PUBLIC HEALTH INSTITUTE
DIALOGUE4HEALTH WEB FORUM
ACCOUNTABLE HEALTH COMMUNITIES DEEP DIVE
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REMOTE CART Captioning

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>> Star Tiffany: Hello and welcome to Accountable Health Communities Deep Dive: Current Models and Lessons Learned. My name is Star Tiffany and along with Christina Ruano we will be monitoring this web forum today.
Closed captioning will be available throughout today's web forum. Karen with Home Team Captions will provide realtime captioning. The closed captioning text will be available in the Media Viewer panel. The Media Viewer panel can be accessed by clicking on an icon that looks like a small circle with a film strip running through it. On a PC this can be found on the top right-hand corner of your screen. On a Mac it should be located in the bottom left-hand corner, or right hand corner of your screen.
In the Media Viewer window on the bottom right-hand corner you'll see the show/hide header text. Please click on this in order to see more of the live captioning. During the web forum another window may cause the Media Viewer panel to collapse. Don't worry. Click on the icon and it will bring up the Media Viewer panel as well.
If you experience technical difficulties during this Webex session, please dial 1-866-22-9339 for assistance. Please write that number down for future reference. The audio portion of the web forum can be heard through your computer speakers or a headset plugged in. If at any time you are having technical difficulties, send a question in the Q&A panel and I or Christina will provide the teleconference information to you.
Once the web forum ends today, a survey evaluation will open in a new window. Please take a moment to complete the evaluation as we need your feedback to improve our web forum. The recording and presentation slides will be posted on our website at dialogue4health.org.
We are encouraging you to ask questions throughout today's presentation. To do so simply click the question mark icon. Type your question in and hit send. Please send your questions to all panelists. We will be addressing questions both throughout and at the end of the presentation.
We will be using the polling feature. Can you please bring up Poll 1?
Great. The first poll is on screen now. Please select your answer and then click the "submit" button. We will like to know if you're attending the web forum individually, in a group of two to five, in a group of six to ten or in a group of more than ten people.
Once you are done answering the poll, click on the Media Viewer icon to bring back closed captioning.
It is my pleasure to introduce our moderator today, Matthew Marsom. In addition to being the PHI moderator extraordinaire, Matthew is Vice-president for Public Policy and Programs for the Public Health Institute. He works to advance and support the public policy goals of the organization's domestic and global health 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 relevant to PHI interests. He was the founding moderator for Dialogue4Health and I'm happy to turn it over to him.

>> Matthew Marsom: Thank you very much, Star and welcome to the next in our series of web forums regarding the Accountable Health Communities Deep Dive: Current Models and Lessons Learned. We are thrilled to have so many of you joining us for what is going to be a rich conversation and dialogue today. I do want to acknowledge and thank the organizations that sponsor this web forum series and their support is really critical. We work together to ensure that the content is as valuable and rich for you, the audience, as possible. I want to call out specifically the American Public Health Association and Prevention Institute and Trust for America's Health.

We are lucky to have sponsors that work so closely with the partners and organizations listed on your screen. Thanks to all of them.

Before I introduce our panelists, in a moment I will do so. I want to acknowledge that this is part of a series and our second web forum on the Accountable Health Communities funding opportunity that is being made available through CMMI. And if you are able to go to the Dialogue4Health website you can download the audio presentation, the slides and materials and the transcript. And the link is on your screen right now. We will actually make sure we can share this with you in the Q&A as well so you can access that. Make sure that all of those listening today and also those who registered but couldn't make it, get that. This is encouragement to go to the website and download. All of the audio and slides from today's presentation will be available as well.

Again, just a reminder we will go through this later on, the date that the CMMI applications are due. That's just an important point.

Last month on our first web forum we heard directly from CMMI staff. They provided details of the funding opportunity itself. That was incredibly valuable. For those who missed it, again you can download that. Today what we are going to do is specifically address and discuss examples from the field that we have selected for the ability of these individuals working locally to highlight current multi-sector efforts in which healthcare and communities are joining together to advance health equity and linking community services. Fantastic examples. Today we are going to have an opportunity to go really deep and hear from those community voices.

We are also going to emphasize innovative models, population health improvement and leadership and multistakeholders as we have been doing through the series and continue to do so as well.

It is my pleasure to introduce our presenters today. Leslie Mikkelsen, Donna Skoda and Heidi Favet. I hope I'm pronouncing that correctly. We are thrilled that each of you could join us today. Each of the bios will be available on the screen but I will emphasize, Leslie, who I know is familiar to many of you on Dialogue4Health because she participated before over the years, is Managing Director at Prevention Institute where she directs the Health Systems Transformation Team, implementation of the Affordable Care Act, and fostering community integration, practices and policies.

I have known Leslie for many years as a tremendous leader. I'm grateful that you could join us today to share your insights.

Donna Skoda has joined us as Health Commissioner from Summit County Public Health Department. She worked in community-based health departments for many years and current responsibility include the overall management of the district and assessment and epidemiological components of the health systems and strategic planning for the community. We are grateful that we can have you on the web forum today, Donna. Thank you for joining us for Dialogue4Health. Again your full bio is available.

Last but not least of the speakers, Heidi is the Care Team Leader of the Community Care Team in the community of Ely and the surrounding area. The Community Care Team has grown to a collaboration of 19 agencies committed to continuity of care for shared patients. As a Care Team Leader she assists in delivering of the essential health practices that address the comprehensive wellness needs of patients including the social determinants of health. Thank you for joining us. Grateful that we can have this incredible panel.

Just a quick overview of the agenda. We are going to hear in a moment from Leslie, who will provide an overview of current efforts and trends. Then we will have a panel discussion that Leslie will facilitate with Donna and Heidi. We are going to open up for Q&A where we will hear from you.
One more reminder, please use the Q&A panel on the right-hand side of the screen so we can have an opportunity to hear from you. If we can bring up Poll 2 on our slides. If we can bring up the second poll. I'll review that for you.
Which best describes how you might engage in Accountable Health Communities related efforts?
A, apply and lead an AHC effort?
B, be part of a partner or stakeholder group engaged in AHC.
C, engage in policy related efforts to support AHC.
D, be a resource to support AHC work or.
E, other.
This is your homework. On the right-hand side of your screen use the Q&A feature once you submitted your response to the poll. Please do click on the Q&A feature and send us in your other examples so we can refer to those during our discussion.
Thank you so much for that. With that, it's my pleasure again to introduce our next speaker, Leslie Mikkelsen, managing director of Prevention Institute. Over to you.
>> Leslie Mikkelsen: Thank you so much, Matthew. Twenty-five years ago I entered the halls of Oak Knoll Naval Hospital as diagnostician and training director. I had one major tool to help patients eat healthier, diet counseling. It's amazing to be part of, that's how Matthew and I know each other well, of a couple of decades now of really strong work that has signaled a sea change in our understanding of how to promote health and equity for entire populations.
And our goal now really is not only to improve the health of patients but to prevent others in the community from needing to become patients. The Accountable Health Communities is a model that we are discussing today. It is really the latest example of this sea change. I think what is really important -- sorry, guys, I have to work on my slide projection here. Is this image about the mod -- mod final factors that influence health. This is in the Accountable Health Communities funding opportunity announcement. I think we all need to acknowledge how important it is that the center for Medicare and Medicaid services acknowledges that healthcare is only one part of what influences outcomes.
Sorry. Having a little technical problems with the slides and I'm working on that now.
So I think part of the sea change is really noticing and being aware of how important community environments are. The places we live, work, and play. They are important not only because they influence health outcomes directly via toxins in the environment or exposure to infectious agents or even the factors that cause toxic stress but they also are a strong shaper of behavior. We know not all environments are equal. If a diabetic that I diagnosed has a neighborhood like this where there's no grocery store and the only source of food is this, a corner store that Devon Jones, the young man who took this picture, called it diabetes on a shelf. It's really going to be hard for folks to both restore their health if they are already sick, and we are going to have challenges preventing illness and injury.
We now have lots of research documenting the impact of place on health. And that there are long-term impacts in life expectancy depending on where you grow up. And we can break that, understand that impact of place in geography through a whole set of community determinants. This is a framework developed by prevention institute using both the research base about the impact of community factors on health and also community practice and community efforts to pro motel health equity and finding a language that community members can identify to think about the place factors, the built environment, the opportunity factors. Those are those social and economic factors and finally the people factors, the cultural and social environment of P and As that we know impact health.
Moving to this framework, what you see in front of you now is the five domains that have been included in the California Accountable Community for Health request for funding. Some of you, those Californians especially will know about that. The reason I wanted to show this here today is because I think this portfolio of five domains of action from clinical services up to public policy and systems

