Climbing Together: Improving Health through Community Collaborations

Thursday, March 9, 3:30-4:45 pm

Going Upstream through Community Collaborations

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Durham, NC, is home to 295,000 residents, 42% African American, 15% Latino, 40% Caucasian and Duke University and Duke Health, a world class Academic Medical Center and University. Over the past 18 years, Duke’s Division of Community Health has designed and implemented multiple health system and community collaboratives in both urban and rural communities. We’ll open the session with actual community collaborative case scenarios taken from our 18 years of experience in Durham and its surrounding counties. The case scenarios include examples related to health care access and utilization, disease management and prevention and particular populations such as patients with behavioral health issues. We’ll particularly explore health care access and prevention programs that can expand the reach of the hospital outside its walls and into vulnerable communities and populations and become an instrumental intervention for accountable care organizations and patient engagement strategies. We’ll present a framework that includes four core competencies that each health system or hospital can strive to acquire and master.

The core competencies address a strategic framework that integrates the hospital’s business model with community engagement strategies. This framework can successfully launch initiatives for vulnerable populations and communities with the goal of increasing access, quality, and prevention. The framework outlines avenues for developing targeted programs that link hospital business models to communities of low wealth, forming healthy places outside the walls. Collaboration and partnerships are two structural platforms that can bring together health system, hospitals, public health, and community organizations to develop and sustain community health initiatives.

Participants will leave the session with Duke’s Division of Community Health “Partnership Evaluation” tool. This tool was implemented by the Division to assess its role and impact organizing and participating in community collaborative to improve health and address social determinants of health.

Learning Objectives:

• Apply several case scenarios of community partnerships that complement classic efforts of public health to align clinical and community services
• Recall four organizational core competencies: Goal Oriented, Community and Partners Context and Construct; Principal and Developmental Evaluation paradigms; Systems thinking; and Polarity Management tools
• Review a successful “Partnership Satisfaction” tool currently used by Duke University’s Division of Community Health
Better Together: FQHCs and Hospitals Engage Communities in Health Improvement
Chaya Merrill, DrPH, Director, Child Health Data Lab, Children's National Health System
Alis Marachelian, MPH, CPCC, Senior Director, Health Promotion Department, Mary's Center

The DC Healthy Communities Collaborative (DCHCC) is a striking example of the power of collaboration in elevating health in an urban community. In the Summer of 2015, the DCHCC membership – four community health centers, four hospitals, two professional membership associations and an active community advisory board with full support from the Department of Health – went on a quest throughout all 8 wards of DC to explore the fundamental health needs of a community... without having a disease-based model in mind. Our session will focus on the collaborative power, crucial conversations and lessons learned of bringing community health centers, hospitals and other stakeholders together in planning, implementing and evaluating our community health needs assessment/improvement plan. We will highlight the immense value of interdisciplinary stakeholders focusing on wellness, not disease, to improve community health.

Attendees will learn how we engaged stakeholders in a robust bi-directional dialogue to identify unmet community needs. Community input was paired with quantifiable health behavior, status, and utilization data, Census data and related social determinants data, to provide the landscape of health and well-being in DC. While DC is a thriving city in many ways, severe health inequities across the city persist. With those health inequities come many pressing community needs. Of key value to attendees will be our demonstration of the structured prioritization process used to arrive at a set of the highest priority needs: mental health, place-based care, health literacy and care coordination. We will then present our population-health based framework in developing our community health improvement plan that addresses the four community needs. Our model places attention on root causes of health inequities with a focus on the social determinants of health. Specifically, we invested in a Policy-Systems-Environment approach that promises to have a measurable and meaningful impact on the lives of DC residents.

