

Panel 4: Community Engagement

So we'll try to break things up a little bit. Our next three panelists are Jessica Curtis, who's the Project Director, the Hospital Accountability Project and staff attorney at Community Catalyst, a national organization that's been doing great work for many years in the area of community health and community advocacy. Our second presenter will be Michelle Lyn, who's the Associate Director of the Duke Center for Community Research, Division of Community Health at Duke University Medical Center. And our third panelist is Dory Magasis Escobar, who's the Director of Healthy Communities for the St. Joseph Health System. Again, we're going to get two great examples of folks working on the ground in hospitals. Jessica, you want to kick us off?

So I was told I have 18 slide, and I am on the clock to get through all of them in 10 minutes, so you guys can hold me accountable. Just stand up and clap if I hit 10 minutes and I'm not done. That would really help.

So, I wanted to start by telling you a little bit about Community Catalyst because I think it explains our view of the world and how we approach the community benefit issue. As Kevin said, we're a national non-profit consumer advocacy organization, and we work right now in about 40 different states on a variety of issues all related to healthcare. And our theory of change is really that the healthcare system won't change the way it needs to unless communities, community groups and individual community members are literate about how the healthcare system changes, how it affects them. And so our work, we work on a variety of issues including prescription drug access and quality, expanding access to coverage, delivery system reform, and community benefit. And we develop a large number of policy tools and support so that groups understand what are the issues at play in community benefit, how do we impact them?

And also that they understand that the political structure that supports the healthcare system, how to influence that as well. But we also do analysis of the state laws that are on the books and what's worked, what hasn't. And then we go into communities and we've developed a number of workbooks for advocates on things like free care monitoring and how to work with hospitals and other stakeholders around community benefits.

So one of the things that I would also mention that we've been very involved in is that, as we're working in these communities, we feel it's really important that they inform what we're saying about community benefit and where it should go.

So we feel very confident about how we think about community benefit because it's grounded in the work of communities in these 40 states, what their experiences have been working on these issues. And recently we were able to take that and use it to work with members of the Senate Finance Committee who drafted the provisions that are in the Affordable Care Act.

So, depending on your position, I'm sorry or you're welcome.

So I'm going to talk really briefly about two different areas. I wanted to just put out there what's the emerging legal framework around community engagement in particular. That's what I'm going to focus on today because it's really struck me that that's what keeps coming up in your questions. Even though we've been focusing on different issues of the assessment and implementation, how do we do that?

So just looking really quickly at ways the law, federally and in the states, is pointing to more robust community engagement, and then give you some ideas of things that have worked in the communities that we see. And I want to talk really briefly, set up a paradigm. No hospitals were harmed in the making of this slide but the paradigm is Hospital A and Hospital B. And this is really based on what we've seen. Hospital A could be a hospital that has a community benefit report. They may have a community needs assessment, they may have an implementation strategy, they may not. They probably have a brief description of their charity care program on their website. They may be able to show you, if they're non-profit they have to show

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you, their numbers around charity care. But they might not engage very fully with their community. They may hire consultants, and that's the extent of what they do. Hospital B, on the other hand, will have spent some time really investing in community benefit. It's very clear that their community benefit folks are invested with power to make decisions for the hospital. There's a commitment by senior leadership in community benefit. And there's engagement also. You can actually find a community group that's worked with a hospital on its assessment or implementation strategy. They can point to the final plan and say that was a recommendation that they made that they took and this is how we're working together. And I would just submit that both of these groups are headed for the headlines in one way or another. The hospital that is not well positioned or not responsive to their community won't be there for reasons that want to be, whereas the hospital that is engaged is more likely to make the news for programs that are working and partnerships that are working. And, as one example of that, I just wanted to point out -- this comes from our partners at the PICO National Network. This is from a story from their New Jersey chapter. Let me just go back. How many of you read the Hot Spotters article in the "New Yorker" Atul Gawande's article?