change really represents a framework for how to create a comprehensive approach to prevention and promoting improved population health in a community.
And what is important is that the Accountable Health Community opportunity is really a funding resource to put in place those first three domains: Clinical services, community social services programs, and really making linkages between healthcare and community efforts.
Let me just talk that through in a different way. In healthcare, a patient may come in and have iron deficiency anemia. If there is good social screening in place we can also learn that that patient is having a major challenge with food insecurity and his or her household. We can refer that person to an important social service, SNAP benefits.
At the same time I spent ten years working in the emergency food system. We know that many families use SNAP have other challenges, expensive housing, perhaps lack of employment and even with SNAP benefits have challenges putting enough food on the table. A strong community-based effort is also going to consider a community collaborative is also going to consider what can we do fundamentally across the community to better support households in being able to earn a living wage?
We call that here pre-at Prevention Institute a system of health. I want to give a shout-out to the framework which shows the linkages between healthcare, behavioral health, community and social services and community wide prevention to the State of Vermont. Prevention Institute conducted a survey of the it accountable health for Vermont because they were committed to taking the infrastructure they had linking healthcare and behavioral health and community and social services and building in a connection to community-wide prevention.
This next slide actually shows the results of our investigation, which interviewed healthcare community collaboratives around the country that were really trying to get at how to better serve the social and economic needs of individual patients while also thinking at an upstream community level about how to create environments that support health. These core elements listed here were really some of what came up consistently, whether it's focused on that service integration as the Accountable Health Community effort is really focused on or it also expands to include that community wide prevention. I'm going to talk through a couple of examples here of the places we visited. One we sat down with a coalition, myself and Prevention Institute colleagues that is in St. Johnsbury, Vermont, the poorest area in the state. And there was a collaborative in place there, the St. Johnsbury collective impact that included the hospital and a whole array of behavioral health and community service providers.
And the hospital serves as the backbone organization. What was so important is just by being in the room we could sense the deep respect and trust that all those coalition members had for the leadership being provided by the hospital. Another really outstanding characteristic of this collaborative which was focused on making sure the needs of clients that came in any door, into any one of their agencies were fully met, is that in addition to their staff meeting regularly to discuss particular cases, discuss particular clients that maybe had both medical and community needs, a fundamental part of their success is that the CEOs met regularly. That was a real learning about successful governance. Having that CEO level leadership really helps ensure that staff are supported to get the job done well.
Another example I wanted to share, which we've learned about more recently through conversations with an Accountable Community for Health effort that is still under development in southwest Washington, is building on a very important existing healthy living collaborative that has expanded to include and embrace healthcare partners. What you see before you is a set of community health workers that had been trained by the healthy living collaborative and were engaged because this healthy living collaborative is committed that its members were not engaged in deciding what actions in the community were needed to be suggest if you.
These health workers discovered there was an apartment building 100 unit-building in their community where all tenants had been given 20-days notice. A new property manager came in and was planning renovation and wanted to flip the units to have renters who could pay more.
The community health workers brought this concern to the healthy living collaborative and they were able to take action on three levels. The community health workers made sure everybody in the building

understood what was happening, that they had to vacate in 20 days. The members of the collaborative marshaled resources and were able to support 80 of the families in those units get housing.
Finally they asked the question: Wait a minute, how can we prevent this from ever happening again? And they have been working on getting policy passed and were successful in getting a 60-day notice requirement passed in their community. They are working now on trying to strengthen the just cause eviction policies in their community.
So that is a very, very good example of how the work can come together. We see the accountable health community represented on the left side. How do we move from -- how do we take the work focused on what is needed in the communities and expand to focus around the community systems that are impacting health every day. I done want to point out Prevention Institute has been looking deeply at models around the country. You can go to our website to get more resources on this.
Back to you, Matthew.
>> Matthew Marsom: Thank you so much, Leslie. I greatly appreciated that presentation. Thank you again for joining us today. We'll hear from you momentarily where we have an opportunity to have you moderate our panel discussion.
I want to acknowledge one of the comments we received from Nancy, who is listening today in the response to the poll question momentarily, a few moments ago. She was doing a little bit of everything based on the needs of community and stakeholders. I think that is true of so many of the community partners we are working with today, engaging where they are and meeting their needs. And Nancy, you outlined some of the important key strategies that are necessary as we bring together the clinical and community stakeholders.
Reminder, all of Leslie's slides are going to be available to download as well as the audio on the Dialogue4Health website. A reminder you can go there after today to download both the audio from today and the previous web forum as well.
Thank you very much. It is now my pleasure to move us forward on to Poll 3. If you can please bring that up on the screens?
And the question is, again please to respond on the right-hand side. What do you perceive as the top challenges to overcome in the implementation of the AHC opportunity? Please select all that apply.
Funding.
Reach to Medicaid population.
Data sharing or technology.
Connecting patients to appropriate services.
Partnership development.
Addressing underlying determinants of health in the community.
Or other, and please submit your answers in the Q&A feature.
So please select all that apply. You have a multiple choice question. Click "submit" all of the above or some or click other if you want to provide answers in Q&A. It will be really appreciated. Thank you so much.
It is now my pleasure to introduce our next two speakers. And first again, Donna Skoda. We are going to hear from her shortly, health Commissioner with Summit County public health and Heidi Favet. I want to make sure I'm pronouncing your name correctly. I apologize if I'm not, but Heidi is with the Care Team leader with Essential Health in Ely, Minnesota. I know we will hear from each of you to introduce your work. I want to bring back Leslie Mikkelsen who will help moderate this conversation as well.
So Heidi, Donna, and Leslie. I think Donna, you're going to go first to walk us through how your community, Summit County is responding to the Accountable Health Communities opportunity. Donna?
>> Donna Skoda: Thank you, Matthew. I appreciate that. Leslie, I appreciate your thoughtful comments.
I am going to present our model. Okay, it just came up, thank you.

