COMMUNITY-CENTERED HEALTH HOMES: A MODEL FOR BRIDGING CLINICAL SERVICES AND COMMUNITY PREVENTION
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>> Dave Clark: Greetings and welcome to today's Dialoge4Health Web Forum on community-centered health brought to you by the Prevention Institute, the Public Health Institute, and the Trust for America's Health. My name is Dave Clark, your host for today's event.

Before we get started, as usual, there are a couple of things that I'd like you to know about. First of all, realtime captioning is available for today's Web Forum provided by Home Team Captions. The captioning panel is located on the right side of your screen. It can be toggled on and off by clicking the Media Viewer icon you'll see on the top right of your screen or if you're on a Mac, you'll see the icon on the bottom right of your screen. If you would like to use captioning, you'll see a link in the panel that says Show/Hide Header. If you click that link, you'll be able to see the captioning more easily. If the captioning window ever disappears, just click the Media Viewer icon to bring it back again.

Concerning the audio, today's Web Forum is listen only. That means you can hear us but we can't hear you. That doesn't mean, though, that today's event won't be interactive. We'll have a Q&A session at the end of the Web Forum. And you can type your questions at any time into the Q&A panel. The Q&A panel is located on the right side of your screen and it can be toggled on and off by clicking the Q&A icon that you'll see on the top right of your screen. Again, if you're on a Mac, you'll see that icon on the bottom right of your screen. In the Q&A panel, it's very important that all panelists is selected if it doesn't say all panelists, choose that option, all panelists, so that your question gets sent to the right place. You can also use the Q&A panel to communicate with me and my colleague, Laura Burr, if you're having any technical problems like audio issues or anything else, just let us know and we'll help you out.

We're really interested in your thoughts and questions. This is going to be an interactive Web Forum. So get your questions into the Q&A panel. We'll try to answer as many of them as we can, I promise.

As a matter of fact, why don't we get interactive right now. Let's bring your voice into the conversation right now. We thought you might be interested in seeing who you're attending this Web Forum with today. We're going to bring up a quick interactive poll so you can tell us whether you're attending today's event alone or whether you're attending in a group. You'll see that poll appear on the right side of your screen. You'll be able to select from one of the four choices. And when you've made your selection, just click the submit button that you'll see down below the poll.

[Reading poll question from the presentation.]

Let us know are you attending individually, alone, or are you attending today all by yourself.

All right. Let's get those results up on the screen. Let's take a look at who is attending today's Web Forum. And if you're not seeing the results appear right away, just give them a few moments to

tabulate. They'll appear on your screen momentarily. If you made a choice and didn't click the submit button, you're going to see an option right about now to submit your answers. So go ahead and do that.

It looks like, not surprisingly, a high percentage of you are attending alone today, about 89%. And it looks like about 8% of you are attending in relatively small groups of two to five people. If you are attending alone today, if you're all by yourself, we don't want you to feel like you're there all by yourself. Like I said, we want this to be very much an interactive, immersive group event today. So make sure to get your questions into the Q&A panel and join in on the conversation.

Let's get started on our conversation of Community-Centered Health Homes. Our moderator today is Matthew Marsom of the Public Health Institute working to promote the global and health programs, responsible for designing and implementing strategy from monitoring and influencing public policy, legislation, and regulations affecting PHI projects and public health policy relevant to PHI interests.

Matthew will introduce us to the rest of today's speakers. So Matthew, over to you.

>> Matthew Marsom: Thank you very much, Dave. And thank you, everyone in our audience, for joining us today for this really interesting and important topic. As we look at a tremendous time of transition and shift in the United States, the implications for our public health and healthcare system, as well as the health and well-being of all Americans, is really at a time of tremendous transition and transformation. This discussion today, Community-Centered Health Home, will address critical questions about how are we bridging between these two worlds and look at best practices from around the country.

I want to thank and acknowledge our supporters today for their sponsorship of today's Web Forum. And I want to acknowledge the American Public Health Association, Prevention Institute, Public Health Institute, and Trust for America's Health. And they are on the screen right now. And I also want to acknowledge as well additional co-sponsors whose logo and names are on the screen and thank them for their ongoing support and for sharing and getting word out about this important Web Forum. So thank you to all of our audience.

And then importantly, I want to introduce our panel. We've assembled an incredibly top rate panel for the discussion today. I want to thank them for their time and for joining us. In fact, they're almost all new names and haven't presented before. We're grateful for them providing their expertise today.

First I want to introduce Rea Panares, a Senior Advisor with Prevention Institute, currently the Senior Advisor where she develops partnerships with practitioners, policymakers and thought leaders and strengthens healthcare practice to advance the Prevention Institute Community-Centered Health Home model. She monitors the related policies and practices and prior to joining Prevention Institute she was an independent health policy consultant working with organizations to take full advantage of the ACA and help positions with Families USA, grant makers in health, and the National Business Group on Health. So thank you for joining us.

Next we have Kyla Mor, Program Manager for Clinical Transformation at the Louisiana Public Health Institute where the focus on social determinants of health in particular leading the Community-Centered Health Home Demonstration Project. And previously she was a project manager at Johns Hopkins with a focus on care management and population health interventions for high-risk Medicare populations. Thank you for joining us.

Chandra Smiley will be joining us later in the conversation. She is the CEO of the Escambia Community Clinic, Incorporated, named Executive Director there in November 2014. She's been with the organization since 2007 and has worked in the areas of social services, community outreach, clinical services, grounds and business development. She graduated from Auburn University in 1997 with a Bachelor's degree in social work and Florida State University in 2000 with a Master's degree in social work. Thank you for joining us, Chandra.

Next on our panel is Dr. Eric Baumgartner, a Senior Community Health Strategist at Louisiana Public Health Institute. And Dr. Baumgartner is a career public health physician engaged in community and national activities focused on issues of health and access to care. In addition to his role at the

Louisiana Public Health Institute, he serves as a commissioner of the Louisiana Healthcare Commission. He has served in a variety of posts in state public health agencies in Mississippi, Hawaii, Texas, and Louisiana.

So Eric, you really have been all across the country in your role. So thank you very much for joining us.

And last but not least on our panel today, Sandra Donaldson, Director of Special Programs with Escambia Community Clinic. Sandra is the Director of Special Programs, and in Pensacola, Florida, and her role includes developing partnerships with key community organizations to integrate clinical service delivery with community prevention in order to improve health, safety, and health equity.

So thank you to all of our panel. It's my pleasure now as we get started in this conversation to hand over to the first of our speakers who will be leading -- I'm sorry, I missed one thing. I actually needed, first, to let you listening in our audience know who you are and where you're coming from today. Just on your slide right now I want to acknowledge that we have all 50 states represented in those who have registered today. We have Australia, Canada, and Ecuador represented. Thank you for dialing from overseas. And we have a majority of states with at least 20 audience members but quite a lot from California, which is very interesting for those of us on West Coast. And in terms of the spectrum of sectors represented, we have a real variety of organizations and sectors represented including nonprofits, city and county governments, state government, federal government, healthcare providers. So great to see such a real variety mix of different audiences represented today.