So, if you've seen it, you've seen that the data is very similar to the maps of the earlier panel. There was a provider there by the name of Jeff Brenner who was really interested in understanding why certain populations, and why certain people came back again and again to his hospital. And he mapped the data and identified hot spots within Camden, New Jersey which, as most of you may know, is one of the poorest, most violent cities in the country. And what he found, he identified certain housing complexes as housing most of the individuals that were returning again and again to the hospital. And he did something I think that was unique, that wasn't necessarily covered in the article. But he reached out to PICO affiliate -- this is a faith-based organizing group working predominantly in churches who had relationships with a number of residents in that community. And they went in with PICO to say, Here's the data. We want to know what's the issue that's at hand here. And really what it came down to was just transportation and people not having access to primary care doctors, people not being about to get to them. In the words of one of the people they worked with, six blocks is the distance to their primary care provider. Six blocks could be the universe, for all they care. And so what this picture shows here is that, working together, they decided that they wanted a nurse practitioner clinic in their building. And they were able to do that together. And those of you know the Hot Spotters article know they were also able to reduce costs for the hospitals. The hospitals are supporting this initiative. It's a great example of coming, using data, and working with the community. Really quickly, emerging legal framework.

So you all are probably familiar with this language. Conducting a community health needs assessment, you have to take into account input from persons who represent the broad interests of community and then make your strategy available, widely available, to the public.

So, from a community advocate's perspective, there are a couple of things here that are really interesting that we're focusing on. What does it mean to take into account input?

How do you define the persons who represent the broad interest of the community?

And what does it mean to make that widely available and widely usable by the community, not just the hospital?

And I would also say that our advocates aren't interested in the assessment alone, what they're really interested in is how does engagement get maintained and sustained over the life of not just the assessment but implementing the strategies that arise from the assessment then back again and again as you refine and reassess?

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And, of course, we have the notice from the IRS which came out last week that talks a little bit more specifically about who hospitals must take input from, leaders, representatives, members of medically underserved, and who they may consult with.

So, it's really an interesting group. We were very pleased, of course, to see advocates on this list as well as this other list of individuals. All of these, I think, really speak to the wide array of folks that you want to be working with as you do your assessment and implementation planning. There are also a number of state laws that have required or mandate if you do a community needs assessment who you talk with. These are some of them. I just want to flag that Indiana snuck onto this list. I don't think it really belongs there. Instead, I would substitute Maryland, which allows for community input but requires that hospitals consult with their local health departments.

So, that's an interesting, I think, issue for this group.

So, one of the things that we've been really talking about though is how do you move past a compliance framework. And I would say that for most of our advocates, the issue isn't really holding hospitals accountable for the sake of holding them accountable. It's really about how do we actually get in a room and work together to address the issues that we're both facing and seeing?

And so, some of the things that we've articulated are a set of principles that, from our experience in the field, really are the hallmarks of strong community benefit programs that get this bigger picture and can move the conversation forward. And so, for those of you in the back who can't read this, I apologize, but we say, Quality community benefit programs engage communities, first and foremost. They improve access to necessary care. They create long-term opportunities for strategic change. And some of the principles that we've identified is that they really are flexible enough that they can react to local needs and local priorities, and that they can move and address those upstream issues which we all know have such a huge impact on health, that 80% that Julie's slides earlier pointed out. They will open or sustain lines of communication among different partners including public health and community members. They will be accountable and transparent. And we'll talk about the importance of that in a few moments. Importantly for us, they also target and reflect the needs of the most vulnerable community members, those who are most at risk. And they will empower those same community members. This is different from taking input, it's different even from engaging. I think in our view, it's really empowering the community itself, particularly those vulnerable members, to be a part of the change that's necessary.

So really quickly, I think of this in terms of how do you do this. I think of it as a book report -- you know the who, what, where, when, how and why of community engagement. And you can see Where's Waldo is in the middle there. I think one of the most important things to understand is where is your community. And especially when it feels like it's all around you, how do you know who to work with, how do you work with them.