It is a little rough on that first slide. I want to talk briefly, probably in, oh, it had to have been 2011, 2012 we were very fortunate in Summit County Ohio to have Dr. Janine Jenowski who authored the first white paper that projected the idea of these community caring models that would help us bring community integrated systems together. As you heard from Leslie, the part of it is the whole mission of what you are going to do in a community. We were capable of bringing together partners around the health impact pyramid. And successfully convincing our partners that we really weren't getting a lot of bang for our buck on the one-on-one education. Even I am a dietician as well. I think of all the diet consults I've done. That isn't really what is impacting health for individuals. Certainly the knowledge is important. But if you're looking to make a true integrated change in your community, it happens at the other levels of that pyramid.

Clinical interventions are great because people have to control their blood pressure. They have to take their diabetes medication. Long lasting protective interventions are excellent as well. Immunizations. But where we really found we were starting to get traction was changing the context and what people lived, making the easy choice the default choice for individuals. So if they had to make a lifestyle or a behavior choice, they could do it easily. It was easier than making the wrong choice. And then, if can, the socioeconomic factors which truly we all know the impact of poverty, poor housing, inequality and just poor food access has on health overall.

Now, I want to just move in to what we decided, because I want to give a few examples. But I really want to talk about our components. And the ACA components really were that it be integrated, that we had collaborative public health models and professional teams available to work on the project. We had to have robust health information and technology and infrastructure. And I can tell you, many of the projects that we talked to around the country, and we worked with and just on our own project, the sharing of information and data is a tough nut to crack. Because you get into all sorts of problems. It really does take a great deal of your effort. It is really worth the time to figure out how to make that work because it will give you a rich data set that will allow you to make really good decisions.

The other piece was we needed to know how to take what we discovered as best practices and to learn what best practices were. And to be able to share those across our partners.

And that it was really, the best way I can describe the effort is really just trying to get everyone to move in the same direction. So if we determine that these ten priorities were important for our community, that meant every foundation that gave money out you had to talk about how you were going to address those priorities. It has to be a community effort that moves everything along. And it is a leap of faith. I'll be honest, you have all these little projects running and you hope they are getting you to where you want to be with a healthier population, with better metrics. The bottom line is you have to do those little projects or you are never going to reach the people.

We also were very interested when we started out. We did an extensive policy scan to see exactly what were the policies that were actually promoting health or that were causing the hinderance of good health practice. That was helpful in the early days of starting.

I can honestly say the component that probably helped us the most was getting to move in the right direction.

The next was metrics for success. We had to decide, you know, what are we trying to prove here? Do we want to spend most of our time looking at the participation? That was process, yeah, we had to have the people participating. We had to have the individuals from the organizations able to come together and want to work together. We even thought about early on, okay, we have the hospitals at the table. They are giving money. We have the bio-innovation center and they have a grant and they are doing a lot of work. We have intervention measures. We have the clinical improvement. We have the patient safety. We have all these things we can measure.

Really, what is making a difference? How are we measuring it? This took a lot of time. And actually, when we look at some of our social determinant measures like our more graduating from high school, if we do an early intervention campaign and get more kids to go to school being able to read, more kids prepared when they leave preschool to kindergarten, first grade, second grade, third grade. Are we

able to see and measure that, we have to level a lot of that locally to develop the systems to collect that data to make sure that we are moving in the right direction.
Now, I want to talk briefly about a couple of the projects that we've done that might spark some ideas or actually give you some hope that you can really get this work accomplished. We really settled about two years ago on doing bidirectional referrals, meaning looking at healthcare providers, the healthcare system and then referring to the community and vice versa and going back and forth.
So we chose hypertension. We trained 20 family practice physician groups to be able to provide resources to us. We trained everyone on Million Hearts, how do you identify, the campaign to reduce blood pressure.
We trained everyone in their offices to be able to make referrals to us. So if they were worried somebody wasn't showing up or worried that they weren't being attentive to their medicines or they were worried they didn't have food, they could refer to us.
Same for us, if we stumbled across individuals who were identified that needed help, we could refer them as well for medical care.
Bottom line was we were able to have many referrals come to the public health as well as go back to the medical community. We were able to reduce, get better controlled blood pressure patients. Those were the measures we were using. Are we able to get better blood pressure control by having someone intervene in the home or in the community around what that person needs to be successful in the management of their disease?
And the answer was yes. It worked very well. It was very inexpensive. We did it on about $20,000 from the Ohio Department of Health and HO grant, National Association of County and City Health Officials grants. We were able to have an impact on those practices by setting up the referral systems that a look loud us to do what we did best: One, provide the medical care. One provide the community.
We also currently, another project that we worked on, embarked upon was maternal depression. We decided to work on that in a very similar way. The problem we were having, women were being screened for maternal depression. The problem was, the appointment waiting time, the ability to see a provider immediately was difficult. So what we were able to do is for lack of better words, we put ten mental health professionals on retainer. So once a physician screened, they were able to immediately refer to that provider and get that woman an appointment that same day and or within the same practice.
So that there was immediate treatment for maternal depression. We have seen amazing results with the ability to be able to get very timely care, be able to take care of the baby and the mom and the infant. But we have seen amazing results and again, very inexpensive program to operate and run. It really just was more of a creating the environment where everyone understood what everybody needed in order to be successful.
I think that will conclude my comments. Back to you, Matthew.
>> Matthew Marsom: Thank you so much, Donna. Heidi, it's over to you as well and again, thank you for joining us. We look forward to your presentation.
>> Heidi Haney Favet: Thank you. This is Heidi Haney Favet. I'm in the Ely area of Minnesota. And our Community Care Team is an interagency collaboration that serves the entire population of our geographic area. We have placed special emphasis on individuals with mental health needs and on youth and families because they repeatedly rose to the surface as people who, none of the services that were already in place really were sufficient to meet their needs.
As you can see here, we are very far north. Our Community Care Team, the Ely area is marked by the yellow bubble on this slide. But we serve five small communities in the surrounding townships. So it looks rather large on this map but it is actually a total of 12,000 permanent residents only.
Straight south of us, 100 miles straight south you can see Duluth on this map. You can see we're a little bit south of the Canada border.
Our area is rich in natural resources. But the remote rural setting makes accessing health and wellness resources a strong challenge. The Community Care Team began with the early roots in 2011 as a way