Just also a final reminder that all of the audio and slides for this Web Forum will be available to download on the Dialoge4Health website following the Web Forum.

With that, it's my pleasure to hand over once again to Rea Panares, the Senior Advisor at Prevention Institute. Over to you.

>> Rea Panares: Great. Thanks so much for that warm introduction and welcome.

Good morning or good afternoon, depending on where you're coming from. I'm so excited to be participating on this webinar along with our partners in Louisiana and Florida. We have almost 1,000 participants registered for this webinar so there is certainly a hunger and a thirst for this type of work and really finding strategies for bridging clinical services and community prevention. The more we go around the country discussing this work, the more we see this hunger.

I also just wanted to start off by acknowledging the foundation, early believer and supporter of this work, supporting much of our work around CCHH including our ability to do presentations such as this and also supporting our work with LPHI which you'll hear about shortly.

Prevention Institute started with the idea that while most communities have access to this, a place to get treatment in emergency situations, we wanted all communities to also have access to this, a place where people were constantly thinking about prevention and the practice of quality community prevention. This is a picture of our offices in Oakland, California. We're a national organization that works across the country to ensure that prevention efforts span the spectrum and specifically include strategies to change community environments.

We define quality prevention as comprehensive, so spanning the spectrum from individual behavior change to strategies and policies for changing community environments where people live, working and play, also including the voice of and wisdom of community residents, and making the healthy choice the norm and, of course, collaborative in nature.

More and more we're seeing healthcare institutions from the national level to the individual provider level recognizing that the determinants of health or community conditions matter to the health of their patients. This is important as it signals a different approach to healthcare for this nation. At the provider level, this sentiment is described by this quote from one of our colleagues.

"I diagnosed abdominal pain when the real problem was hunger. I confused social issues with medical problems in other patients, too. I have neither the skills nor the resources for treating them. I ignored the social context of disease altogether."

That's from one of our leagues, Laura Gottlieb. This is a sentiment we're hearing a lot these days. So we know we need strategies and solutions so that providers such as Dr. Gottlieb feel like they

do have the skills and, just as important, the resources at her disposal to address these issues for her patients.

So given her history and expertise, advancing the practice of community prevention along with this momentum we were seeing, a pretty unprecedented momentum we were seeing, around health systems transformation and healthcare institutions and organizations really interested in identifying how social determinant and community conditions were impacting their patients, we developed the Community-Centered Health Home back in 2011. We were asked by the Center for Care Innovation, the community clinics' initiative at the time, to document what safety net clinics were doing to improve community health. So we conducted research and did a series of interviews with clinics from across the country from places as diverse as Hawaii to South Carolina and in clinics that were identified as leaders in community health, those that were really helping to build healthier communities outside their clinic walls. And from those interviews, we saw a pattern begin to emerge and developed a framework and a core set of practices that were common to clinics engaging in community health.

So the original paper really provided a road map and some examples of how healthcare institutions can take an active role in making sure patients are living in healthy communities. And we've since begun to build on that and to build on the practice of Community-Centered Health Homes.

After that report we began to hear back from the clinics that characterized much of the work that they were already doing but described it in a systematic way that put a structure and framework around those activities.

The model has its origins in community-oriented primary care and the work of the doctors pictured here who opened up the first community clinics in the Mississippi Delta. We like to tell this story of Doctors Geither [ph] and Hatch when they saw that food insecurity and hunger were key issues in the community. They and their colleagues began writing prescriptions for food. Health center workers recruited black-owned grocery stores to fill the prescriptions and reimburse the stores out of the pharmacy budget. So they began stocking fresh foods and vegetables in the pharmacy and distributing the foods like drugs to the people. When federal officials got wind of that, they said, Umm, what are you doing? You can't do that. This is a health center pharmacy. It's supposed to carry drugs for the treatment of disease. And they said, "The last time we looked in the book, the specific therapy for malnutrition was food."

So CCHH gets us back to the simple concept of providing people with what they need to be healthy. Sometimes that involves prescribing medication for the treatment of a condition but that also means making sure there's a role for healthcare institutions and making sure that people have food to eat or safe places to live, work, and play.

The CCHH model builds off existing models like the medical home which has -- which says every person should have access to medical care in a timely matter, the patient center medical home which does a bit of a better job in trying to link patients to social supports and things outside the healthcare institution that can better manage care and possibly involve families. But the Community-Centered Health Home model takes these models a step further and works in partnership with other sectors to improve community efforts. And you'll hear more about the important role that partnerships play in this model from our speakers and from the discussion.

What we found by talking to clinics and others is that the CCHH model is more fluid than other models out there; that it really depends on the local context in which you are operating, the environment in this those communities, but that the CCHH model provides a framework of where to start or how to build off existing efforts and that the defining feature of a CCHH is a Community-Centered Health Home not only acknowledges that factors outside the clinic walls affect patient health outcomes, it actively participants in improving them.

So now here's the model pictured here. As I mentioned, it provides a framework for healthcare institutions to make the link between providing high-quality medical services and improving community conditions. And it includes three elements: inquiry, analysis, and action further broken down into core practices and activities.

So through the process of inquiry, a clinic might collect data on a patient's social, economic, or community conditions and then aggregate that data. So some simple examples might include adding additional questions to patient interactions, like on a patient intake form, convening regular internal discussions with staff so that staff at all levels can share reflections on the patient population from the nutritionist to the medical provider, perhaps even the receptionist or the health insurance outreach person, examining clinical data with external community data sources.

Through the process of analysis, along with community partners, a clinic would analyze that data along with, perhaps, other locally available data and identify any trends. For example, an increase in Type II diabetes among children may coincide with the closing of several local parks or an increase in crime in the neighborhood. Some examples might include sharing data available to community partners, participating in or convening meetings with community coalitions, and then regularly convening discussions with diverse community leaders.

And lastly, taking that information, a clinic could take action along with community partners. Some examples include providing testimony at city council hearings, informing patients about local campaigns that might affect them or state or national, and serving as an example by implementing a healthy and local food procurement policy.

For clinics implementing the CCHH model, we've identified four core capacities that provide a foundation for implementation. I'll quickly mention them here but we'll go into them a bit more during the discussion. They include adaptive leadership that prioritizes CCHH as part of its mission, vision, and operations, partnerships with community organizations and other external stakeholders, dedicated staffing for CCHH coordination and implementation, and staff knowledge of community prevention and healthcare's role in advancing it.

In the five years since we first conceptualized the model, we're happy to report that we're in the early phases of testing supported by several organizations and philanthropies. So the Blue Cross/Blue Shield of North Carolina Foundation is supporting work to advance the concept of community-centered health. Episcopal Health Foundation in Texas has launched the Texas CCHH Initiative in partnership with us here at Prevention Institute. And Louisiana Public Health Institute is funding five clinics in the gulf states region, which you'll hear from very shortly, hearing from one of those clinics.

