support and participating in bringing you this to you today. We have an agenda in front of you. In a moment I'll briefly introduce the panelists. What we're going to do is hear opening marks. We'll have some research findings. We'll have an opportunity to hear from local, regional and national efforts to address the collaboration between the health care hospital and public health communities and then we'll have takeaways and a rich dialogue and discussion to provide a opportunity for you to participate through Q and A. The objectives are provide an overview of health improvement and community prevention. We want to underscore the value of collaboration between public health, hospitals and other key Stakeholders to improve population health. And learn about key state and national efforts to advance and spur -- we're going to hear the Kentucky study on a variety of hospital collaborations. We're going to learn about the Detroit regional infant mortality effort. We're going to hear from the centers from disease control regarding their current efforts to advance public health and other collaborations. There's incredible case studies we'll be learning about today. It's my pleasure to introduce our panelists. First, someone who has participated previously is president and CEO of public health Institute Dr. Mary Pittman. She's the CEO. Mary became CEO in 2008 and since its founding in 1964 she's actually the second CEO. She's guided a development of strategic plan to build strength and achieve greater impact on public policy and public health. PH circumstances named one of top places in the -- 50 best nonprofit workplaces in

the nation. I can attest to that. Our next speaker Larry Prybil is the Norton professor in health care leadership college of public health university of Kentucky. He's the Norton professor and the professor emeritus in Iowa we served as associate dean and senior adviser to the dean. Before returning to Iowa Larry held senior executive positions in two of our country's largest nonprofit health systems for nearly 20 years. Including ten years as CEO for a six state division of daughters of charity national health system. Larry received his masters and doctoral degrees from the university of Iowa college of medicine and a life fellow he in the American college of medicine. Next on our webinar shall web forum is Dr. Kimberlydawn wisdom senior Vice President of community health and eke quit and chief wellness and diversity officer at Henry Ford health system. She's the senior Vice President of community health and board certified emergency medicine physician. She's the chair of the endowment on multicultural health and appointed as Michigan's first state level surgeon general. In 2012 she was appointed by President Obama to serve on the advisory group of prevention, health promotion and integrative and public health. She's been on the faculty of university of Michigan's medical department. I'll also mention we'll thrilled that Dr. Wisdom served on the board of directors of public health institution. Pleased to have one of board members on the panel today. John Auerbach is the associate DIRECTOR for policy office of the associate director for policy centers for disease control and prevention. He focuses on the promotion of public health and prevention as components of health care and payment reform and health systems transformation. Prior to his appointment at CDC he was a distinguished professor of practices in health sciences. He was the commissioner of public health for the commonwealth of Massachusetts from 2007 to 2012. We're thrilled we could have you join us today and look forward to hear you from you. With that it's my pleasure to introduce Dr. Mary Pittman who will lead us through the first presentation with her opening.
>> Thank you very much, Matthew. This is really an exciting first in this web series to engage us in a dialogue about multicultural and multi-sector stakeholders. Looking at the issue of community health. The emerging models of population health are opening up new and transformative models for public health and health care agencies and professors to -- professionals to work together. The affordable care act as well as the growing burden and recognition of the burden of noncommunicable disease are driving the changes and opportunities. On this panel we'll share how then tire field is evolving to meet the new challenges. Thank you. The ACA has brought these to focus on the broader look of health. If one looks at the implementation of the affordable it has brought communities together to achieve the aim of better care, better care and lower cost. However we if we just focus on that without including other topics we might miss some of the critical factors that address the root causes of illness and disease and contribute to health and vitality. For many as you hear on the panel, this broader framing is part of the transformation of the community health landscape. Many of the opportunities in the ACA including the expanded Medicaid coverage, delivery system forms focused on the care through team-based care and including community-based prevention initiatives focused

on policy systems and environmental changes. Hospitals, health systems, government and philanthropy have invested in various demonstrations and pilots to test out ways we can build healthier communities. These efforts have spanned many decades and have resulted in models now being replicated and we're developing an evolving training and leadership program including one here at PHI helping communities figure out what is the best approach for them to bring together multiple sectors. We've developed new partnerships spanning disciplines and funding streams and all are focused on ways to prevent illness, develop strong sustainable systems for resilient communities. We're not there yet but you'll hear about stellar examples and approaches on today's panel. A recent survey by the ACHI of the American hospital association and the Public Health Institute in -- last spring found that 85% of the hospitals responded to -- responding to the survey reported strong or total commitment to population health and many of those hospitals have population health in their vision statement. Less than 20% strongly agreed that the hospital has programs to address the socioeconomic determinants of health. But what do they mean by population health? Well, one of the things we recognize and acknowledge is that the term population health means different things to different sectors.
It's important to understand the lexicon and the way the terms are being used when we try to work in a collaborative environment. Some health care organizations and insurance plans may think of population health in terms of managing clinical and often chronic disease and the outcomes of patients who are enrolled in a particular he provider network or plan. Hospitals may think of population health as living in a specific area, often the service area. As you see, there are many definitions of the term population health and while there isn't uniform agreement on the definition for the participates of today's conversation, we will use the definition that the Institute of medicine roundtable and population health has utilized which is the health outcomes of a group of individuals including the distribution of such outcomes across and within the group. While not part of the definition itself, it is understood that such population health outcomes are the product of the multiple determinants of health including medical care, public health, genetics, behaviors, associate factors and environmental health. Could I have the next slide, please? Let's look at some of the other definitions often associated when we talk about multi-stakeholder:race. First the term anchor institutions. This will be mentioned by Larry later. Typically they are part of local economy and social fabric. Typically they are colleges, universities, large non-profit organizations, community development institutions, banks. Anchor institutions often partner with businesses to build local jobs in the economy and typically they don't move locations. They are there for the duration. Second term often use is the backbone organization. As a separate organization dedicated to coordinating the various dimensions and supporting the collaborators involved in an initiative. It is important to note that the backbone organization has been identified as often central to effective classes. It usually is plagued by an entity that embraces the principles of servant leadership. That is they play the behind the scenes role supporting others who are doing the work, and making sure that that support allows the common goals and common