to build a safety net by knitting together the community resource that is we do have and then working collectively to address the deficits.
Four and a half years later, our Community Care Team is a network of 19 organizations. They represent healthcare, mental health services, social services, education, nonprofit, as well as consumers and families from the community.
The collaboration works together to make sure there's no wrong door to individuals getting their health and wellness needs met. That means two things: That our providers in each and every one of our agencies, whether it be a small nonprofit serving youth and families or the elderly, that that nonprofit as well as our clinic providers and our public health staff and our teachers and school counselors are all trained to recognize that someone has more than a need than just what they came to them for today and they get them to the help they do need. That has been a really valuable process here in our community. We developed strong referral systems and our own care coordination model that specifically is aimed in particular at addressing the social determinants of health to make sure we address the full spectrum of needs, from simple to complex. And that we have the tools and systems in place so that we can partner with the individuals as well as with the other agencies. And we work as a team to continually develop tools and systems and services to facilitate this work throughout our area and to continue addressing those services that are completely absent in our community.
With that I'll turn it back to Matthew and Leslie.
>> Matthew Marsom: Thank you. Thanks so much, Heidi. If I could bring up the presenter slide again for the next panel, we are going to now have Leslie moderate a discussion with Donna and Heidi. As you are listening to this discussion and Leslie is going to facilitate questions with the panel, I would encourage our audience to send in their own questions during Q&A. Following this panel discussion we will have an opportunity to incorporate your questions as well.
So thank you so much again, Leslie. And it's over to you.
>> Leslie Mikkelsen: Thank you so much. And it was so great, Heidi and Donna, to really hear a little bit in the short time you got to present about what is going on in your communities.
One thing I would love to turn to you, Heidi, because you mentioned you really now have strong referral and care coordination protocols in place. Can you tell us, give us a little insight about what it took in the early stages to get this set up? What would you advise someone who is just starting out, trying to build this kind of infrastructure?
>> Heidi Haney Favet: So we started with first some research. It was interesting, Leslie, to see that you mentioned St. Johnsbury, Vermont. One of the first things we did was participate in Commonwealth fund meeting that took place in Vermont and we were trying to learn about the different approaches that were already out there and I read a lot of white papers and articles and kind of taking a look at what is already happening.
But it was sitting in that meeting and hearing from the folks in St. Johnsbury that a nurse practitioner from our clinic was there with me. We looked at each other and said this would work in Ely. It was sort of the inspiration that we brought back as a place to say: Okay, then how do we start to make that happen in our community?
So I began by approaching each of the administrators of our larger complex organizations, our schools, hospital, clinic, county social services, count public health and community services and our community mental health provider, mental health center. Sitting down individually with those directors or CEOs and talking about what do you see as needs in the community? What are the needs for your own agency as well as for the broader community?
How would a network or a collaboration like the Community Care Team idea, how would that help you? What are the challenges to being involved in something like this?
Really trying to gather local information next after those broader models. And then taking all of that and bringing together a proposal and seeking that administrative buy-in. The initial meetings were with those top administrators and looking for them to come to sort of help outline the bigger vision for the Community Care Team for this area that they could support and getting their commitment that if we

built this, they would make sure that their front line staff were able to participate on a regular basis and we could come back to them for broader, long-term guidance.
While we were working together, one of the early problems that we felt like we really needed to solve was taking a look at how do we even acknowledge that we work with the same people? Most of those institutions all have a lot of strong privacy laws that they are required to follow. As well as some internal, just culture of privacy and protection for the folks they work with. And so we recognize that we couldn't even begin to collaborate on care if we couldn't even acknowledge we worked with the same individuals.
So we came up with a solution to develop our own interagency shared release of information, because we also heard from our community and family partners that one of the biggest barriers to them receiving care was needing to go to the same agency -- or to each individual agency they worked with and complete the sale paperwork and then provide, I have to re-loose my cool to talk to the mental health provider and the mental health provider to talk to the clinic, but the clinic still can't talk to the school. How do we release? It was against what the individuals wanted to have happen. They said we want, when we have a complex situation we want our providers to communicate on our behalf and create a comprehensive plan of care.
So we designed a form that allows people to choose who they want to be able to communicate in a professional way about the relevant information to create a comprehensive plan of care. So that was some of our early work that allowed us to work together. Then once we got that in place, we found our smaller nonprofits. They didn't need to be asked twice. They jumped right on board and said please, let us be part of this. Because that feeling that we are not in this alone and that we can work together to address these needs was just so strong that it started, we quickly launched into become a network once we solved these initial approach problems.
>> Leslie Mikkelsen: One detail I would love to ask and maybe I missed this. How did you figure out what questions to include in the screening tool?
>> Heidi Haney Favet: I really sat down and just looked at what do I -- getting some broad information trying to find out, make sure I had a clear understanding of what their agency did. Was really looking at strength and challenges, concerns for network involvement and needs that, where could we look at what they saw as deficits and how could we leverage the collaboration to help address those needs.
>> Leslie Mikkelsen: Each of the individual patients?
>> Heidi Haney Favet: Actually, the needs of the individual agency was the focus at that time, looking so that they were focused on their individual patients but that they could see within their practice or their organization that there were unmet needs out there.
And often in some cases being able to show the benefit to their own providers was the -- sometimes it was to the provider or the patient or the client is where the win was going to be to bring that benefit in and convince the participation.
>> Leslie Mikkelsen: Thank you so much for that.
So Donna, I really wanted to turn to you now. One thing that I can't help but want to ask, I was impressed with your description that you developed a method for getting women with depression so importantly into treatment right away. What did it take to make that possible?
>> Donna Skoda: I think for us, and it was when Heidi was describing her process of getting her care coordination set up, it was a similar process we went through here. We were again identifying those gaps and looking at -- everybody will talk about infant mortality and the strategies. Everybody was willing to work on the issue. It was just a knowledge deficit of knowing how can we make these referrals quick and easy? In these practices all of the providers are busy, running around, trying to get women seen. And many women don't go back for the post-partum exam. That's huge, and getting them back there so they can be screened.
We looked at it from both, it's important from a client perspective, it's important to have the six week follow-up and from the actual providers perspective it is important to screen women. Their concern was if I screen and identify, how do I know I can get that person seen quickly? That was where the work

came from us. We said okay, we'll get a group of people on retainer. We guarantee you. You call us, will's get them seen immediately.
It was almost a relief to them. As Heidi indicated it is meeting the needs of what they couldn't do. They knew they needed to be doing something but didn't have a solution. Once we provided the solution, there was total buy-in. And more women are getting screened because now they feel comfortable, they have some place to send them.
>> Leslie Mikkelsen: That's great, but I still just want to dig one more level. Basically you were able to have a retainer. Having been working for food banks, I know how hard is to get those places in mental health. By retaining a certain number of hours, that meant that then you had enough slots. That's amazing.
>> Donna Skoda: Yes, we had slots. If we called and said we need to get someone to see Ms. Jones, she was seen that day.
>> Leslie Mikkelsen: What was the funding mechanism?
>> Donna Skoda: We had the early intervention issues and there were dollars there. We have general health revenue dollars that we put into that and the alcohol board, drug, mental health, there's a lot of folks who paid into this project to try to make sure that it works. Again, it's not really that expensive in the big game of things.
>> Leslie Mikkelsen: Wow, that's great. Heidi, I want to hear a little more detail about the actual process. I know, of referrals. I know you mentioned that there is every door, people can enter through every door. In addition to providers screening folks for social needs, do you have some kind of Community Care Team or community health workers that are out in the community?
>> Heidi Haney Favet: Yes. So we really have two prongs that fill this need forgetting people to the right places. One is that whatever provider they are at is now becoming much more aware of the things that people come to them with that isn't really why I'm here to see you today.
For example, coming into the clinic and they hear, "Yeah, I just been hungry a lot. Money is awful tight." So that the provider then knows: Oh, I can refer you to somebody who can take care of that. Or they may know directly that the food shelter is open on these days at this time and give it directly or they know who within the clinic can get that information to them.
Each of our providers has gotten good at knowing the resources and making warm hand-offs. Sometimes somebody needs more than a warm hand-off. They need that in depth service. That's where we developed the CCT model which is based on community health workers. We have them in multiple settings. It started with me as a community health worker here in the clinic and being able to provide that directly but taking referrals from the community as well as the clinic. And now we are on a state innovation model grant. That's allowed us to expand and we have one and a half community health workers here in the clinic. We now also have what we call a family resource facilitator, but essentially a CHW embedded in the Ely public schools. So addressing needs with youth that arise during their day as well as being a resource to families for services that go beyond the academics of the school day.
We have Northern Lights Clubhouse is a mental health clubhouse here in the community. They've trained and have a community health worker on staff at their organization. And we have a free clinic that our Care Team helped launch. They also provide care coordination with this model at their site. And we have a nonprofit that serves just seniors and elderly, helping people have a great quality of life no matter their age. And they provide amazing community care-based particularly around the issues of dementia and aging.
>> Leslie Mikkelsen: Does each agency train its own staff? Or do you do some training across the community? For community health workers?
>> Heidi Haney Favet: Each agency has done its own, on a broader level. But then we have meetings where I have worked directly with each agency other than the northwest partners which their model is older than the Community Care Team working with the elderly. Their model is older but they participate in monthly CCT meetings and have had the chance to take that, our type of work back into their own agency.