So, just to wrap up my portion of the webinar, the best way to describe CCHH is really by highlighting the work of clinics around the country. So you have one representative from Escambia Community Clinic here today but I want to quickly go through a case study. The model was developed by a series of interviews with clinics and synthesizing what we heard. One was Aging Health Services, down the street from us in Oakland, California. Aging Health Services is located in a densely populated area of the city's historic Chinatown area. It's also one of the largest elderly populations in the city. And because of where it sits within the city, it's also one of the busiest in terms of car traffic. It serves as gateway to the neighboring city of Alameda and the port of Oakland. So you often used to see sights like this unsafe pedestrian crossings, not enough time to cross the street, particularly for elderly residents. And there was an unfortunate incident years back where the father of a board member was struck and killed outside the clinic. So this naturally spurred the clinic into action to reduce pedestrian injuries and fatalities in the community.

First, the Aging Health Services started with a health education campaign around pedestrian safety with clinics staff, informing patients about how to safely cross the street. But it went beyond that to the clinic assessing the community environment. So with the help of high school teenagers, Aging Health Services starting gathering their own data about traffic lights and street crossings. They timed traffic lights and intersections around the clinic and talked to residents and found the lights were a few seconds shorter than other places in the city; again, because it was an area with heavy car traffic.

So city planners had designed these lights to move car traffic through quickly not to ensure pedestrian safety. They then combined the data they gathered with feedback from focus groups comprised of community members who shared their perceptions of safety as pedestrians crossing the

streets. And while their initial goal was to educate patients about safe street crossings, they realized the physical environment ultimately needed to change to really improve pedestrian safety.

So to take action, a coalition was formed, led by the clinic, that worked together and included these diverse partners in the city officials, law enforcement, business owners. And they worked together to change traffic signals in the streets surrounding the clinic. And what they came up with was this, a scramble system in which traffic stops in four directions for pedestrian traffic, walkers can cross diagonally, which is much faster, and pedestrians are given more time to cross the street.

So this quote from the founding CEO of the Health Services says an ecological system approach can more effectively address a chronic public health problem, and health centers can function as catalysts of community and economic development. So this is one example of a clinic going beyond clinic walls to change their community environment, their immediate community environment.

This is listed as one of their resources. I just wanted to point to an updated document we did where we re-interviewed a number of clinics and updated the original report for some updated learnings and findings.

And lastly, I just wanted to end with a quote from a recent meeting we had with our partners at Episcopal Health Foundation in Texas where we brought together 20 community clinics to really learn more about the model and start the first phase of their initiative. It really got to the heart of what we mean by this CCHH model. And she says, "CCHH is not just what we do, it's who we are." It's really about a paradigm shift in thinking about the role of healthcare and healthcare systems in improving the health of their patients.

With that, I am going to turn it back over to Matthew. I just wanted to provide some quick info on where you can get more information about Prevention Institute.

>> Matthew Marsom: Thank you so much, Rea, for that great presentation and providing the important context for this conversation.

I now actually want to bring up on your screens poll two. Having heard the outline that Rea provided and the examples, I want to direct everyone's attention on your screens to the poll question: How would you rate the strength of existing efforts to bridge clinical services and community prevention within your organization/community/area?

And the answers are --

[Reading poll question from the presentation.]

Please do respond on the screen, click submit, and we'll bring those responses up in a minute. But I do encourage folks as they're sitting in front of their computer screens or on your iPads, make sure that you can click on the poll so we can hear from you and make this as interactive as possible.

Also, if you have examples of things that are working, areas that perhaps need improvement or challenges you had as well as successes, please use the Q&A feature. It's on the right-hand side of your screen. Send in your examples as well as questions for the panel as you're hearing the conversation today.

There we go. 71% feel the existing efforts to bridge clinical service and community prevention need improvement. So clearly there's a lot of work to be done which underscores the importance of this conversation today. So, again, please do share your comments in using the panel.

With that I'm going to hand back to you, Rea. I know you're going to introduce two of our panelists again and you're going to have a presentation from them and also a panel discussion. So back to you.

>> Rea Panares: Yeah. Great. Thanks again, Matthew.

I'm really excited to introduce Eric and Kyla, our colleagues from the Louisiana Public Health Institute. Matthew went into their impressive bios so I'm not going to go into them here. But I do want to intro their presentation by saying they've been one of our earliest partners in our work to advance the community-centered model in practice by really taking interest in the model early on. And they'll talk to you about how they are funding the first CCHH demonstration program in the country.

So I'm going to turn it over to my colleagues, Eric and Kyla.

>> Dr. Eric Baumgartner: Thank you very much, Rea.

Good morning and good afternoon, everybody. We want to describe for you our Community-Centered Health Home Demonstration Project out of the Louisiana Public Health Institute. A word about the institute, we were established 1997; we are a stand-alone nonprofit with a public health mission and we are a member of the National Network of Public Health Institutes. Across the portfolio of engagement that we have is work that has been working with community-based primary care for at least the past 15 years, from a variety of engagements and means of funding, we've been able to provide re-granting and supporting funds to clinics at over $100 million in this time, primarily to community health centers that are fairly qualified health certainties or look-alikes but we have worked with other community health centers that are not. In addition to providing operational support and funding, we provide technical assistance and facilitate a peer exchange.

One of the more recent funding engagements that we have been involved in is that of the Gulf Region Health Outreach program. This program was created by the Deepwater Horizon Medical Benefits class action settlement in U.S. District Court in 2013. And with this BP Oil company funding, the six-year funded program was created. We're now in the fifth year of the six years. In the settlement, it named 17 eligible coastal counties and parishes along coastal Louisiana, Mississippi, Alabama, and the panhandle of Florida. The program has five aligned projects, also including community engagement. And those projects are around working with primary care and integrating behavioral health and environmental and occupational medicine.

The work that we do that works across the clinics in all 17 jurisdictions in four states is called the Primary Care Capacity Project as one of the five aligned projects in the whole gulf region health outreach program. And the charge is to build high-quality, integrated primary care capacity as a means of contributing to the resilience of these vulnerable coastal communities. The focus on FQHC's and look-alikes has allowed us to work with clinics who already have a community mission and have a precedence for quality improvement projects and learning collaboratives. We are now about to go into our fifth year of support to the clinics, again with a mix of funding, technical assistance, and peer exchange.

When we established our approach to these clinics, at the beginning, four, five years ago, we laid out a frame of what our goals should be and created what we call the attributes of high-performing clinics. Our original frame for those attributes drew upon our usual approach towards patient-centered medical home, meaningful use, and behavioral medicine -- behavioral health integration. But it was just at that time in 2011, that the Prevention Institute's leading document on community-centered homes which was featured earlier came out. And with that, we saw it absolutely honored the fullest expression of the purpose of the Gulf Region Health Outreach program, Primary Care Capacity, in the community as part of the overall ability for communities to be sustainable and resilient.