So the who of community engagement; first I would say to set an inclusive table. Make sure that you're drawing from a broad spectrum within the community served. Pay particular attention to people who are underserved. And pay attention to the racial and ethnic makeup of the group that you're working with or consulting with. And ask them, don't just ask yourselves, but ask them who's missing from this table.

So this can really run the gamut from individual community members who are coming in through your doors. I know that some hospitals have patient family advisory councils that they regularly draw from. I think you should also look to -- hospitals should also be encourage to look to the uninsured and underinsured who are in their communities, involving them in understanding the needs during an assessment. Other usual suspects include faith leaders and organizations, civic leaders, existing coalitional partners, healthcare advocates, consumer advocates who tend to understand the political dynamics in your field as well, business

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and labor, your board, elected officials, other providers in health related organizations. And again, just to reiterate points made earlier in comments, these should be individuals who aren't just familiar, I think, with the healthcare system but also outside of health who can speak to the issues around housing and financial income and those sorts of things. You also want to structure programs that send the right message. And these are things that we've talked about with our advocates. I think one thing that's hard often for hospitals to understand is how monolithic they appear from the outside. And so the groups that we work with and that we encourage hospitals to work with often don't understand hospital dynamics, don't know who to speak with.

So these are some of the things that we've encouraged them to do to look for, to understand. Is their hospital really working in relationship?

Is it interested in partnering with the community?

Looking for a mission statement that has a commitment to the community, board and senior management who are invested, a health needs assessment that looks at the needs of vulnerable populations, and the resources that they can also bring to bear. Not just their needs, also their assets. The community, there's a clear link between what the community has said in the assessment and what's chosen in the implementation strategy. There's transparency around reporting. Then most importantly for a lot of the communities that we work with, that their financial assistance policies, debt collection policies, are also fair and reflect the income, the insurance status of their community members. That's the other section of this part of the Affordable Care Act that we're not talking about today. But for the groups that we work with, you cannot step over it on the way to addressing disparities. Involving the community early and often. I'm getting the one minute sign here, so I'm just going to go through these really quickly. The simple point, when should you involve the community?

The entire step of the way. And also, one other point to mention is that, you know, we've talked a lot about the IRS looking at these reports. But I think from our viewpoint the real audience for your reporting should be your local community. Common challenges to successful engagement, I think I'm going end on this slide actually because one of the things that I think we also need to recognize is that none of the hospitals or the health departments that are going out into the field are walking into a blank slate.

So, in addition to the macro level challenges that their communities are facing around access, around income, education and jobs, there are also simply competing priorities. When you think about extremely vulnerable community members and what they're facing, coming to a meeting at your hospital to discuss community benefit is not on the list of getting food on the table, finding child care, finding elder care, finding transportation to your meeting. These are things that, at a very practical level, hospitals are going to have to consider. There may also be a lack of trust or perceived value in participating in an assessment. And one of the things that we hear most frequently is, Well, they came in and they asked us a bunch of questions. And then they left, and we never heard from them again.

So, I think that one of our challenges is how do we work together in the assessment and implementation process to really change the value and change the perception of value. There may also be changing demographics. I know that I've heard from a couple of Boston hospitals that the problems haven't changed in the communities, but who the communities are have changed. And that's going to have implications for who hospitals should be partnering with and reaching out to. I also mentioned that community engagement is time-consuming, and it definitely is. But there's a lot of value. We can skip through this slide. How to focus on the process, just to talk about what's the value of community engagement. I think a lot of you have hit on this, but it's an ability to leverage data effectively. It can give you opportunities to build consensus on key priorities. And most importantly, you know I think to look at community benefit as an opportunity to really invest in building leadership in the next generation, to move forward to those broader system changes. I

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mentioned earlier the example from Camden, New Jersey. Those community advocates have worked with hospitals across the state to build support for a piece of legislation that now will take their model and build a Medicaid accountable care organization, which I believe just passed both houses of the New Jersey legislature.

So there's a real opportunity, I think, for us to work together to build longer term investment.