With the others, they have the chance to help mold and be part of that development as each one developed.
>> Leslie Mikkelsen: That's great. I can't help myself. You mentioned you're a community health worker and that's how you started in this. Any advice you have to communities trying to set up a similar initiative about how to recruit really quality folks to become community health workers?
>> Heidi Haney Favet: We have really looked at this issue here and felt like we went with the community health worker model. We felt it's not about someone having a specific background or a specific licensure when it comes to addressing the social determinants of health. Our clinic manager talks about it being the right person. And we've really looked at, that's got to be an individual who's got the passion and the ability to be self directed, be a problem solver. Somebody who is willing to get in there and say: Boy, I don't know what the answer is to that or where we can turn to, but I'm going to stick to you until we find that solution. And be a little bit dogged in breaking down some barriers and calling that health insurance company to say: Can you look one more time and tell me why you turned down the pump for that 12-year-old child that the doctor referred? Down the line you find out, boy, it was the way our clinic's lab sent the documents, is the reason that it kept popping up at the insurance company to say this is not medically necessary that the way our lab documented, they didn't use the exact wording the health insurance company wanted. It's those kind of personality approaches more than saying oh, somebody has a background in social work. Some of our community health workers do. We have one who has a background in education and one who is a lunch lady and a radio personality. So we've got a variety of folks in the community. It is about those personality characteristics more than the licensure that has been very effective.
>> Leslie Mikkelsen: Thank you. That's great to hear.
Donna, I would like to turn to you now to talk a little bit more about the partnerships you've established, which are pretty widespread because you are covering both individual service providers and I recall learning more about the Accountable Health Communities, you have this integrated community of workers and you have a range of community organizations that are more focused on the upstream community systems.
Regardless of what kind of partner, I think we know partnerships really require trust and really understanding what motivates different partners to be at the table. Could you talk a little bit about that in Summit County and what your experience has been about how to get partners to be committed and stay with you?
>> Donna Skoda: I think for us here Summit County is near Cleveland, Ohio. It's south in Akron Ohio, 550,000 people. It's always been and I don't know if it's something in the water here or if it's just the way folks are, but it's always been an extremely collaborative environment. The community, even though they are competitors, they are still collaborators often.
And it has been a very interesting experience because I worked in other communities where it wasn't as collaborative or easy to get things done. But I think for here the two main things that kept folks invested is, number one, it can't be just one more meeting they are going to. They have to feel as though they have some say and we're deciding things and making changes, and that there's actually some involvement by the community partners and that they are getting their needs met as well. Because many of the partners, whether it's a large public system that is at the table or a large health system or it's a small group of community members organized at the neighborhood level, they all have needs. And they all want to see certain things happen. I think it's taking into account, Web able to bring those folks to the table, gather lots and lots of community input. Not do things to people but with people. And I think it's made a huge difference in how we have been able to keep our partners engaged.
Plus I think they say there always has to be a backbone organization. You have to have somebody ... well, when Austen BioInnovations decided they were no longer going to be in the work, all of their work on accountable care transferred to the health district. We have taken on the administrative tasks as well as keeping the group cohesive. There has to be that backbone organization that is willing to go out and look for dollars, money, partnerships. So you bring something back to your members as well.

So it has been a very good experience. I don't know if Heidi's experience has been similar, but it just has been very, very, very, very rewarding here to be able to get all of our partners to come. I've always said, you know, there isn't as much money as there used to be around to do some of these things with. So we've really here taken the approach that we need to really look at this. Regardless of if we have the money or not, this is worth doing and we have to figure out how. If it means each of us has to put in five nickels, we do that. Once the money is gone, we are committed. Married, no divorce. We have to move this ahead because we believe in it and we know that's what is going to make a difference in our community.

I think when you have money and when you don't have money and your partners still stay around it's a good sign that you are doing something. We have been very fortunate that way.

>> Leslie Mikkelsen: I would certainly have to agree with that. Just following up, because the Accountable Health Community, tier 3 does require an integrated organization. That's a role your health department is playing.

Could you talk a little bit about the skills that you or the staff that are part of being the integrator need to have?

>> Donna Skoda: I think the number one skill is you have to realize that it is not the world according to you. That all of these folks come to the table with boards, with requirements, with all sorts of things. And that one skill we have always looked for in anybody who works in our accountable care or helps run these projects is someone who is a great convener. Someone who can see all sides of an issue and not get angry or think that they are right and the other one is wrong. To be honest, there are many ways to look at an issue and many ways to solve a problem.

What you are trying to do is convene of a group of the brightest and best and find out the best solution for our community which could be very different than another community, but you have to be willing to leave all of your baggage behind and look at this group and work with them.

The other skill I think you need to have is extreme tolerance and patience. And you have to be willing to be the kind of person -- much like a community health worker. You have to be a problem solver. You have to be lying a dog with a bone. You want it done. And if you don't have that, it is going to be very difficult to keep the momentum in that group going.

>> Leslie Mikkelsen: It really sounds like persistence, vision, tenaciousness, they are all part of it.

>> Donna Skoda: They are. And like I said, most of all it's the ability to not bring -- think you are the only one who knows what to do here. I mean, you know, you have to be willing to listen to others and their ideas.

>> Leslie Mikkelsen: Excellent. Thanks so much for that. So I want to turn to something that is quantitative. We have been talking a lot about the people skills and relationships, but data, data is a popular theme. I think with the advent of electronic health records and with the need that part of an Accountable Health Community is about screening, I think there's a lot of interest in: What is the right system for collecting that information? How can it be shared? How can it be analyzed?