Learning Objectives:
• Develop strategies to build a successful, multidisciplinary coalition to improve health based on the experiences of the DC Healthy Communities Collaborative
• Design an innovative, community-engaged process to conduct a community health needs assessment, including the use of a structured prioritization process to select the most pressing community needs
• Discuss the move toward population health-based improvement strategies that capitalize on the collective strengths and resources of a multidisciplinary group of stakeholders

Partnering4Health: Moving Upstream to Address Chronic Disease
M. Elaine Auld, MPH, MCHES, Chief Executive Officer, Society for Public Health Education
Quinney Harris, MPH, Program Manager, National WIC Association
Elizabeth Hartig, Project Coordinator, American Planning Association

Chronic diseases are responsible for 70% of deaths each year in the United States and account for a major portion of health care costs. An extensive evidence-base demonstrates the importance of changing policy, systems and environments to impact and bend the cost curve. Beginning in 2014, the Centers for Disease Control and Prevention funded a $28 million partnership of five national organizations to facilitate policy, systems and environmental changes to reduce chronic disease risk in local communities. The American Heart Association (AHA), the American Planning Association (APA), the Directors of Health Promotion and Education (DHPE), the National WIC Association (NWA) and the Society for Public Health Education (SOPHE) collaborated to provide training, technical assistance and funding to 97 communities in 36 states over three years. Communities were funded to implement population-based approaches that promote healthy eating, increase physical activity, reduce tobacco exposure, and strengthen community-clinical linkages.
The five national organizations established the National Organizations Collaboration Strategy Network to build on the strengths and capacities of each group in an overall effort to reduce health disparities and develop a stronger evidence-base for sustainable reductions in chronic disease. This presentation will describe major features of the National Network that facilitated collaboration, challenges such as organizational cultures and timelines and lessons learned. Examples of successful policy/systems changes implemented through multi-sector coalitions in local communities, including Colorado, will be highlighted by NWA and APA. Given the increased involvement of hospitals in community partnerships and population health, this presentation will provide insights and promising practices that can be replicated in other communities and elements that can strengthen the likelihood of improved health outcomes. It is vital to engage public-private partnerships for policy change success; embed targeted policy and environmental changes in broader community initiatives whenever possible; and continually engage and interact with the broader community.

Learning Objectives:
• Describe a three-year effort of five national organizations funded by CDC to accelerate policy, systems and environmental change in 97 communities to reduce chronic disease risk and elements contributing to successful partnerships
• Recall lessons learned from grantees of the National WIC Association who facilitated community-clinical partnerships in local communities for improved maternal and infant health
• Name successful examples of local policy partnerships that were funded by the American Planning Association that improved the built environment and physical activity opportunities

Friday, March 10, 10:30-11:45 am
Engaging “Hard-to-Reach” Communities in Research through Community Resident Research Teams
Farrah Jacquez, PhD, Associate Professor, Psychology, University of Cincinnati
Lisa Vaughn, PhD, Professor, Pediatrics, Cincinnati Children's Hospital Medical Center, University of Cincinnati
Gabriela Suarez-Cano, BS, graduate student, University of Cincinnati

Some populations, often those most effected by health disparities, are difficult to engage in research due to challenges with social, cultural, and economic factors like trust, access, language, and transportation. Because of these challenges, “hard-to-reach” communities are underrepresented in the very research where their inclusion is most crucial. Health disparities will most certainly persist if these communities are ignored, so innovative research strategies must be used that directly engage communities in the process of research. One promising strategy is Community Resident Research (CRR) teams, or long-term partnerships between community members and researchers working toward health equity. CRR teams are characterized by shared decision-making throughout the research process but are distinctive among other community-engaged research approaches in two major ways.

First, the partners are not service providers, agency leaders, or other individuals with positions of power in the health field. Instead, community partners are individuals who live in the communities that are experiencing the disparity and therefore bring the expertise of lived experience to research inquiry. Second, CRR teams are formed as long-term partnerships that conduct iterative projects aimed at collaboratively developed long-term goals. Fitting within the topic track of Climbing Together, we will present an example of a CRR team that engages Latino immigrants in Cincinnati, OH. Over the past four years, Latinos Unidos por la Salud (LU-Salud) has engaged in three iterative grant-funded projects to promote Latino health: a survey of 500 Latino immigrants, a concept mapping project to identify intervention strategies, and a community-based stress intervention program delivered to 115 Latino immigrants. We will present the process and details of engaging Latino immigrants in a CRR team and discuss how the model can be used with other hard-to-reach populations.