agendas to get done. The third time I wanted to review is multi-stakeholder partnerships. Often we talk about partnerships in this manner that result with a diverse group across different disciplines and different organizational sector, government, nonprofit, private, public organizations, community groups and often individual community members come together to address issues that affect their community. I want to provide very quick examples of collaboration between public health, hospitals and original key Stakeholders to improve population health N. Seattle, king county, familiar faces initiative, which soon ongoing initiative now. It started in 2013 in king county as a partnership between local government and community Stakeholders to develop a plan for an accountable integrated system of health and human service to support the high number of individuals who had had multiple jail encounters and who also have a mental health or substance abuse condition. The county founded the -- funded the local health department to convene this effort to collect the data, analyze and then redesign the system to support and serve this population. The county invested in the effort and they believe through system redesign they can achieve savings that can then further found the work and needs of this population. What is unique about this initiative is that the participants came together when they had previously worked in separate silos using different funding sources, different programs and perspectives to meet the collective charge and answer the question: Can we by bringing these sectors together focus on a set of shared outcomes and make lasting improvementses for the population? The data showed them they had high rates for those with four or more jail bookings, at least one medical condition and more than 50% were homeless. So in this effort, they decided to find a way to way to make a coordinated system of services, bring funding together and stop thinking about brick and mortar and look at how to create recommendations that cut across both policy and processes for the full continuum of services for this population. The second example is from New York state where the state was developing their prevention agenda and their framework for their delivery system reform incentive payment model. The shorthand for that is DSRIP. In New York what was unique is they use their prevention plan as a way to integrate into their Medicaid waiver program and focus on prevention under domain 4, which are population-wide projects. Examples were promoting tobacco use cessation among those with mental health issues. I lift those two examples up, and I don't have time to go into more, because they are illustrative of how those are coming together to change how Stakeholders can work across the different silos that existed in the past and bringing unique ways to bring funding streams together. I'm going to turn the session over to Larry Prybil. And just before Larry starts his presentation, we have poll number two up. If you could take a moment and answer poll number 2 and Larry will review his stellar study of how public health and hospital collaborations have been strengthening the work individuals have been doing. Larry, I'm handing it off to you.

>> Thank you very he much. It's really my pleasure to join this group today to talk about multi-sector collaboration. My assignment is to give an over view, a study by completed earlier this year on multi-sector collaboration that includes

hospitals, public health departments and other stakeholders. Hopefully in a compact way. I'll talk about the purpose of the study, how we constructed it and selected recommendations that emerged from our work. The genesis of this study was a conference we held in Lexington two and a half years ago that involved the executive directors of ASTO and the President of AHA. Talking about the need for more collaboration, for multi-sector collaborative efforts and raised the question could we find some of those and see what the lessons learned from the experience was. A team of us accepted that challenge and with the help of funding from RDBJF and other organizations we did a study directed at finding successful partnerships of a multi-sector nature, learning about them in in-depth and trying to extract lessons that would be helpful for others from their experience. The phases are outlined here. I think it's important just to underscore we began with looking at all the literature we could find in the health sector, business sector, other sectors in our country and other nations as well. What characterized successful partnerships? And what causes partnerships to not succeed? We knew on the front end that about half partnerships. That is activities where two or more voluntary parties come together on the own volition to address a common purpose. We know half partnerships fail. We were interested in finding successful partnerships. We tried to discern from the literature what characterizing successful partnerships. Using that as a template and with the help of many others, including most of the sponsors of the series we sought -- we sought applications, nominations from around the country. We wound up with 157 nominations we felt met our general criteria. We then went through a process of sorting them. We got down to about 63 and then we asked those for more detailed information about their measures, metrics and about their impact. We held our breath hoping that they would respond. We were happy that of 63, 55 provided it. We proceeded to continue the sorting process, finally getting down to 17 partnerships that we thought really had every indication of being extraordinary both in durability and success. Those were the ones we studied in-depth.