And Kyla will tell you more about our CCHH Demonstration Project within the Primary Care Capacity program.

>> Kyla Mor: Thank you, Eric.

Hi, everyone. I'll tell you a bit about how we've managed to put this CCHH model into action. And as Eric mentioned, we value the CCHH to further our work at the time clinics and the PCCH program and we chose out to reach out to the Prevention Institute and work closely with them to develop a model and framework for a system and project. So it's turning the CCHH model framework into a demonstration framework.

We thought about, you know, what would PCCH look like in action in these clinics, what technical assistance would be needed to help them be successful, and what qualities or experiences should clinics possess already to ensure that they are ready for an initiative like this one.

Nine clinics applied to this RFP that we developed. And five were selected with representation across the four states that we were working with. And we chose to go with clinics who really already expressed as they saw themselves as CCHH, as community-centered and identified with the model already. So we have two clinics that are based in New Orleans, one in Biloxi, Mississippi, one in Mobile, Alabama, and one in Pensacola, Florida, which you'll hear from today.

The program kicked off in March 2015 and is going to continue through the end of April of next year. The award amounts to each clinic was $250,000 over the two-year period. And we've also offered a non-competitive mini grant or what we call the Community Grant to support the clinics in developing really a specific project or initiative with the community partners that they are working with so to encourage them to really get out into the action phase and create some early wins with our partners. And to support the clinics, as mentioned, we provide technical assistance in addition to that funding. And the bulk of our technical assistance really happens kind of in a tailored approach during coaching calls.

And you'll hear from Chandra and Sandra today from one of our clinics. They are really the authentic voice, I think, in talking about what the experience has been so far but what I can tell you about what we've learned so far and what we've observed in working with these clinics and reflecting with them, that they have successfully created clinic change both internally as well as in their external functions with their community partners. And they've done that to fulfill at least several components of the inquiry, analysis, and action phases that Rea described earlier. And they've all expressed that it's been a great experience so far and that they want to continue to reinforce both the work itself and the quality and themes of CCHH moving forward. And some of them have already found funding or found staff roles that will be able to continue that work moving forward.

And I can also say that LPHI is conducting a program evaluation that will allow us to look deeper in what the experiences and what the outcomes of interests are.

Now I'll pass it over to Chandra and Sandra at Escambia Community Clinics to tell you more about their experience as an awardee.

>> Rea Panares: Great, thanks Kyla and Eric. This is Rea again. I'm excited to introduce and hear from Chandra and Sandra of Escambia Community Clinic. We've kind of been going from, like, 1,000-foot level to mid-level and now we're really going to get into the level of how you really implement this model at the health clinic level.

With that I'll turn it over to Chandra and Sandra.

>> Chandra Smiley: Thank you, Rea. I first want to say that this has been a great experience for our organization. It's been a game changer for us and we're real excited to share with you the initiative that we have underway as part of our CCHH.

I'm Chandra Smiley, the Executive Director of the Escambia Community Clinics. And I have with me Sandra Donaldson, our Director of Special Programs.

So real quick, Escambia Community Clinics, we've been around for about 24 years. We were formed out of the closure of our local county-wide hospital back in the early `90s that primarily served our uninsured residents. And the two local hospitals and the county government came together and formed the Escambia Community Clinic to create or fill in a gap for services for our uninsured residents. So we were birthed out of a partnership of the hospitals and county. And we were primary care strictly for the residents of Escambia County. And in 2007, we became a Federally Qualified Health Center. And our service line grew from pediatrics to mental health, medication assistance, chronic care management, women's health, and our ability and increasing access to care went from serving about 13,000 lives to close to about managing 36,000 unduplicated patients.

But in 2015, we were granted the opportunity to be a part of the Community-Centered Health Home project. So I'd like to talk now about some of our initiatives. One is specifically targeted, Oakwood Terrace, one of our public housing communities here located in the 32505 zip code, where the majority of our patients reside.

Oakwood Terrace has -- it's a food desert, a high crime area. There is a significant lack of transportation, overwhelmingly social and economic situations that certainly drive our patients who reside at Oakwood success in being able to care -- or be involved in their healthcare. We did -- as part of a community schools project we conducted a community assessment specifically looking at the elementary school and community that Weis served. And at Oakwood Terrace, we discovered that a third of the elementary school students lived at Oakwood Terrace. And in that community, over 82% of the children are on or receive SNAP assistance. 32% of the households live in poverty. This community

has the highest level of child abuse and neglect reports at 47%. In 2014, almost 16,000 adults were arrested over 1400 youth. This is the highest rate of United Way 211 calls, request for utility assistance, food assistance, housing. It's the highest rated pediatric ER visits in our area. And, again, over a third of the students who attend Weis Elementary live at Oakwood Terrace.

This next slide is actually a picture of Oakwood Terrace. It's not really depicted very clearly but there's a wall that surrounds the entire complex. And a little over a year ago our local county commissioner really fought to have -- it was a barbed wire -- similar to what you see in prisons -- over the top of that exterior wall. He fought to have that removed. Recently we discovered that the mailboxes -- there were about 80 families who were not receiving their mail because the mailboxes had been damaged and they had not been receiving their mail for about six months. And so with the efforts with the owners, we were able to get some new mailboxes installed. These are families who are on public assistance and if they are not meeting their reevaluation or eligibility requirements, they're at significant risk of losing some of that assistance.

I'll turn it over to Sandra who will talk about our Wellness Cottage at Weis Elementary and how we are connecting Oakwood Terrace and the families at Oakwood into our community school project.

>> Sandra Donaldson: Well, as Chandra elaborated on, as far as our community efforts, Weis Wellness Cottage is a collaboration with the clinic, collaborated with three other partners to include Escambia County School District, the University of West Florida, and [Indiscernible] Home Society to address some of these social and health determinants inside of the school with children that are predominantly living inside of this project of Oakwood Terrace.

We realize that this particular community needed a more collaborative approach to some of the needs that the families were facing in regards to food, healthcare -- we're talking about educational needs as well as just the bare minimums of what families need to survive every day. So Weis Wellness Cottage is a clinic embedded inside of the school. And Weis Community School is a great effort in which ECC has been able to produce primary care to these children within the school where they can receive their immunizations, they can be seen for acute visits where they're treated, and they are back into class much quicker than they would be if the parents had to go through hurdles in order to get that child seen.

This is a direct access point in what a true CCHH project would look like. And that embedded services inside of schools, inside of the community, where we can meet families where they are, this is an opportunity for us to be able to collaborate with other organizations in regards to what these families need. We used it as a access point for services. It has been very impactful to the families and students of Weis.