Heidi, I would like to turn to you first to have you share a little bit. You talked about the kind of forms you have been developing. Maybe specifically about what kind of data your collaborative is collecting, what kind of data is being shared between providers. But then also are there ways that there are perhaps some kind of aggregation of data to look at patterns of need across the community? And then the other question I'm going to put, add to that. Donna, I'm going to ask you the same questions so you can hear it now. What are your evaluation outcomes that you are looking for? And perhaps describing some of that may be quantitative data and of course there may be some qualitative data as well. Everybody wants to know how do you evaluate if you're successful? Heidi, can you comment on some of that?

>> Heidi Haney Favet: Sure. Our evaluation process has been really critical to both sustainability of our network as well as to expansion and outcome success.

And we work with Dr. Pat Conway who is with the Essentia Health Forum. She has a background in social work and broad experience in teaching social work and developing systems in that area from her

past. And before she became a researcher, really, that was another person who was the right fit. It has been excellent for us.
Our evaluation process has been both a process outcome and -- a process evaluation and an outcome evaluation. The process evaluation, then at variable levels. We looked at the formation of the team has an evaluation process. We have a care coordination evaluation that is both gathering data from the medical record and then we also have a patient-reported outcomes evaluation that we are doing. We are evaluating on a variety of levels and using social network analysis as well as surveys of the team to look at making sure that we are really meeting the needs of our Community Care Team members, our Community Care Team members. As Donna mentioned, their time is valuable. Coming to the meetings has an outcome. Their words are heard. They female like an equal at the table whether they are a community member, a physician or a nonprofit program manager.
And so we are evaluating that piece of our team and then looking at how do the relationships grow over time between our organizations.
Then the data that we are collecting, we have been most successful because we are within the clinic. That's our backbone organization is the Essentia Health Ely clinic. Because we are in the clinic we are able to mine information from the medical record. That has been really valuable to us because we are within that and we can go through the process of getting approval through the IRB to make sure that we are acting within the protection of patients but also able to get that input.
We just finished our second data collection round on that and found that when we look at the number of visits to the emergency room before care coordination, using the Community Care Team model versus after care coordination with those involved in our model, those visits were reduced from 75 visits to 50 for the individuals.
>> Leslie Mikkelsen: Wow.
>> Heidi Haney Favet: That's reflected from the first data collection round as well. It was roughly 30 percent or greater reduction in emergency department visits.
That's why I say it has been crucial to our sustainability as well as expansion of our project. We are piloting this for additional sites and looking at it for essential elements of our program, data collection like that. We are doing patient reported outcomes, both satisfaction within care coordination as well as using an overall general wellness measure. So the SF36.
The challenges we have seen to data collection, now that we are doing care coordination at an additional site, how can we gather that data? The Minnesota laws are more complex and challenging than federal laws. So data sharing of that type across agency lines has been harder for us. We have a mental health subgroup, the Behavioral Health Network of our Community Care Team. They are specifically looking at that issue right now to see how we can overcome those challenges from the privacy laws.
>> Leslie Mikkelsen: Right. I think that's a challenge a lot of places are facing. Thank you for that. Donna, could you comment on your data sharing infrastructure and also evaluation?
>> Donna Skoda: Yes. We too are doing a combination of process and outcome measure. I think simply because the process is a lot easier to get at. And then in certain pieces, parts of the projects that are integrated network has picked up like the million hearts, for example, we looked at very specific outcome measures. Did we reduce the out-of-compliance patients in those practices? Were we able to see significant decrease? The answer was yes. We were able to provide very minimal involvement in the community with a visit, with a medication compliance check, with whatever the strategy may have been. And yes, in fact we did see a reduction in those patients that remained out of control with blood pressure. We looked at those sorts of clinical indicators.
When we've tried to go higher, and we are in the process of doing this right now. We have lots of data from individual projects. When we try to integrate it in the care coordination, we do a very similar evaluation tool with the emergency room. Have we been able to keep Mr. Jones out of the emergency room? Has he not gone in there because now we are able to give him the guidance he needs? If we are able to send a public health nurse to the home, is that making a difference?

So we look at the outcomes based on both the process and then the outcome of the individual. We do a lot of client satisfaction surveys around did this help you? Did this actually make a difference in how you perceived your health or your life? And we also use an SF12 to 36 depending on where we are at to get the patient's perspective on their health. Is there a perceived improvement in their health based on these other resources being wrapped around?
We have just begun, as I indicated, to start mining some of the EHR data and clinical data from our partners.
The difficulty in that is some of the privacy law. But de-identified we can get around some of that stuff. The issue we are having is the actual mining of the data. I would tell individuals to be very careful if you are trying to set up a system that just because somebody was checked for diabetes doesn't mean they have diabetes. So you really have to be quite careful when you start analyzing data to make sure you are not thinking you're looking at one thing when in reality all you are really measuring is how many people got checked for diabetes. It doesn't mean that all those individuals had diabetes. That takes a lot of work, a lot of investment on the front end to make sure that the metrics you are collecting actually are telling you the story you want to be told. It is a problem if you don't do that. So we are still gathering, but it is very similar. Heidi's journey seems a lot like ours.
We just purchased a software system that will connect all of our partners for the bidirectional referrals. We are looking at a care coordination piece to install with the 12 partners who are helping to make referrals back and forth. Public and private. And expanding out the network. We are just now in the process of getting that up and running.
>> Leslie Mikkelsen: That's so helpful to hear, Donna. Can you comment because a lot of the data is thinking about the individual patients and how to support them. Interestingly, in the early poll, 100 of our 348 participants voted that their greatest challenge is really addressing underlying determinants of health in the community. We have a lot of interest in that.
Could you comment just credit briefly because then we want to open up the Q&A, you know, how do you connect that sort of -- there's that great work you're doing around the services but then how are you connecting that to the community environmental change effort?
>> Donna Skoda: Since 2003 we've looked at our social determinants, for lack -- we looked at housing, employment, educational, attainment, food deserts, entertainment. We have been able to drill down into data to very low census blocks around housing conditions, lead, anything for which we think is a predicter that this individual may struggle with health issues and/or access to health issues.
We have also looked at getting involved with other things that you wouldn't think fit within public health. We do a utilities program. We actually accepted dollars to run a utilities program because it gave access to many individuals who didn't, when they walked through the door, just didn't need an electric assistance or gas. They needed help with many things that we were able then to concentrate and solve those problems for them.
So what we have been doing is really trying to get to the heart of the issue and collect data around how many of our care coordination calls are for housing, and then compare that to the geocoding and mapping we do, where we know the housing stock is poor, where we have the greatest lead or greatest pockets of poverty exist.
Then we are able to tie those social determinants to the health programs that we want to do.
>> Leslie Mikkelsen: Does that also tie to some of your interests in health in all policies?
>> Donna Skoda: Yes, we have legislation ready to go before both our county council and our City Councils to start adopting health in all policies. We have had both of them adopt a food policy so that we are able to talk about food deserts and the availability of fresh fruits and vegetables and food recycling, all that stuff. They agreed to that so now we are moving forward with the health in all policies as well.
>> Leslie Mikkelsen: I want to thank you both for this portion. I enjoyed very much the opportunity to dig in deep. Our chat is going off the hook. I'm going to pass things over to Matthew to start to ask you some of the questions that have been coming in from our participants. Matthew? All yours.