I want to display here what we believed to be the characteristics of successful partnerships. This is say distillation. In our study there's appendix that gives these in more detail along with the indicators. The indicators ever characteristics. We discovered eight. The important point is that whereas all partnerships don't work, they display all or most in a significant proportion of these eight characteristics have a much, much higher probability of succeeding. Up to 80, 85% of partnerships can succeed and survive if they display a health your quotient of these characteristics. I think at the root of all that is the confidence of trust based partners, community committed to the partnership. Without that partnership simply will not succeed. To the extent that partnerships embody the characteristics they are much more likely to succeed. Not a guarantee because partnerships are difficult, as all of us know. Partnerships are difficult to operate, but they can succeed if they display these characteristics. Of the final set we were able to study 12 they are listed here including the Detroit task force that Dr. Wiz will talk about in a moment well.

We got down to a smaller number we looked for diversity. They are located in 11

states. They are diverse in not only location but particular focus. Their missions differ. They are all focused on address and improving the health of the community they serve and they all include a broad range of partners. Those are the common threads and they've survived. They are durable. They proceed the regulations that called for joint community needs assessment. So they precede that. Very important development in our country. We're going to talk about a half dozen of our recommendations. We did our best to make all of our recommendations evidence-based. We're going to talk about six today quickly. The first gets back to the concept of trust. Partnerships are tough. We believe it's important to begin with a group of partners when begin with some previous relationship that led to some degree of trust among them. These partnerships need to expand and broaden the base if they are going to endure in working to improve the health of their communities. But it really isn't feasible to start out with 100 partners some who know each other and some who do not. We believe when you are out and about starting a partnership focused on community health or anything else that you need begin with a subset of partners who have a prior history of working together who have a collaborative instinct or orientation and then as you add partners to the equation, which you surely must to succeed, constant effort to build and maintain trust just as in this -- as in any partnership. If you cannot build and maintain trust, partnerships simply will not work. We found that in many of these communities, organizations that compete in other ways can find common ground in collaborating on community needs assessment. For example the quad city health initiative on the Iowa Illinois border. The health systems compete on everything. I know he the CEOs well. We studied them in-depth. They compete on everything in their communities, in the multi-city communities but they are absolutely committed and anchor institutions to supporting the quad city health initiative. The point is that one can compete and collaborate if the purpose is powerful enough and if you have a trust among those partners to work in a collaborative fashion. There we go. I advanced too quickly. We're on four -- advanced too quickly. We're on four. It has to do with the concept of anchor institutions Mary Pittman spoke about earlier. Community based partnerships focused on community health, need to build a strong base. You need many, many parties around the table pitching in on addressing your particular facet of community health you are focusing on. It's clear to us that to build a solid foundation and to assist in durability there need to be some organizations step forward that make a longer-term commitment that are power envelope their commitment. And many of whom contribute financially, economically as well as non-economically. In the quad city health initiative that I mentioned earlier the two health systems Genesis and unity point are anchor institutions for the quad city health initiative. Assist in many way. The CEOs sit on the board. They support it economically and non-economically in a very, very solid way. In other settings it may not be a health system or a health system and some other party. In portland, for example, a for profit invest your own company Intel. In this set of 123 partnerships there were multiple but I want to report that of all of the funding for the last fiscal year of the 12 partnerships we studied, 70% came from the participating hospitals or health systems. They all sought other

grants. Some had multiple sources of funding. Sustainable founding is a great challenge for all of them. But 70% of the operating funding for the previous year came from hospital and health system partners who stepped up as anchor institutions just as Henry Ford health system is for the Detroit infant mortality reduction task force that Dr. Wiz will talk about in a moment. As you build a partnership with, say, two parties or three, it's pretty easy to determine how decisions are made and how it's going to go forward. The two or three partners make the decisions. When you grow, when you add additional partners, as you must, school systems, business organizations, local government, other parties, health plans, as you build the structure and scope of partnership, it's critical that there be a -- we call you l -- call it a positive setting -- policy setting body. You may want to call the a partnership board or steering committee. The name is not important. The charter is important. But all of the partners need to agree that there will be a smaller group of individuals probably representing key anchor institutions and originals who set the direction for the partnership obviously in tune for the wishes of primary partners. In looking at the 12 successful partnerships, all of which endured, all of which have many challenges but are doing great work. There needs to be a mechanism for setting resource decisions, setting policy direction, providing priorities and dealing with issues or crises when they arise. So at some point without a policy setting body with a charter, the partnerships can deteriorate in sort of mass confusion which is not going to be helpful. The sixth recommendation has to do with population health and the definition of that which Mary spoke to so well earlier. I'm not going to repeat all what Mary said, but there's a vast array in this country of notions or interpretations of the term population health. Even in the partnerships that we studied, there was some of that variation on viewpoint, much less than you find in the communities at large. It's our believe -- belief that to inspire and provide clear understanding for your partners, it's paramount to define what you are going to mean by population health. Terms can have different meanings to different people. Misinterpretations or different interpretations can cause confusion or conflict. The idea of achieving clarity in definitions of terms, we think is really paramount in building a partnership of this nation including in the community at large unless we have common lingo and common understands, it's difficult to have a clarity and a focused direction. The seventh recommendation related to measurement and evaluation. It's not easy to improve community health. All of these partnerships have a somewhat different focus on what they are trying to address in the scope of their community health needs. Whatever the mission, what the goals of a particular partnership it's critical that the leaders develop measures and metrics and targets to keep track of where you are trying to go and are you getting there or not. In the case of partnerships that adopt big long-term population health measures to change.