There's a hyperlink embedded inside of this slide that is just a snapshot of what the services has been able to do inside of this school. I noticed on one of the polls there is an issue in regards to data that will help strengthen the effort to bridge clinical services and community prevention within your organizations. I think this will be a good visual for you to see exactly what type of that collaborative really looks like and how it will impact the families in which we all serve.

>> Rea Panares: Great. Thank you so much to our speakers: Eric, Kyla, Chandra, Sandra. This is Rea again, We have about 30 minutes to really kind of get into a facilitated discussion. We have some questions that we want to pose to the panelists and then we're going to open it up to questions that we're receiving from the audience. We're receiving a lot of good questions so we're combing through them now. And we'll be addressing them in about half an hour.

I first just wanted to start by asking Chandra and Sandra, just following up from your presentation and your description of your CCHH project, I want to talk a bit about making the case and making the case both to your board and what you needed in terms of making the case for embarking on this type of project but also staff buy-in. How did you educate your staff about this model, get buy-in, make sure they were understanding community prevention and the CCHH model?

>> Chandra Smiley: Ok. Are we on?

>> Rea Panares: Yeah. We can hear you.

>> Chandra Smiley: Thank you.

Really, part of making the case -- and it really goes back about two years ago. It was part of the introduction to the panel. I was named the CEO in late 2014. I've been with the organization going on 10 years now. So I was promoted from within but I took over an organization that recently had come out of a major financial crisis as well as an H.R. investigation. So morale was low. There were some insecurities felt throughout the organization. And here I was the new CEO.

So about the same time that I was named the CEO, we were beginning our journey with the Community-Centered Health Home Demonstration Project and looking at how might this model fit with the community schools and the efforts at Weis. One of the first things I did was I conducted an employee satisfaction survey just to get a finger on the pulse of where my staff were in terms of morale and communication in connection to our mission and purpose. And overwhelmingly, and not surprisingly, morale was low. Staff didn't feel that there was good, clear, consistent and transparent communication but there was a significant connection to our mission and our purpose.

At the time, we were at about 140 FTEs or employees. I had a 42% return rate so I considered that successful. And then what I did was I started with some frequent CEO briefs that went out to the entire organization and highlighted the things that we were doing at Weis. Our efforts at Weis not only included establishing a pediatric clinic but we partnered with the school district and Children's Home Society in securing funding to erect a playground that not only the children at Weis could enjoy during recess but would be a safe place for children and a community park for children to come and play during the weekend and summer months. Certainly going out to Oakwood and doing focus groups and hearing some of the needs identified was part of what was communicated back out to the entire organization.

Then in late 2015, I really sat down and put together a making the case, if you will, for CCHH for our senior staff. I needed my chief and my top-level staff to understand that what we were doing was not just a flash in the pan and that this was going to be a project that we were going to pat ourselves on the back and said we did something good but that this was going to drive who we are moving forward.

Then in January of 2016, at our annual board meeting, I rolled out the same presentation to our Board of Directors.

Frequently, as a matter of fact, Sandra is coming to our board meeting to report about the community-centered health.

I spent a great part of this past year going around to all of our sites -- we have 12 sites. We are now at about 213 employees -- going to every single one of our sites and showing that presentation, talking about how this is the next stage for us. This is the next chapter for this organization. As part of our onboarding and orientation process, community-centered health is part of the discussions to our new staff to understand that this is inherently who we are. We are right now going through our long-term strategic planning process. We're in the final draft of our strategic plan. And I plan to take that to the board in December.

And in that, it is overwhelmingly -- community-centered health is in our strategic plan. It's in our strategic plan as a rebranding, a rebirthing, if you will, of ourselves to the community. We're in a prime opportunity for us as an organization to reintroduce ourselves. Our main service site was significantly damaged in the 2014 April flood. We have been temporarily displaced since then. But this past year we purchased an old elementary school that's located and embedded within a neighborhood that's going to be our new main service site. We expect that to be a year process for renovation. And while we're doing that we're engaging a marketing company that's not just going to give us some sizzle and zing but is going to really spend the year with us in what they call branding from the core. And what that starts with is who are we as an organization.

And who we are is we're community-centered. That's our roots. That's who we are. And we want to be that neighborhood help facility for our patients. I say to my staff and I've said it frequently that we are looking at changing our culture from being a community clinic to the community's clinic. And locating our main service site out of a main thoroughfare but embedding within the neighborhood is what that truly looks like.

So making the case, it's a journey. And it's a continuous discussion. It doesn't stop. This type of work has to be a daily conversation and at the forefront of how we deliver care, how we reach and do outreach, how we do in-reach, and how we report out to funders and to our community partners and our Board of Directors.

>> Rea Panares: Great. Thank you so much, Chandra, for that really thorough and, you know, description of your systematic approach to making the case and really describing it more as a journey. I love what you said about really making the case that this isn't a flash in the pan project but it's really starting to drive who you are as a health center and the clinic. So thank you for that answer.

I want to move now and talk a bit about partnerships because we've mentioned it as part of the core capacities. We're getting a lot of questions in about the role of community-based organizations or local public health departments and others in the community. So I wanted to spend a bit of time with the panelists talking about this important role of partnerships because we know that partnerships is key and central to making the Community-Centered Health Home model work.

I wanted to start with Eric because we've had long conversations about this in talking about the model. Talk a little bit about building authentic partnerships as a core capacity of CCHH. Tell us a bit of what you learned over the course of the demonstration project and what it means. And then we'll turn it over to ECC to talk about -- a bit about a real-life example about what partnerships already existed and which ones you had to build.

>> Dr. Eric Baumgartner: Sure. Thank you.

And, yes, it is core to being community-centered. When we first started this demonstration project with our clinics in the Primary Care Capacity project, we borrowed language from the Prevention Institute monograph as well as some way that we were relating to clinics in our usual work with them to try to very much express what was consistent with patient-centered medical home about what we would encourage them to do but also went beyond that complemented that, and was distinct from the traditional PCMH suite of attributes. What we found is that a lot of the clinics really heard our words, which we thought were clear from our perspective, through the lens of their usual world. And that is, clinics were hearing partnerships around partners to help the clinic affect interventions that they wanted to do around population health management, chronic disease control, or community prevention through clinic strategies.

So with that realization and observation we revisited how we were describing this and then went back out and had conversations with the five clinic CCHH teams, including Chandra and Sandra. And we said keep in mind that where it is important that you continue to have quality improvement projects and where you continue to project ways based on the clinic role intervention, that you evolve your services. But being community-centered has some fundamental distinctions in that community-centered means the a-- community-centered means the community--- the priorities and strategies are set by the community. And who you even think about as community may require a little bit more reflection than when you typically are looking for implementing partners for a clinic intervention that has a role in a community setting.

So all the clinics, to their credit, started to reflect and say now we start to understand that what we're talking about is being part of what is really the aspirations of people in our community and stakeholders in their behalf who are trying to understand where there are disparate burdens of illness or disenfranchisement. And for those people who are trying to find community change agenda that would create circumstances that would improve health and independence and help mitigate some of those disparities in the community, how partnerships with those people, those change agents by the clinic could help bring new insight into community diagnostics or new action with the community partners to help them be successful in community change.