So, I'm going to end there. These are some of our resources. I'm going to turn it over to my other panelists. Good morning. I'm Michelle Lyn, and I have the privilege of serving as the Chief of the Division of Community Health and the Associate Director of the Duke Center for Community Research at Duke University Medical Center. As such, Kevin asked that I provide an academic health center perspective to this panel on community engagement that touches on our tri-part mission of healthcare services, research and education. Let me give you just a quick context -- oh, should I have done that -- slides.

Sorry, no.

Sorry, I apologize. Just let me give you a quick context of Durham, North Carolina. We're located in the central part of the state. We have approximately 275,000 individuals within our county. 37% are African-American and 12% are Latino. And, while we are indeed called the City of Medicine, we are also an example of the unfortunate paradox of many academic health centers and their communities, which is that state of the art healthcare and lots of physicians and great hospitals don't make for communities of health. In fact, while minorities make up 40% of all births in Durham, they account for 66% of infant deaths and 60% of low birth weight babies. While 40% of our residents hold a bachelor's degree or higher, 16% live in poverty and 27% are uninsured. I could go on in terms of health disparities, but let me stop there simply to say that we know as a community we can do better and that indeed we believe we are on the road to becoming a community of health. In 1998, Duke created the Division of Community Health with the sole purpose of building a bridge between Duke and the communities it serves. In 1998, we were a division of about three folks. Today we're up 140 faculty and staff who are dedicated to building collaborative community engaged programs to improve health. The programs, if I can work this correctly, which apparently is not going to be the case -- right hand in the circle, there we go, okay. The programs, beginning as far back as 1998, we certainly started with looking at our data. The map on your left, the crude map on your left from 1998, shows our ambulatory care sensitive conditions that were showing up in our emergency departments and our in-patient units at both Duke and Durham Regional hospitals. We have two hospitals within Durham County. The shaded areas on the right of that left map are the areas with higher rates of ambulatory care sensitive conditions; and shockingly, they are areas in which we have some of our poorest communities.

So there's no surprise there. If I had layered over a map of our clinical services in 1998, you would have seen a nicely peppered in those light colored areas to the left hand side of that map, certainly not in our most vulnerable communities. To get to the map on the right, which is a much more improved healthcare landscape, we began a process with our health and human service partners and our residents that is an iterative process. It's one that we still do today, and it begins most importantly with asking and listening about the barriers that affect health and healthcare within our community. We do indeed analyze healthcare utilization costs, not just Duke's healthcare utilization and costs, but those of our community partners and costs to the individual patients. We do indeed explore barriers to appropriate care, both intentional and unintentional in some cases it seems. And we do identify partner needs and resources. We have many, many candid conversations with our health and human service partners. It's no surprise that we all touch the same people within our community. Why are we touching them on different days for slightly different reasons when we should be coordinating our services together to maximize what we can do for our community?

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And we actually plan and redesign services together. Most importantly, though, we track outcomes and we feel like we share accountability, both to our individual entities as well as to our residents. A few examples over the last, oh 12 to 13 years that we've put together are neighborhood clinics, built with the residents within those neighborhoods, of course school-based health centers, certainly not a new concept but built in collaboration with the school system and our health department and our federally qualified community health center. But it's not just about placing new facilities in neighborhoods. It's also about getting outside of that facility-bound model of delivering healthcare. And it's about thinking what does it take to deliver the right care at the right time with the right information by the right provider in the right place. And I could keep going on with what the right, right, right part of that is, but as such it's about thinking about what matters to folks, what matters in the content of their lives and what makes sense for them, so where they live, work and play.

So an example of that would be perhaps our home care program for the elderly and disabled. We're in 13 buildings across Durham. It is public and subsidized housing for elderly and disabled. Average income \$7,000 a year, average age 77, difficulty with three ADLs at a minimum, five chronic conditions, and 44% with a comorbid mental health condition. We actually deliver care through teams of nurse practitioners, physician assistants, RTs, OTs, the list goes on, RDs as well. And what we've seen in the last six years of running that program is actually a 68% decrease in in-patient admissions for this population, a 49% decrease in ED utilization. We've increased their pharmacy costs by 25% because they are indeed taking the right medications. And we've increased our home health costs by approximately I think 30%. It's good. They're living at home where they want to be with a quality of life that they want to have. In addition, under contract with the State of North Carolina, we run care management programs for Medicaid in a six county area covering about 50,000 individuals. But let me just move quickly, because I already got the five minute mark. We consistently ask questions of each other. And, as I mentioned, it is thinking about health from both an individual and a population level.