>> MATTHEW: Thanks, Leslie. Thanks, Donna and Heidi, wonderful, rich conversation and the panel discussion has been fantastic. Again, all of the comments that were made during this Q&A discussion panel is going to be available to download as audio after today. So make sure that you go to Dialogue4Health.org to access both the presentation slides as well as the audio and the conversation. It will all be there as well as the slide information and audio from our last web forum as well.
I do want to, as we open up for the panel discussion I want to bring up Poll 4 on your screens. And this, after listening to the conversation and I know many of you are engaged in your own responses to the funding opportunity right now. I want to ask what would be most helpful to you as you engage in this work? Please select all that apply.
A, examples of successful AHC efforts.
B, information about how to establish AHCs.
C, strategies for establishing strong cross-sector partnerships to support AHC work.
And D, strategies to address underlying social and community determinants of health. We have a couple of questions about that coming up. So please respond. If there's an other and you want to send in your comments during the Q&A, please do that. We will be grateful. Send in your questions for the channel. Send in your comments. We do want to hear from you.
With that I want to bring back Leslie, Donna and Heidi. We have about 15 minutes left now until the end of the web forum today. We have had a number of questions that have come in. I'll say they vary from the very specific to the more general.
But I think one of the questions as we look at linking community efforts together, a question from Tammy that I want to ask Donna first and then want to make sure we hear from Leslie and Donna. What are the.
Has it been easy, difficult, how long has it taken to address the needs of the whole person?
>> Donna Skoda: When we trained that original group of providers, I think the training that we did, we did a whole day training and offered SMEs and talked about the social determinants and how it impacts health. There was a sales job up front to get them to understand why we were trying to do this and we thought they could have better outcomes but we also brought it to their level around, you know, are you struggling with patients that never come back? They disappear. You don't know what happens to them. Are you worried? Are there patients that you know aren't taking their medications and you are going to add more drugs and they are not taking the ones you gave them in the first place?
Once it started to come home to them that it was relevant and she felt comfortable. And I think training the entire staff in that practice, not just the physicians. It was not just one more thing that the physician had to do it. The front desk person or the nurse or assistant could do that. You were able to identify the strategies to identify the signs and symptoms. And you'll discovery whether a person is having trouble making that referral to us. It was offering CMEs, which is huge and doing it on a Saturday so they can actually get there. It was very, very well appreciated that they were able then to engage their patients at a different level. And we still have those partners engaged today.
>> Matthew Marsom: Great. Thank you. Heidi, your thoughts on this question and engaging providers and really bringing them on board to adopt some of these strategies?
>> Heidi Haney Favet: I think one of our greatest strategies is that we have a nurse practitioner within the clinic who is very passionate about this work and she has been a great champion for the Community Care Team as well as our care coordination model. She has done a lot of referring. And then when she is working, the Ely clinic is very collaborative. The providers work closely together and consult each other a lot. As she is listening to a colleague talk about a situation that they are struggling with or feeling at a loss for how to help, she has been wonderful at then saying: Hey, have you considered bringing Heidi into this? Or getting a community health worker involved in that situation? Sometimes they'll say oh, does it really work? She has been very encouraging to have people give it a try. Try it, you'll like it!
Once we've achieved, helped a patient achieve a success, then the provider is often much more likely to come back and say hey, that worked out so well. Can you help this one? Can you help this patient? I think the biggest challenge we find in that engagement is that some of the providers can see -- the

unfortunate term train wreck sometimes comes up. Somebody who has so many problems, it's clear that they are not holding any of it together anymore. That's often the case. There are a lot of people who could use this type of -- they have a few things that aren't going well, and they are more able to hide that perhaps in a visit. I think if we could get to the spot where we can do a little bit more screening to recognize those challenges when somebody has just a few needs and address those up front, we can prevent some cases from getting to the extreme situations that sometimes occur.
>> Matthew Marsom: Leslie, do you have any thoughts from the Prevention Institute perspective on this issue? And recommendations for folks listening who would be thinking about how to tackle this in their own planning?
>> Leslie Mikkelsen: Well, yes. I think that picking up on the points that Heidi and Donna raised, one thing we know, there is actually a lot of clinician dissatisfaction these days. It is for exactly the reason that they recognize that the medical treatment they are providing is not going to be successful as long as folks have a lot of social and economic needs. So I think that is right away a gateway for providers to be provided about the opportunity to be part of a network that supports individual patients.
Likewise, a lot of our community-centered health homes work and framework for institutions has been focused on how can a clinical institution really use its resources, its community credibility to help support the kinds of policies like Donna is mentions, health policies or supporting access to housing. I think what is important in terms of promoting that is understanding that an individual clinician, their job will not necessarily change. What is great about a coalition and partnership is that there's a division of labor. So that a healthcare organization can lend its voice, and as part of the partnership say yes, we know ultimately to improve health these changes are needed.
At the same time the folks that carry the day-to-day work forward may be the organizations that are more experienced in policy. I think there's a real great division of labor that can happen that can impact health across the community.
>> Matthew Marsom: So we have had several different questions that came in. I can see Renee, Cindy and others who asked questions about screening tools. Clearly there's a lot of folks in the audience who had questions about this. I'm wondering if we can start perhaps with you, Heidi, to talk about how are you getting your screening tools? Are you creating them collaboratively?
I think Cindy asked whether or not anyone has access to the CMS required screening tool questions. There was a final, I think I'm scrolling down to make sure. Well, we'll come to the other one later. Start first with how are you getting the screening tools, and did you create them?
>> Heidi Haney Favet: To date our collaborative has not really used a screening tool so much as a general recognition when somebody comes into the office that they are not doing as well as they would like to be. So it might be their own words or it might be physician observation or provider, hearing somebody say, "Boy, you know, I have to wear my coat at home all the time." Whatever it is that comes up. We are working right now on developing a routine screening system for mental health needs across agencies and we are still determining, looking at the PHQ9 and can we do an anxiety measure and/or a chemical dependency measure? We are still in the process of evaluating what the right way to go with that is. We have not used a screening tool to date.
>> Matthew Marsom: Donna?
>> Donna Skoda: Yes, we have several screening tools. On the phones, the care coordinator that take the direct calls and referrals ask the individuals a group of questions regarding their stability, regardless of what the need is, the call is. Our belief is if you have a need or you are calling us for one thing, there's perhaps some other things.
In our programs we have an alcohol or drug screen we use in the community, particularly in light of the opiate problems that have been surfacing around the country for everybody. But we have a drug screen that we use. We have a mini mental screen that we use, home-based to identify depression and/or any sort of dementia. We do some of those screening tools. Many of them, some of them have come through the agency, through individual practices like mental health has the mini mental that we use that helps identify those needs.