It's critical that they adopt intermediate goals and measure tools to see if they are making progress toward the broader, longer term goals. And without that it's very difficult to know if we're making progress or not. And it's very difficult to inspire Stakeholders if you can not demonstration A what your goals and measures and metrics and targets are and, B, provide evidence based progress toward the it or

not. Clearly the recent RDBJ and Iowan reports are great contributions and advance the cause. Even these successful partnerships we studied are still on the journey of really nailing down measures, metrics and keeping track of how they are proceeding toward achieving their mission and gels. It's a great -- mission and goals. It's a great challenge for them. Which gets us to number eight. This is the last recommendation that I'll speak to today. The concept of impact statements. Without clear goals, measures, metrics and targets and evidence-based assessment of progress, you cannot have impact statements. But if we want the partnerships to deserve and generating sustainable funding from the community, from the anchor institutions, from health plans, from the community at large, from employers, they have to learn to put out in front of those Stakeholders what we call impact statements that lay out in a clear way, an evidence-based way, where we're trying to go in improving community health, the reasons for that, why it's important and the progress we're making. It simply is not possible to go to health plans or the business community or to nonparticipating health systems and ask for support and engagement, economic and noneconomic unless there's an evidence based -- the investment being senate majority leader a good investment that is going to result in a healthier community as we try to build a healthier America. Those are six of eleven recommendations. All are explained in more detail in our report which is available at the web site here on your screen. And I would just conclude my brief remarks today by saying that we came away, our team which is multidisciplinary came away from the study inspired by the work of the 12 partnerships including the wonderful work that Kimberlydawn Wisdom is doing in New York. It can only happen in a multi-sector manner. The -- manner. The problems are too big for hospitals to address alone. We must work together. We viewed the 12 partnerships we selected out of 167 nominations. As harbingers with hope in the future we came away inspired and convinced that multi-sector partnerships are not the magic answer but they are part of our getting to a better place in this country. The old ways are working in silos have not worked. They are not working. We need to do better and multi-sector collaborations focused on some facets of community health we believe are a promising part of our future. So thank you for the opportunity to share these thoughts with you.

>> Thank you, Larry. Before we go to Dr. Kimberlydawn Wisdom. I want to remind -- Kimberlydawn Wisdom are being followed. There's been a rich presentation from Larry and Mary before hand and we'll hear from Dr. Wisdom and John Auerbach. I want to remind to you send in comments and questions for the panel. Following the presentation we'll hear from the panelists. Please send in comments and questions below so we have an opportunity to hear from you as well. With that we're going to move to Dr. Kimberlydawn Wisdom and hand the presentable to Dr. Kimberlydawn.

>> Thank you for the segue to the next portion of webinar here. I want to thank Larry on behalf of Detroit infant mortality reduction task force for including us in the study. We're honored to be included and delighted to share with you today the power of an unlikely partnership that was developed to achieve regional transformation as relates to the health of women and children in the Detroit area.

Holly, I'll need assistance advancing my slides. Wonderful. I want to achieve by the end of this presentation have the members participating gain an understanding related to why our -- what we consider a game-changing partnership is more than a cameo role. The Detroit regional infant mortality task force was established in 2008 at the request the Henry Ford health system CEO and three other colleagues from the Detroit medical center, Oakwood and St. John Providence.

They called charged a group of us to address the credibly high infant mortality rate that we see in Detroit. On average 200 babies diaper year within the city of Detroit. Nancy knew that several of us had a lot of passion around the work. That was one of charges that the governor had given me in terms of addressing that cross the state. Combined with experience and passion amongst people in our community we launched the Detroit infant mortality reduction task force to address infant mortality and the related social determinants of health. We had health systems involved, public health organizations, academic partners as well as community-based partners. What is key the health system partners are competing partners, which you'll learn more about as I progress through this presentation. The task force objectives was to assess the city. Our decision to address infant mortality meant that we needed to understand the landscape of the city and clearly understand the extend of the devastating statistics that I shared. 17 community health workers trained by one of our partner organizations the Detroit department of. Community health workers are considered our frontline workers and we decided to utilize them to address the issue due to their ability to navigate both the community they are committed to as well as systems and organizations. Of the 17 trained, we actually hired six that we called community re-- navigators. Also part of our effort related to the task force was to provide health care equity training to physicians and providers and deliver resources to the membership to influence quality at the system and policy level as well. Planning efforts got underway immediately in April of 2008. The Detroit regional infant mortality task force had its first meeting. The task force was assembled -- consisted of key leadership decision makers amongst the various organizations able to move things forward in a way that would not work so well if all mid-level and entry level professionals were involved. The inputting continuous feedback has been essential in shaping the game changing proposal that we ultimately wrote that you'll hear about shortly and was critical to the ongoing success of what we call throw up the safety net or the win network Detroit. This represents some of the groups and nongovernmental leadership as well. The task force began with a comprehensive inventory of programs that serve women at risk for low birth weight or preterm infants. We found 100 separate programs to support women and infants. And we also found that many of these programs were under subscribed and it was pretty astounding realizes that so many programs existed and many of them were not well utilized. That was when the task force knew that we needed to find a way to close the gaps of communication and service and hence throw up the safety net was born in a vision of reducing stopping infant mortality. Some are listed here. Community health worker leaders, leaders from various other organizations as well as other