Learning Objectives:
• Analyze the use of Community Resident Research teams to address health disparities with hard-to-reach populations
• Describe the process and details of Latinos Unidos por la Salud, an example of a Community Resident Research team
• Discuss how the scope of Community Resident Research teams can be broadened for use with other hard-to-reach populations
**Improving Access to Health Services via Partnerships with Community Pharmacies**
Sarah Kelling, PharmD, MPH, BCACP, Clinical Assistant Professor, University of Michigan

Community pharmacists are considered one of the most accessible health care professionals, particularly as 90% of Americans live within five miles of a community pharmacy. Furthermore, community members are often able to interact with these highly trained professionals without an appointment and during expanded hours. In addition to dispensing medications, many pharmacies are offering additional services including immunizations, point-of-care screening, comprehensive medication reviews, disease state management, and transition of care services. In order to maximize the values of these services, pharmacies are looking to develop and expand partnerships with local health systems and health departments. A significant portion of time in this session will be dedicated to working in small groups and large group discussion. It is expected that this session will be relevant to any individuals who work for hospitals, health systems, health departments, community pharmacies, and other type of organization that provides health or human services.

Learning Objectives:
• Summarize literature related to community pharmacy partnerships with health systems and health departments in order to improve accessibility of health services
• Describe opportunities and barriers related to the development, implementation, evaluation and sustainability of community pharmacy partnerships with health systems and health departments
• Identify potential opportunities for collaboration that may exist in your local community

**A Rural Collaboration: Healthy Smiles for All**
JoAnn Miller, MA, MPH, Director, Community Health Promotion, Samaritan Health Services
Marty Cahill, MA, Chief Executive Officer, Samaritan Lebanon Community Hospital
Earlean Wilson Huey, MA, Oral Health Program Coordinator, Samaritan North Lincoln Hospital

The Coast to the Cascades Community Wellness Network (CCCWN) was formed in 2009 with a mission to provide leadership to enhance the health of communities through development and support for collaborative partnerships in Benton, Lincoln and Linn Counties Oregon. The CCCWN membership consists of key leaders and decision-makers from health care, education, government agencies, non-profit organizations, and tribal councils. The CCCWN supports the local coalitions that address the social determinants of health. In 2012 the CCCWN developed the Benton, Lincoln, Linn Counties Regional Oral Health Coalition of Oregon to review the oral health needs within the region. The BLLROC is comprised of members from local organizations and residents. The BLLROC reviewed several model programs and recommended a three prong approach to address the oral health needs in the region.

The first approach is the co-location of an Expanded Practice Dental Hygienists (EPDH) within the medical clinics in rural communities who will provide preventive care to underinsured/uninsured and low-income residents. The second approach is integrating the Adult Emergency Dental Voucher program with EPDH services. The AEDV program provides vouchers to private practice dentists to provide care to patients with emergent dental needs. The AEDV program will provide vouchers to the rural medical clinics to offer preventive care to uninsured/uninsured and low-income residents. The final approach is expanding and coordinating dental van services with local non-profit agencies in the region. Currently there are Expanded Practice Dental Hygienists co-located in rural primary care clinics in Brownsville, Lebanon and Sweet Home Oregon with expansion to 5 additional clinics in Lincoln County. The Adult Emergency Dental Voucher Program is providing preventive care in East Linn County with sites being planned for the city of Albany and Lincoln County. The Dental Van program now offers unorganized and sporadic dental services throughout the region.
This breakout session will provide an overview of an Intermountain Healthcare led community collaborative focused on reducing inappropriate use, overdose and death from prescription opioids. Prescription drug misuse and overdose are at epidemic levels nationwide with Utah ranking fourth in the nation for overdose deaths. Intermountain Healthcare began working with community partners in 2015 to develop the Opioid Community Collaborative (OCC): a collaborative and multidisciplinary approach to decrease the burden of prescription opioid misuse, abuse, and overdose. Community partners in the OCC include two local mental health authorities, the Utah Department of Health, the Utah Division of Substance Abuse and Mental Health, and a Federally Qualified Health Center.

These partners have collaborated to plan and implement efforts to improve public awareness, provider education, and access to treatment related to prescription opioid misuse. A description of these efforts including factors that have led to success, the challenges faced, and outcomes achieved will be presented as part of this successful effort to Climb Together. In addition, Intermountain’s efforts to use collaborative strategies to improve internal efforts and expand reach will be highlighted. The presenters include a community partner from the local mental health authority who will discuss the process and collaboration from the perspective of a partner.