So in that, these clinics have had, I think, two new awarenesses and then acting upon that awareness. One is where they had relationships with people in organizations and in the community, they found now that they could get into a deeper agenda about what was going on from just a transactional agenda around programming to a reflective agenda around what community change needs to take place and then as Chandra may have a chance to tell more of her story, for these clinics

being in that sense of community-centeredness and a community-authentic agenda, realizing that they were not in relationship at all with some stakeholders whom are primary to the community interest and that the clinic would want to go ahead and initiate a new relationship with those relevant players. So each of them is on their own path, their own pace, of acting in that way in either deepening existing relationships or deliberately talking new relationship that relate to the community mission.

>> Rea Panares: Great. Thanks, Eric.

And maybe, ECC, a quick example of what partnerships already existed in your community and which ones you might have had to build.

>> Chandra Smiley: The ones that have existed -- and it goes back to our beginning -- were the two hospitals. We were formed out of a partnership between the hospitals and the county. So that partnership remains today. As well as working with our local Mental Health Association and how we share chronic care patients and how we can co-locate services to increase access and broaden our reach.

Those were partnerships that had existed and, again, remain today, but under the whole CCHH model we have definitely expanded our partnerships in a very meaningful way that historically have not been involved with us. And I can't tell you how many times I've had people in our community come forward and say, I didn't even know you existed or you were one of the best kept secrets in Pensacola. Part of actively working with some of these unprecedented partners has really put us out there as a trusted resource for the communities we serve.

And Sandra will talk a little bit about specifically some of our new partnerships.

>> Sandra Donaldson: Well, as Chandra stated, building upon these existing partnerships and setting the tone for future relationships are connective measures to build the success of a true CCHH community partnership. There's no one entity that can address the complex issues that affect healthcare and social determinants. We realized very quickly on that we needed to identify who we need to be partnering with and who we need to share our resources and services with.

One of our most recent partnerships is with Healthy Start. The mission of Healthy Start is to include the development and support of local systems to care and optimize health for moms, babies, and families. And this is a very unique partnership which consists of Escambia Community Clinics co-locating services with Healthy Start families. This is both Healthy Start and ECC. Plus most of these families that qualify for the same services, both people reside in the same building, which allows for direct referral service for pediatric services both dental and primary care, with an ease of access.

That's very important. Families need to be able to get access to healthcare. And this will reduce multiple appointments hindered by transportation -- of course as we know transportation is a huge issue for families -- as well as time requested off for parents that have to take off work to take their child to the doctor, which means that could be a utility bill or some other financial hindrance on the family.

The community schools project, which I talked a little bit about shortly ago, is one of our most impactful partnerships. The services include a wrap-around approach to children in a community that not only addresses the educational needs of our students but the general, social, economic, full insecurities and environmental conditions and house for these families.

With these collaborations of social services we produced a health forum. This heahlth forum was a resource that we utilized to be able to identify some of the issues that our families were facing. The health forum is used as a direction of services for our families in which addressing those issues that we're monitoring with families by asking those questions about: What are you eating? Do you have access to healthy foods? And we embed that into our H.R. management system so we can reflect on some of those barriers and then we can address those barriers in regards to the healthcare outcomes.

Weis Community School has been targeted as an area in which we have embedded quite a bit of services. Many of our families that reside in Oakwood Terrace, the children, about 200 of the 500 or so reside inside that Oakwood Terrace community. So it was important for us to be able to identify that particular area in our community and be able to offer services for that community.

Out of that initiative, we realized on the health forum that a lot of our families were struggling with food insecurities. Many of our children go home each Friday with a backpack of food which will supplement food throughout the weekend because we had children that were panicking in the classroom on Friday evenings because they knew they were not going to eat over the weekend.

So we had a local community church that started off with a backpack program that would feed the families over the weekend, the children, and perhaps something a little extra for the family members.

So based on this health forum, we were able to work very closely in regards to the community grant that they offered us and we were able to tie in some of the food insecurities into this specific project of Oakwood Terrace. And what this is going to look like, Thursday we're going to kick off our Food Insecurity Program that is going to allow for biweekly food boxes for these families. It's going to have nutritional literacy classes. We're going to also have financial literacy classes.

And a lot of people don't realize that piece of the education for families towards their financial literacy. They are often budgeted very small budgets in regards to what they have allowed for food, what they have left over for electricity and so forth. And it is important that these families are able to understand that they have a very limited supply of benefits and how do you mitigate those benefits, how do you stretch out those benefits throughout the course of the month. And then if you're able to do that piece of education, then maybe it will pass in regards to what that child has available at home to eat which adversely affects their educational needs and healthcare needs.

We also are working with a Food Pantry, also a member in our community. And they have been brought to the table in regards to access to the food, in regards to the food boxes. So they will provide a food box for these families biweekly. And we just received [Indiscernible] which includes nutritional value boxes that has fresh fruits and vegetables as well as other nutritional foods the families can utilize throughout the two weeks prior to them receiving their monthly benefits.

>> Rea Panares: Great. Thank you for that great description of all the different partnerships, ECC, that you are engaging with in the community. And both talking about the specific partnerships as well as Eric kind of building on authentic partnerships as a core capacity at CCHH because we know it's such a foundational piece of CCHH.

I'm going to attempt to move us along in the interest of time because we're getting such great questions from the audience and we still have a list of questions that we wanted to make sure and pose to the panelists before the end of this call.

I want to talk a bit about this piece that I mentioned at the end of my presentation around CCHH really being about not what you do but who you are.

Chandra, you mentioned about how the CCHH model is driving who you are as an organization. I want you to talk a bit about how this CCHH demonstration has helped to catalyze and transform your work and culture at the health center. And at the same time, respond to a question we received from the audience. And I'll just read it for you here.

The effort you propose, talking about the CCHH model in general, are outside the practice of medicine. Our community mission is to improve access, diagnose and treat properly, charge reasonable fees, stay in business, remain open extended hours, and provide inpatient and home-based services.

And I just wanted to point to Chandra about how you may respond to some sentiment such as this.

>> Chandra Smiley: Well, we are -- as a community health center we are charged with looking at how do we improve and increase access to care. And so for us and our organization, one way to do that is through a CCHH model. If we are a trusted resource in the community, then the community will come and they will be loyal.

Part of a community, you know, a 330 -- I mean, we were formed back in the `60s out of war on poverty. We were a neighborhood health clinic. So community-centered health is really going back to the roots of who we are as a community health center.

Now, yes, we have to charge appropriate fees. Yes -- I mean, right now from a business standpoint and a budget standpoint, because we haven't transitioned to a value-based system, or

payment system, our budget is built on productivity. So when we sit down every year and look at our operational budget, we look at how many projected visits do we think we'll get in the year and what are the payer also classes of each visit, categories. And then how do we build our budget. But we're also held as community health centers to quality standards as well. And we are patient-centered, medical home level II. We are certainly looking for to continuing our certification. And quality and integration of behavioral healthcare are significant pieces of that certification.