organizations such as the Michigan association of health plans.
The top photo was taken at the Robert Wood Johnson visit which was one of the funders. Here we outline the funding partners.
The task force completed a Robert Wood Johnson Foundation in a 2010 with local funding from the KRESGE foundation. The hospitals came to the table also as funding partners. Competitors working together to reduce infant more tally. It was quite inspiring to the philanthropic community. In the only did the funding come through but funding from the university of Michigan school of public health, PNC bank foundation and a substantial grant for the Kellogg foundation. This demonstrates the portion of work as well as commit and trust of organizations. The total funding over the last six years has been in the order of $3.4,000,000. The items that you see asterisks of the names are the anchor organizations of the task force. These community level partners are truly helping us make the decisions we need to make in the lives of the women we serve. We get together formally and informally to leverage resources, share information and just help support each other's work because we have the common goal of improving the lives of people in our community. The traffic force member roles have been defined as connecting with non-traditional contributors to health. Realizing that health is much more than health care. Health occurs where people live, work, learn and play. Also establishing an ongoing learning collaborative. Also associating for policy and system level change. We know he at a program level we can have impact but we have to look regularly at how to influence policy and system level changes through addressing collective impact framework. Looking at social determinants of health, looking at long-term strategies related to the reimbursement of the provider type, the community health workers. I just want to address utilizing community health workers. Community health workers have the unique ability to knave gate communities and organizations.
It's because of their ability that throughout the process of the objectives of throw up the safety net or win network Detroit they have the task force of changes and amendments as well as what is work well and what is not working well. The brand evolution. You hear me referring to the effort as throw up the safety net and that brand occurred when we talked to women in the community.
When we submitted the grant, the funders throw up the safety net residents well with them and resonated with the team that submitted the grant. However, going out to the community to implement the program, the name did not resonate well with the community. Women were wondering where they falling through gaps why did a safety net to be sewn up. It moved from sew up the safety net to the win network. Women said we're inspirational. We're winners. We're resilient and resourceful, so have a name that reflects who we truly are. This helps with brand evolution and relaxing boundaries to include neighborhood associations. First with we within clearly defined neighborhood boundaries and we relaxed some. They have also been instrumental in assisting management and the task force in maintaining, appreciation and nurturing key community partnerships. The role of community health workers, begun see listed there. And they he are natural helpers, trusted workers within the community that played a major key role in terms of addressing infant mortality reduction in southeast Michigan.

Also civic engagement has been very key and a major contribution of the community health workers. As you see here we have the WIN network Detroit community mosaic mural. It's one of effort that's community health workers assisted us with. This depicts 5,000 very small tiles that have been aggregated to create this mosaic. Each of those tiles were drawn by people in the community as well as people in health systems academic institutions, community based organizations as well as Vice Presidents and senior Vice Presidents within health systems. Also the civic engagement. We have engaged the women to be involved in volunteer experiences, mobilizing the community and involving all in advocacy efforts as well. At this point I want to share a -- at a very high level some of our data. As you can realize when working with pregnant women they are steadily delivering babies and we're monitoring the babies when they reach the first year of life. We take snapshots in terms of looking at the data, aggregating it and reporting it in snapshots. This is summary between January 2012 and December of 2014. We had over 1,000 web site visits. We engaged 364 pregnant women were enrolled in the program. As of that date we had 200 live births. We had zero infant Dialogue4Healths of the delivered or one year out. We -- zero infant deaths of the delivered for one year out. This is a relation of low and very low birth weight participants in looking at the WIN data and the data versus the overall Detroit statistics from the health department. If you look if he first two bars that really represents that snapshot of data of Detroit and WIN. You can see the prevalence of babies with lower weight. Then we have the neighborhoods represented. You can see that in two of those three neighborhoods WIN rates were much lower than the overall Detroit rates.
If you look at the third neighborhood it looks a little different because the Detroit data represents white women as well as Latina women. And the other communities were primarily African-American. Our study very much focused on the African-American community where we see the overwhelming majority of infant deaths occur. And those are infants that die before the first birthday. In terms of additional information the average age at birth is 38.3 weeks. We're trying to achieve the 39 week level, 89% full-term. The average birth weight was nearly 7 pounds with only 12% low birth weight. Only 13% of babies use NICU mostly multiple births. We had five twin births represented in the numbers of zero preventable deaths. At a public policy level we've been looking at what is occurring nationally and identifying opportunities we would have locally in Michigan to have a sustainable model related to the funding of community health workers. Nationally we could see we wanted to provide support for community health workers beyond the grant cycle. We learned a lot from the work and the legislation that occurred in Minnesota. Also the federal register changed for community health workers in 2003 stating that various states providing the Medicaid departments were in agreement with that you see the Medicaid expansion that only occurred in some states. Increased provide your and managed care plan and community health workers. In Michigan, we felt it was some of what a breakthrough. We understand we may be the only state doing this. In the Medicaid reed by this year -- rebid this year it was required that the plans have one community health worker per 20,000 members. Also throughout