So, as we gather with our health and human service partners, and our residents, we do ask about how do we actually classify risk and disease burden, the health status of both the individual and the population of what is the interaction within that. What are the best practices for community engaged approaches to population health and by whom. It's not always our traditional answers that we often find. And, of course as always, what are the key metrics we should be using. Again, the metrics aren't always the obvious metrics. Let me give you an example that takes us over to our research platform, Durham Health Innovations. In 2006, we received a clinical and translational science award from the NIH. And, for those of you who are familiar with those, that was NIH's challenge for academic health centers to speed discovery and to translation into population. Health improvement -- one of the interesting things of that was what if you started with where your community wanted to start in terms of informing your research platform. And so, under Durham Health Innovations we actually put together an oversight committee that was co-chaired by our Vice Chancellor for research as well as our Director of our Durham County Health Department.

And the members of that community represent both institutions across our University as well as across our entire community. And what they put the challenge out to Durham community was to actually have the community develop innovative approaches to translate best practices in community settings. Develop an actual model for delivering prevention and/or healthcare services, using advanced informatics and health services redesigned principles. All total, we had 500 folks working on the initiative representing over 90 community organizations. We actually issued an RFA for planning grants to our entire community, which is how we had the turnout of 500 folks on those two teams. Those are the areas that the teams indeed worked in. And, as you can see, they actually align nicely with the community diagnosis from our health department within Durham. In order to ensure that these teams had access to all appropriate resources and data that they would need to really analyze those particular health issues that they chose to work on, as well as what could be done to improve those particular issues, we actually put together technical assistance corps that were collaborative across not just Duke but across our community partner entities. And so, as you can see, we had

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a co-community engagement corps that helped teams who, for many folks on those teams were working together for the first time, work through their issues of community engagement and working together as well as data and analysis so that we weren't just looking at Duke data but again data from our health and human service partners as well as school, etc., demographic data. And then, of course, plan development, because we asked them to put together a plan. It's not enough to come up with a model, how do you sustain that model?

How does it really fit into either the existing system of services, or how does it create a new line of services?

Where we are now, we actually have an implementation community that is co-chaired by our Executive Vice President for Clinical Health Services for the entire Duke health system as well as our county manager, whose job it is now to take the plans that the teams developed and actually develop pathways working with individual neighborhoods of how to roll those plans out. Across the 10 plans there were indeed commonalities no matter what the subject area was that the teams came up with which was, of course, to classify patients' health risks, information technology that the teams actually work through in terms of existing information systems rather than waiting for the almighty information system that we all seem to weight on all the time. And how to create a web of options of appropriate providers delivering the appropriate care at the appropriate time. What we expect to come out with, and what we're on our way to coming out with is care that is close, whether it's home, school, neighborhood; again, making sense in the context of people's lives, connected to individual health providers as well as patients to providers, providers to each other; and certainly, above all, accountable, coming up with performance metrics that we all agree on and that we all agree to hold each other accountable to. It's a fundamental redesign of the way we think about health in our community and the way we think about healthcare delivery in our community.