But as an overall screening tool we don't have anything that is like six questions we ask every single person except on the phone lines for care coordination. We ask them about housing, food, their security and resources and other needs that they have.
That's basically it. I don't know if we have a cure-all for one because they are all different for the needs.
>> Matthew Marsom: Thank you, thank you. So moving forward to another question that has come in from Richard and Leslie, I would like to have you address this and certainly have Donna and Heidi give their thoughts as well. Richard asks what role can economic development and business play in these Accountable Health Communities? I know we talked previously about the importance of multi-sector partnerships, we had web forums on that topic related to community prevention strategies. Folks can go online and listen to the archive from those presentations before.
Leslie, can you give us your assessment of those important sectors, for example on business?
>> Leslie Mikkelsen: I certainly can. In Chittenden County, Vermont, around Burlington, we met with a partnership that was being led by the metropolitan planning commission. It was basically the seat of the -- it was a partnership of the business community and the agency's focus on land use and transportation planning. And around the table they worked on looking at a regional development plan that could address some of the critical issues in the community like lack of affordable housing and transportation for problems that seniors were having. It is extremely important to have those partners at the table.
I will mention as a follow-up to the story, I told about the healthy living collaborative that one of the collaboratives staff mentioned to me that a banker actually stood up at their meeting where they shared the story about the housing development and the fact that a property owner had taken it over and was kicking everybody out. He got tears in his eyes and said "I gave a loan to that property owner!" It was really eye-opening to him. He hadn't thought that his actions as a banker were having an impact on people in the community. I heard that part of the story yesterday. It really said to me how often folks working in other sectors besides health don't understand how important these variables like housing or transportation or land use decisions are in impacting health.
I took away a high hope that if we set up good collaboration that includes those business partners there can be really learning together from the voice of community about the changes that are needed to promote health and equity.
>> Matthew Marsom: Thank you. Donna, do you have any comments to make as well on strategies that have worked as well to bring those sectors to the table?
>> Donna Skoda: I think yes. We have been able to -- again we have some really gracious and generous individuals in town that are builders, come from the Home Builders Association and any number from the community development end of things. We are launching a formal program with a builder, it's Testa. And we are looking at a community that needs to be modified because of some sewer overflow issues. There's an opportunity to do some major demolition and reconstruction in this six-block area. There's a school. There's a grocery store. It's in a very, very poor area of town. We are looking at trying to take that, and with this builder when there's demolition that occurs for this, to rebuild low income housing and look at mixed income housing which we think is a much better strategy and to look at health of that community based on how we put things back.
And we are just launching that project. And that is our first experiment. There have been other projects done locally that involved community development dollars, block grand. CBG block grant dollars, around sidewalks, walking trails, anything that promotes help. It helps a lot to have the health in all policies in place because it gives folks a roadmap of things that will make a difference if you just included this in your project.
Another example that is when they are rebuilding school buildings with federal money that's a good time if you want a school based clinic, to make a pitch to put that school based clinic in there because they'll put it in there for you.
We are investigating the idea of when we have the dollars to rebuild the school buildings, we are putting school based clinics in them so it is not a thought afterwards but intentionally built into the community that is going to be there, the school environment.

>> Matthew Marsom: Thank you. I have a question I'm somewhat reticent of asking this right now when we only have about three minutes left but it's such an important one that Tammy has asked on the panel -- I'm sorry, on the Q&A today. I'm going to ask Heidi or Donna if you could volunteer to answer this rather than call on both of you and we can follow up to get further responses offline but what are the savings that have been captured through your efforts and what are we seeing with respect to double bottom lines, health outcomes and health savings? Can I ask one of you to tackle that in about 60 seconds and give the opportunity for the other one to follow up afterwards?
>> Heidi Haney Favet: With the scope, Donna, I guess you're in a better position to answer that.
>> Donna Skoda: Let me tell you one piece that I can off the top of my head remember. We looked at diabetes intervention with individuals. Every year we could keep people engaged -- when individuals first came to us without insurance using the ER they were costing -- this is looking at some fancy statistics that modify the numbers, but the bottom line is folks were costing about $200 a month to maintain them in the safety net. This is not in-patient. This is external, out-patient basis. These individuals were being maintained in the diabetes project.
The longer we could keep them engaged and in care and people having supportive services around them, at the end of five years their care per month dropped to about $65. We were able to over five years save longer -- the minute you dropped out of care, the minute you dropped out of that intensive follow-up, the wrap around services, the same costs were right back up there again. So we were able to justify that very well with the diabetes. We have done a similar analysis with hypertension, to look at those to see if in fact it is a cost savings.
Now, if you asked me overall how much we saved, I don't know. But I can tell you in human suffering and pain? You can't measure it.
>> Matthew Marsom: Uh-huh, absolutely. Thank you, Donna. And I know we've got about a minute left. So we could go all day, if not over the next several days with this dialogue. It is incredibly rich and valuable. What I want to do now, I'm going to thank each of the panel members and ask you for just your take-away items, if we can. So first, Leslie Mikkelsen, managing director, Prevention Institute, your take-aways for the audience today.
>> Leslie Mikkelsen: My real take away is that this Accountable Health Community opportunity is a chance to look at existing systems that I think are in most communities: Medical care, behavioral and community health and community services, and community prevention efforts, and really start to weave them into a whole system of health that can have a greater impact on health outcomes.
>> Matthew Marsom: Thank you, Leslie, again, for joining us on the web forum today. Donna Skoda, thanks to you for joining us. What are your take-away messages for the audience?
>> Donna Skoda: I think with all those melt partners there's more than one way to solve problems and the way you solve that problem today may not be the way you can he it toward, when Affordable Care Act Medicaid expansion, things changed. You still needed the systems and the services. Building a system where you have collaboration and individuals willing to work together can weather any storm. And that is what I say you've got to have as your main focus. You have to have a mission and say we stay together regardless, in the good times and the bad.
>> Matthew Marsom: Thank you. Again, last but not least, Heidi Haney Favet with the Community Care Team, Care Team leader in Ely, Minnesota. Your take away with the audience thinking how do they move forward with the fund their responses to the funding opportunity?
>> Heidi Haney Favet: When we look at the social determinants of care coordination, recognize it takes a lot of patience because change takes time. It takes a lot of time. Often it is not uncommon for a community health worker to spend ten, 20 hours in the first weeks working with an individual. And it is also about being focused on the individual first. So what looks like the obvious problem to solve initially to the provider may not be the obvious problem to the individual. And that is where we start. And we can't be successful unless we are looking at the individual's needs. What do they want to achieve?
In the same vein the Care Team itself. It is its own patient. It requires its own care coordinator who looks at things in the same way, putting the team itself, not just trying to direct where it goes but letting

the team direct where it goes, being patient and recognizing it takes a lot of time and a lot of energy. But the outcomes are worth it.
>> Matthew Marsom: Okay. Thank you, Heidi, for your contribution and thank you to all our panelists. I do want to note there were so many questions we couldn't get to. We will make sure we capture all of the Q&A and share that with the sponsors of the web forum so we can be sure to follow-up. A reminder as well, the first web forum audio recording and transcript are available on the link now. You can go to Dialogue4Health.org, I won't give the whole thing, but go to Dialogue4Health.org and find it, there's a search feature. Applications are due March 31, 2016 and LOI was not required, so you can still submit even if you didn't submit an LOI.
I want to thank as well you the, the audience, for sticking with us and listening to this incredible presentation, as well as to the factors, there's a picture to me as well as moderator. Thank you to our sponsors, American Public Health Association, PHI, Trust for America's Health, and Prevention Institute, and our will partners, thank you to all of the organizations on your screen currently. So this is the Accountable Health Communities Deep Dive. We will look forward to you joining us on our next web forum in the series. Thank you so much and we will see you soon. Thank you.
(The session concluded at 4:04 p.m. EST.)
(CART provider signing off.)