the state of Michigan two well attended Stakeholder forums that occurred at the state capital looking at how statewide multi-sector collaborations could address the model. We're working close by the Michigan community health worker alliance that is working towards standardized training and the community health worker certification process. I'll mention briefly partnership benefits, challenges and opportunities as well as lessons learned over the last many years related to our work with the partnering organizations and community health workers.
How do we engage great partners?
We tried to be a great partner. We base our goals and strategies on addressing community health needs as well as assets. We used a population health approach. We also talk about focus on shared wins, what we can do together and what we can't do apart. Look at how we can sustain, scale replicate and the also choose metrics from mutual accountability and ongoing community and reporting is what we regularly evaluate. Partnership organization funding partners which is key, having decision makers at the table, playing to the strengths of each partner. I can go into more detail on that during the Q and A period. If you work in an equity lens it's important to be transparent and integrate same messages programmatic successes throughout the integration, equity policies and understanding the determinants of health and impact on at-risk populations. Here are some of the challenges and opportunities that occurred. I really want to focus on the importance of building trust. That is something that you don't build at the beginning of a relationship and then feel you have got it. It's an ongoing process. We have to build trust, share date why and you are regularly addressing market issues. There's many opportunities to learn and to practice population health approaches and evolve as we learn more, gain more tools and skills in working together. We also have the opportunity to share at multiple national forums. I really appreciate the picture here which represents all four of the health system partners as well as the community health department partner. You can see he there we presented at many national meetings. And this represents the CEOs or four health systems involved that had to come together as we were submitting the final application and going through the application with the Robert Wood Johnson organization. In conclusion, with he when we talk about a game changing partnership what that partnership truly is is much more than a cameo role. At this I'll turn it over to holly and look forward to entertaining questions.
>> Thank you Kimberlydawn for that presentation and we'll good to John Auerbach momentarily. I would like to bring up slide three if I can and -- should be on your screens momentarily. I want to encourage you top respond to the poll.
This is a can he -- to respond to the poll this is a key question because this helps us determine the sort of technical assistance, education and follow-up that you might find useful. What are the biggest challenges you are currently face something in sustainable funding, meaningful trusting partnerships, building consensus, sharing language or developing relationships or all of the above? Please do respond to the Q and A. Sorry the call and if up additional examples to share please share those in the Q and A option as well. So with Senate poll

question done I'd like to move up to the final panelist John Auerbach with centers for disease control. John, it's over to you.
>> Well, thank you very he much, Matthew and hello, everyone. Representing the centers for disease control. I'm pleased to share our perspective on this important issue. I would like to highlight that there are two main reasons that I'm particularly pleased. One is this discussion relates toes to one of key directions we've identified mainly strengthening the public health care collaboration. These defined broadly to include other members of community that distribute in a meaningful way to promote health. The second reason is because this is an unusual time period that we're in. It's really what I would refer to as a sentinel moment of American health with regard to health. I would share with you, just as a reminder of what the indications are, that this moment is particularly important and focusing on what we can do at this moment to promote policy that makes a difference in terms of health is key. First of all we've seen a dramatic increase in the percentage and numbers of people who have health insurance within the country as a result of the affordable care act and other state based activities. This slide shows you some indication of what the changes have been in a relatively short period of time. It looks at the population by race, age, gender and educational level. In just one year the green bars representing those uninsured in the country compared with the blue bars representing the uninsured in 2014 has decreased a statistically significant amount. That's not just true based upon these categories of the population, it's true across the country. We didn't know it would be the case initially. We thought just the states expanding Medicaid would see significant increases. But as you can see from this slide those states that have coloration, blue coloration had statistically significant increases in the percentage of the population who were insured. Interestingly the dark blue represents the states with the largest increase. Those include some of the states where there was not, in fact, a Medicaid expansion but increase in access for other reasons. Happily, that increase also resulted in indications of increased access to primary care providers in patient centered medical homes. This chart shows that across the country there were 11 states that showed a statistically significant increase in the residents of those states that reported they had a usual health care provider meant as an indicator of having a primary care provider. By the way, these charts are all from the latest survey of the behavioral risk factor survey by CDC. We haven't released all the data widely but we're sharing them with you for many of you for the first time. We're also seeing not just an indication of increased access to insurance and increased access to primary care providers but seeing dramatic changes taking place with regard to how we pay for health care. As we move away from service to value-based contracting. One indication of that has to do with this chart which shows states that have received funding from the CMS innovation center to make dramatic changes through the model. To the extend that the entire resident was state will receive insurance value based and 80% of the entire residents of the state will be cared for by a patient centered medical home. The innovation model grants, by the way, total $1,000,000,000 and significant changes are taking place within those states. I will point out that the state innovation model requires that each of the states that