So if you look at, for example, in the 32505 zip code, which is where we have focused the community school and the public housing, if our doctor knows that his diabetic patient lives at Oakwood Terrace and he knows that that's a high crime area, it's a food desert, that transportation is an issue, he's not going to spend 15 minutes of his exam time educating them on how they need to exercise and how they need to eat fresh fruits and vegetables. Instead it's bringing in a community health worker or a social worker to be a part of that treatment plan on what can we do, what can we leverage in terms of resources and partnerships to help that person be successful with the resource that they have.

And how that looks in 32505 and how that looks in the northern end of our county where we're establishing a new practice with Healthy Start is very different. And I think customizing our approach and becoming that trusted resource, going back to being the community's clinic, then we are the place that the community will come to not only for care but appropriate utilization.

One of our funders -- or two of our funders are the local hospitals. We have [Indiscernible] navigators embedded within the emergency departments of the hospital redirecting patients to appropriate level of care. But if we're not trusted, then they are not going to come.

So it is a balance. There is a balance between, yes, we've got to provide medical interventions and we have to charge but speaking about healthcare in the out of the box fashion, I should say, and really embedding ourselves in the community is going to keep those patients coming and it's going to break down any perceived or real barriers to access.

>> Rea Panares: Great. Thanks so much, Chandra.

We're getting a number of questions about where public health fits into this model. One questioner asked: It seems like they should be driving it assisted by healthcare not vice versa. We also have a question around: Health systems are increasingly interested and responsible for population health. How can public health sell its value to large health systems to have ample resources?

So why don't I start with that question to share some reflections generally about where CCHH fits within local public health and I'll turn to Eric and Kyla at LPHI to also complement that question.

But I'll just start by saying, you know, the CCHH model is really a framework for healthcare to assess its role in changing community environments, to better the health of their patient and patient population. And as Chandra just mentioned, this is a part of overall healthcare delivery and ensuring that your patients have access to the resources that you may be recommending to them as part of a treatment plan.

The CCHH model is really not meant to replace or compete with existing efforts in the community like local public health or the role of community organizations but to really add as a complement to those efforts. So where there is more relevant data to be shared either with local public health or community coalitions, the clinic can, perhaps, share more realtime data or reflections on what they are seeing in their patient population, sharing their expertise and role as a clinical provider in the community to participate in local public policy campaigns is another role a CCHH can take.

And lastly, I'll just mention that the CCHH model in comparison to other models like PCMH or the medical home model, is more fluid. And we've always described the CCHH model as really being attentive to the communities in which they are operating in and which they are serving. So it really depends on what's available in the local communities, what the resources are, and how to really make sure that the health center is complementing efforts that are already going on in the community.

>> Rea?

>> Rea Panares: But perhaps where those efforts aren't existing, that they are actually leading those efforts.

Was that Eric?

>> Dr. Eric Baumgartner: I accidentally pulled the phone off the wall.

>> Rea Panares: Ok. Great. I'm going to have you briefly just kind of quickly respond to this question around the role of the local public health in the CCHH model and then I'm going to turn it over to Matthew to round up the last of the Q&A.

>> Dr. Eric Baumgartner: Yes. It's a very rich question. I'll try to be very quick.

By the way, I have a history of being local health officer and a state health officer and spent much of my career in governmental public health. I would just say that we came to say in public health that public health is what society does. And a community needs everybody aligned. A community with strong leadership than a community trying to be community-centered should seek out that partner immediately and find workable opportunities to be aligned and have strong public health help lead the way and give confidence for early wins.

In the jurisdiction of for whatever reason where public health may be under stress and funding cuts and so forth, if there's a clinic who is inclined to be a collaborative leader among other authentic community partners, then to the extent they can create -- whatever stage of evidence of development it's in to find opportunity itself, it's in everyone's interest that public health find a way to be a strong contributor to the community agenda and in so doing will help inclined healthcare providers to find their place in community health. So I think it's a win-win no matter what the starting point.

>> Rea Panares: Great. Thanks so much, Eric.

With that, I'm going to turn it back over to Matthew to lead us in the last section of the Q&A and round us out.

>> Matthew Marsom: Thank you very much, Rea. We have about 15 minutes or thereabouts left. This has been a really rich dialogue between the panel. We want it to continue. I want to thank all of the audience so far who have been sending in their comments and questions using the Q&A panel. Just to remind folks to continue to do that.

Before we go to the next question, I do want to bring up poll three. This can also help I think to inform the final part of this conversation as well as the ongoing dialogue. It's on your screens right now. So please do look on the right-hand side and click on the response.

[Reading poll question from the presentation.]

I would suggest that for other, folks please submit their suggestions for what that might be needed using the Q&A.

So click on the screen right now. You have an opportunity to respond to your questions. Click submit. We want to make sure we hear from you all. This is really important to please submit your response on the poll.

Just a reminder, so many questions, we're not going to be able to get to all of them right now. We will make sure and our partners on the Web Forum including Prevention Institute, we will be -- we're committed to answering the pertinent questions and sending out responses after the webinar. And all the audio and the presentation and the slides are going to be posted on the Dialoge4Health website. So it's an important consideration.

So I want to go back to another -- on the theme that we were finishing on a moment ago, the question about the role of healthcare and public health, Kristin Erickson sent a follow-up comment which was that she feels this is asking a lot of healthcare settings, going above and beyond and not expecting enough of social services and public health.

I'm wondering if perhaps we could -- going back to you, Rea, as the moderator of this last panel, perhaps you could address that. Certainly from Public Health Institute's perspective we're advancing the health policies approach that it's all sectors of society and all sectors of government that should be working across silos and across government agencies to address these issues. And it certainly is a responsibility of all of those who are serving the public to be addressing these issues and working together to understand those different motivations and incentives. But perhaps starting with you, others have thoughts -- to just respond to Kristin's comment there.

>> Rea Panares: That's a really great question and one I don't disagree with and a sentiment I fully support and do not disagree with.

We created the CCHH model to really provide a road map for healthcare on how to better engage with communities and address prevention beyond the typical individual behavior change and recognize and help healthcare recognize that true prevention, quality prevention, also included efforts to address community environments and community conditions. That's not to say that healthcare, through the CCHH model, is meant to do that alone or to replicate or usurp the efforts of others that had already been doing this work but it's to recognize the role that community efforts play and the role and strategies that healthcare institutions can have as valuable members of the community.

Another model that we've studied and advanced here at Prevention Institute along with other national and statewide partners is what's often called the ACH model or Accountable Health Communities or Accountable Communities for Health. That is where different entities and different stakeholders in this community have responsibilities for promoting the health in a community, including healthcare, social services, local public health, or other community-based organizations. And we promote that model as well.