receives funding also has to have a population health care. Changes taking place with regard to reimbursement has to do with Medicaid waivers. You heard mention earlier of Medicaid waiver impact. A particular type are called the delivery system reform Medicaid waivers. The blue states here, seven states, are indicated as doing very dramatic changes within the Medicaid programs. And then the final indication of dramatic changes is a sobering one. While there are terrific opportunities with increased access, new payment meddle and patient centered medical home delivery systems, we are sadly losing funds in the public health domain at the state, local and federal levels when compared to the funding levels just a few years ago. And this is just one indicator of those. It's a chart that was from a survey by NACHO. Where the reporting locals indicated the budgets decreased in a one-year period. They've heard there have been many jobs lost in public health, the survey found indication of more than 50,000 jobs lost since 2008. These changes are occurring. Opportunity but also sobering indicators of reduced funding for public health. It does make sense to consider how does public health and others at the community level focus their attention at this time to have the greatest impact on population health. I would suggest that there are two things to pay attention to. One is that public health and community providers should strive to focus on population health work of different types. Not a single type. Not a single definition. I'll get into what the different types should be. That doesn't mean every organization or coalition should with you it -- but it does mean that there's a range of different components of population health that should be he addressed within each community. The second point I would make is that if public health and community partners are coming to the table with health care providers and with insurers and broadening those coalitions, they have to come in with clear value added -- this is particularly true with the statewide efforts that are focused on changing reimbursement systems where the potential exists to pay for more prevention or population health approaches. Getting to the table is very important but once at the table having clear value that can be contributed to the proceedings with specific concrete recommendations proposals and information is very important. I'm going to now shift to talking about -- each of which is important to work in as I mentioned earlier. The first bucket is traditional clinical approaches. These are the type of clinical activities that have long been paid for by insurance through the fee for service system. They include such things as immunizations, screening for cancer, colonoscopies, a screening for other indicators of risk and then responding to the indicators appropriately. Even though we know those have been often available paid for my insurance, it doesn't mean that think of been well utilized or that providers have consistently offered those services or that insurers have prioritized them. This slide is one indication of that. This slide shows what CDC refers to as the ABCs and it looks in each category where we know someone is at risk, what are the indications that that health problem is being addressed. Here I would just highlight for you the blood pressure we're only at 50% of those people diagnosed with hypertension that are in fact having their hypertension controlled.
That is a major problem controlled given the seriousness as a medical condition and a cause of this slide shows those who have high blood pressure are airwave

it, being treated and have it controlled. What does this mean in terms of population, health and prevention? It means we shouldn't lose sight of the fact that we have work to do even for people who have good those work to be done to Mick sure appropriate services are offered and utilized and we have to work with the broadest patient populations and we have to work with health care providers. One indication of. It just shows there are targeted efforts shown to be effective that community coalitions may want to consider that may want to take advantage of clinical services and work in a coalition in a targeted way to try to improve care. At CDC we have tried to offer tools to help local coalitions and multi-sector organizations determine where they should start if they are looking for places to start in terms of focusing on traditional measures and we focused on six high burden areas, the ones shown in this slid and culled the information from CDC and from across the country and we've identified 18 different interventions which are solidly evidence based by which we mean in this definition, they will show -- the evidence is that they will improve health and or control costs within a relatively short period, five years or less and the evidence is solid and has been confirmed. We think that is important because when approaching providers and insurers and making the case, we want the evidence to be there. While this is called the 618 project the 6 referring the to high burden areas over time the numbers are change. We'll probably keep the name of 618 but keel keep adding interventions where the evidence base is strong so that we can promote that and provide tools to those working in a community setting. Here are just a few of examples of what the traditional proposals are. I won't go into them. I second bucket is what I would refer to as innovative patient care. This is a category that becomes possible as a result of the fact that we're making the very big change of moving from fee for service to value-based contracting. It offers the opportunity that when we see evidence, sometimes at the community level and pilot programs, when we see evidence that something works, we can more effectively make the case that insurance should pay for that even if it has not historically done so. Here, too, with the 618 initiative, we are pinpointing those efforts that have a strong evidence base and were providing those tools to groups if they are looking for evidence, looking for materials that allow them to go to the payers and providers. What are some of the examples under patient -- under the innovative patient care category. One of them relates to what Dr. Wisdom was referring to earlier. Here we're highlighting on this slide there's a strong evidence base for the use of community health workers in providing home visits, education and also remediation of some of the triggers to childhood asthma for children moderate to severe asthma the evidence is strong here that that we document that you can reduce cost and improve health in a short amount of time if you pay for this. The goal is move from the innovative programs like the ones that have been done in Detroit to scaling up by getting the health care system to pay for some of these efforts that have historically been funded by public health or other types of grants. One additional approach under the second bucket involves addressing hypertension. What I was mentioning earlier hypertension is say problem. It uses, again, very strong evidence that shows that when patients have training in how to measure their hypertension, they have the tools to do that they have

feedback and technical assistance and support then they are more likely to control the blood pressure than if they are given a -- this using a team approach that can include pharmacists or other ancillary provide yours. It gives the patients the opportunity to have monitoring home devices -- devices. Again here this would be difficult under fee for service but with the value based contracting trend that I was mentioning earlier, these kind of approaches are possible now to be paid for by insurers and scaled up. The third bucket is the community-wide or total population approach. This unlike the first two buckets is not patient centered.

It's community focused. So it looks at changing the conditions in the community, in the home, in the workplace in the school. This relates to a chart that -- a slide that you've seen many times, the doctor has developed this and indicates it that if we can operate at the lower end of the pyramid shown here it's possible to reach a larger percentage of the population and to reduce costs and improved health globally not simply within a particular clinical practice or among patients who are covered by a particular insurance program. So what would that look like if we were talking about asthma reduction? Here I'll mention all three buckets. The first is an accurate diagnosis, medication without cost sharing, the development of an asthma action plan in a traditional setting. The second bucket would include a community health worker who visits the patient. The example I gave is a family of a child with moderate to severe asthma and what triggers this the home that can be improved and education for the family and then the third bucket could be working on reducing triggers that exist in the community by working on such things as the housing code, indoor air pollution, citywide bans or other policies that reduce smoking or thinking about coordinated approach to integrated pest management which reduces what can be toxic pesticides within the community. The approach we would say with CDC's perspective would be working in all three buckets increases the likelihood that you'll have a measurable impact in a relatively short amount of time. Thinking of them as three buckets allows a coordinated approach so that what often is the most common approach doesn't dominate the most common within being what is paid for, what are clinical providers and insurers familiar with. This ensures we're operating in that arena in a constructive way but thinking about innovative approaches and community factors. Now going back to the community wide approaches, there are many different groups working on these now.

This slide lists some of them. Foundations, some statewide efforts in Oregon and other states. They are considering how to operate in all three of these buckets simultaneously including the community one. A new opportunity to work in the third bucket been created by IRS requirement that they have to do community health needs assessments and gap filling efforts in coalitions. That offers the opportunity to target hospital community benefits to identify health needs by the community that may fit -- well, particularly I would argue in the third bucket since bucket one and bucket two is more likely to be covered by insurance. So again all three buckets in the most effective way of making progress. We'll be developing tools that are -- making progress. We'll be developing tools use useful to you at all levels.

When I showed the slide about the IRS requirement there's a CDC-sponsored web site that the community health improvement navigator web site that you can google. That will give best practices, technical assistance, information and training opportunities for coalitions look together ways to work with local hospitals around community benefit linkage to community-wide efforts. The final slide that I would offer goes back to the point that I made early on that while we have a number of opportunities with expanding access and payment reform, we also have facing -- are facing decreased resources in the public health community. Happily there are very productive discussions taking place among public health commissioners to try to identify what are the core activities in public health are really needed everywhere? How can they be defined in this particular slide defined ooze foundational capabilities required in all communities and make the case that they should be and must be provided in order to protect the public's health across the board. They've been redesigned to they are much more consistent with the causes of premature death, hospitalization and disproportionate burden of disease now rather than what it was 100 years ago. And the thinking here is as we look at the different funding streams we need to think about which funding streams will siphon off funding from the health care sector to support population health work and where it's not possible how do we identify other ways of funding essential population health activities either through governmental fundings or some of the innovative approaches such as trust or pay for improvement social impact bonds and the like. With that I turn things back over to you, Matthew.
>> Thank you very he much. John. We are getting close to the hour and close to the end of web forum. We don't believe we'll have time go through the comments and Q and A. We can commit to ensuring we can collate the questions and have the panelists and sponsors and cosponsors address the questions and provide resources to make sure that all the audience has the opportunity to get the questions answer. A reminder that the audio and the slides available on Dialogue4Health.org you can go there to there to archive the web forums we've provided previously. I would like to bring back Mary Pittman to identify questions raised and key takeaways. Mary, over to you.
>> Thank you very much, Matthew. I know because of time we've gotten some stellar questions, and I apologize we can't go through them. But as Matthew stated, we will make a commitment to compiling your questions and having the panelists answer them and we'll send them out to you. There were some common themes that you heard. Obviously the issue of trust is a critical one for all the panelists. Blending different sources of funding, having clarity of change wig, measurement and data -- language, measurement and data. I really can't do justice to the really rich examples that were given by Larry, by Kimberlydawn and John. I think it's exciting to see CDC in particular moving to a more expansive definition of public health and the way that that is connecting with the clinical care. One of the questions that was presented was, you know, how do we make a business case for collaboration? I want to state from my perspective I don't think we want to spend our time trying to make the business case for collaboration but instead be working hard to establish the business case and look

at the return on investment for the work that the collaboration is doing to improve community health. Matthew I think given our brief time that we have left, I want to thank all of the panelists and suggest that we not try toll take on the rich list -- not try to take on the rich list of questions presented on the phone and on the web forum but instead to commit to having everyone please share your information with us so that we can send out via email the responses. And we will also post them on the web site.
>> Absolutely. Just a reminder as well. We do have. This is the beginning of a new series on Dialogue4Health. We'll have additional web forums where we're able to address the questions. We may be able to have these woven to the takeaway topics we'll have in coming weeks. I want to have an opportunity now to thank again the panelists for today Dr. Mary Pittman the President and CEO of Public Health Institute. Larry Prybil the Norton professor at the college of public health at the university of Kentucky. Dr. Kimberlydawn wisdom, and last but not least John Auerbach the associate director of policy at the CDC. Thank you to the panel and also in addition to that to thank the sponsors APHA, trust for America's health and originals for tremendous support and sharing and promoting this web forum and on going contribution, support and collaboration of the cosponsors. We're exactly on the hour. I want to thank everybody for their support including behind the scenes we couldn't have done it without them Joanna and holly with Dialogue4Health. We'll again be sure to continue this dialogue of it's just the beginning of this conversation. Thank you on behalf of dialogue for health and Public Health Institute. We'll look forward to continuing this conversation. Thank you so much and good day.