The CCHH model is really meant to focus on how healthcare can strategically, you know, as Chandra has often said, start to not look at community health initiatives as flash in the pan projects but how that could really drive who they are as an organization in support of other projects and initiatives and activities in the community.

>> Matthew Marsom: I'd like to ask other members of our panel -- Rea just referenced the ACH community model as well. One of our audience members asked perhaps if we could clarify, distinguish, between the concepts of the Community-Centered Health Home model and the ACH community model. Eric or other members of the panel, could we just perhaps provide a very quick, in a nutshell -- I know it's a complicated issue but some of the key distinguishing factors between the two concepts?

>> Dr. Eric Baumgartner: I'll be happy to give you my quick -- I think this is all the context of the United States trying to go to value-based and creating population health and the recognition of the social determinants in trying to get alignment within the medical sector and across the medical sector with other sectors of communities. And I just think of it as these are the equivalence of different parts of the medical system.

At the big system level, integrated delivery system level, there's this CMS incentive, California incentive, towards having big systems align towards population health where anything that could create different circumstances for population health is going to try to be rewarded, including those things that happen to patients between visits.

At the hospital level, there's this thing called community benefit or its equivalent which more and more in this country trying to have whatever might be the consumption of hospital treasure that goes toward that purpose that it ends up having lasting, positive change in the community as a result.

And CCHH, I see it as the equivalent of this at the individual primary care practice level at a community where it can make its contribution.

Now, I'll say at the end that any system of care has, I think in its foundation, primary care provider panel to the extent that more of those primary care practices individually and then as a collective are finding doable ways within their mission and margin to help be part of creating population health drivers, then that can accrue, I would hope, my hope, over time towards measurable change that ultimately accrues back up to observable population health change and bending the curve of healthcare costs in this country.

>> Matthew Marsom: Eric, you mentioned value-based payments and this country is looking at a shift towards that. Chandra, in your comments earlier, you recognized that that's not the case yet and the demands on you and the requirements based on you and the way you need to look at individual delivery of the services you provide in order for you to meet your costs and to run your clinic. Perhaps you, Chandra, could speak to where you see this moving and what the timeline horizon is.

I know we only have a couple of minutes left and we could have a whole conversation about this but perhaps in one minute just your thoughts on what needs to happen for us to move in a direction so you can really truly meet the -- as a provider, someone who is delivering the service in the

community, how are you able to meet these demands that you can deliver this change in communities that you hope to see for your patients, your community members.

>> Chandra Smiley: Well, I think the shift is going to happen in the next five years. And one of the things that we are doing, we have a value-based team that we've created here within our clinic to really look at managing those patient centers impaneled to us and really reaching out to get them in for their preventive visits. We're working with the hospitals on transition-to-care as well as follow-up from the ED's. So we're trying to position ourselves.

And how I see the community-centered health model is a natural, I think, extension of that value-based team. If you have -- if we're out in the community and we're working with the communities and we're looking at ways to leverage our resources to improve the health and well-being of the communities, it's a natural bridge into what happens into the clinic and identifying the specific patients us and reaching out to get them in.

A big piece of community-centered health is also looking at the data and being able to utilize the data and with a value-based approach, managing the panels. If we know from a geo map or heat map what's happening in the neighborhoods that we're serving, it's going to help that caseworker or that community health worker better reach or help identify what some of the barriers are in getting them in for some of those visits.

>> Matthew Marsom: Thank you so much.

We have only a couple of minutes left. I'm going to, in a moment, thank our panelists individually but I'm going to come back to you, Rea, with Prevention Institute with some final closing thoughts.

We've had so many questions we're not going to be able to get to them all individually but many of them are looking at how those listening in the community can start similar efforts in their own area, in their state, their community, their neighborhoods. What's your recommendation, after the panel conversation that you facilitated today, your experience in this area, but for folks listening as they think about the change that's coming on the horizon that Chandra just spoke to, what's your recommendation for our audience and where can they go for more information?

>> Rea Panares: Sure, thank you so much, Matthew, for that question and for moderating this wonderful discussion and to our panelists.

I would say, you know, one of the points that I want to drive home from this webinar is one that has been brought up from all of our panelists starting with thinking about how CCHH is not what you do but it's who you are as an organization and really thinking about that as an organizational work and culture shift.

I would say entities that are interested in embarking on this journey of becoming a Community-Centered Health Home model can really start by assessing where you are and building on those efforts. So, for example, if you're doing things like aggregating data on your patient population for certain health conditions, thinking about what community determinants are affecting those conditions. So if you're looking at asthma, looking at what issues in the community might be impacting those conditions, and then thinking about how you can assess some of those conditions within your patient population either by adding questions to a patient's intake form or doing focus groups with your patients. I would say, you know, just really starting by assessing where you are and where you can build towards other pieces of the model.

And I'll just say in terms of resources, you can certainly turn to the Prevention Institute website. We have a section on the CCHH model which includes the original report as well as the updates and learnings. And you can start there. And by contacting us.

>> Matthew Marsom: Thank you so much, Rea, for your participation today and the leadership you've provided and the conversation you facilitated. Thank you for joining us. That's Rea Panares with the Prevention Institute.

I want to thank, as well, our other panelists, Eric Baumgartner with Louisiana Public Health Institute for your input today and your colleague Kyla Mor as well with Louisiana Public Health Institute, and Chandra Smiley, the Executive Director of Escambia Community Clinics, for your comments today,

and your leadership on this issue, you know, for this country, and also last but not least your colleague Sandra Donaldson for her input and comments today. The tremendous conversation from the panel. I want to acknowledge all of you.

I also want to thank our sponsors for today's Web Forum, the American Public Health Association, Prevention Institute, Public Health Institute, and Trust for America's Health. Couldn't do this without the tremendous support and background work of colleagues at these organizations.

I also want to thank our co-sponsors whose logos and names are on your screen now for their support for this Web Forum.

And I want to thank the Dialoge4Health staff, Dave Clark and Laura Burr for their work behind the scenes for putting this together, incredible work for this -- facilitating this conversation.

This has been Community-Centered Health Home: A Model for Bridging Clinical Services and Community Prevention. You can download the information online at Dialoge4Health.org.

Thank you so much.

>> Dave Clark: And a big thanks to all of our presenters today into Community-Centered Health Homes. As Matthew mentioned, a recording of today's session as well as the presentation slides will be available shortly at Dialoge4Health.org. He mentioned that earlier in the session.

You will also receive an e-mail with a link to the recording and the slide. So check your in-boxes for that. That e-mail will also include a link to a brief survey we hope you will take. We'd really like to know your thoughts concerning this Web Forum that you attended today and especially what topics you would be interested in for future Dialoge4Health Web Forums. Please let us know. We really do read those comments. So be sure to take a couple of moments and complete that survey. We'd really like to hear from you.

Thanks so much for being with us today. That does conclude today's Web Forum. Have a great day, everybody.