It's not a substitution model and it's certainly not a lesser model of delivering care to improve health. I'm at that one minute mark, so I know that perhaps we wanted to talk a little bit about education and what we're doing on our health professional school side. And what I may do is hold that for maybe part of the question-and-answer period. But, needless to say, what we have learned in our work around community engagement, we would be remiss if we actually weren't weaving this though all of our health professional school's curriculum. And giving our students the opportunity in a structured manner to participate in community engagement activities. It's not throwing that doors open to communities and saying, Go forth, students; but it is proving structured matters in which students can participate all levels of community engagement activities. And so, we've redesigned our own residency program as well as schools of medicine, nursing, etc., programs to incorporate community engagement teaching and research. And it's what we all know. We have learned what we all know already. Health requires more than medicine. Healthcare certainly requires more than physicians. And don't forget, I stand here as a faculty member of a school of medicine. Improving health requires teams in the office and the community. And those are non-traditional teams very often within our community settings. And certainly community partners add expertise and resource throughout the entire continuum of the process. And, as we know, needs vary. All healthcare is local, goes right down to the neighborhood level. As we were just talking just a few seconds ago, a few blocks make a world of difference to people. And above all, we know that we can do better. It's why we're here this week.

Thank you. Hi, everyone. I'm Dory Escobar. And I get to look silly up here with the -- thank you. There we go.

So, I'm Dory Escobar. I'm with the St. Joseph Health System in Sonoma County, California. Beautiful wine country formerly known as the Redwood Empire -- culture change there. And, as I've been listening to my colleagues here on the panel and to some of the questions, it's really struck me that I want to start with seeing if we have a common understanding and agreement about community engagement what we're talking about. Because we keep talking about what we are doing to engage the community. And I think that in my mind, community engagement is also multi-directional. And sometimes we need to be willing to be engaged

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by the community. It's not just the folks with knowledge and certain skills and certain knowledge going out and helping the community. But if we're talking about really authentic relationships and equitable partnerships, it's multi-directional.

So that's the way we approach it. And I also want to say that, with the building knowledge and deeper understanding through all kinds of data about the social determinants of health, how they affect our ability to make the right choices and do the right things for ourselves and for our loved ones and our communities, it requires also comprehensive responses. And so, if we understand the importance of the social determinants of health, we also need to understand the importance of the strategies to address them and the investments we need to make in them. And so I know there's been conversation and hopefully more conversation about health protection activities, community-building activities and being a reportable community benefit is not the only reason that hospitals and other healthcare organizations should engage in a community health improvement initiative or activity. And so, if we know that it needs doing, we need to make the investment.

So in our organization, we take a very comprehensive approach to this very comprehensive and complex problems that we find in our needs assessments. And so we go as far upstream as we can, and we also recognize that there are immediate issues that need to be addressed downstream.

So, through a focus on advocacy initiatives that involve legislative advocacy and a lot of local advocacy with city councils and our board of supervisors, and institutional policy change as well as public policy change. And then we look at the social determinants health through our health communities, initiatives, and programs. And the heart of that is a community organizing team, known as the Neighborhood Care Staff . And a grassroots leadership development program that together we've developed, which we call ACTION, or agents of change training in our neighborhoods. And it's -- this is really the heart of our community benefit work, and no longer actually reportable as a community benefit activity. But I'm very proud to work for an organization that chooses to make that investment anyway because we've seen the difference it makes. And we'll talk a little more about that. And it also harkens back to the founding of the Community of Sisters, who are the Sisters of St. Joseph of Orange, who founded our organization, because they came together about 400 years ago in France as a group of women who went out into their community, into their neighborhoods, identified who has influence, who has concerns, how do we bring them together.

So the whole thing started through community organizing and we still do it. And then we have our community health clinics and programs. We've got multi-disciplinary, in-home program for frail seniors. We have a mobile health clinic, a mobile dental clinic, dental disease prevention program, a school-based program as well as a fixed-site dental clinic. But I really want to focus on the organizing work and the health communities work for today.

So we have a lot of frameworks. One of the frameworks we use are the core principles and the processes that were developed through the work of advancing the state of the art in community benefit led by the Public Health Institute, Kevin, and a lot of folks in this room. And we truly found that they were so congruent with our organization's values and the way we were doing things and really helped to inform our work and be another framework. We also are very much committed to the framework of the spectrum prevention developed by the Prevention Institute. And our needs assessment collaborative, which are the three primary non-profit health systems in our county: ourselves, Kaiser, and Sutter. Together, with our public health department. We're just now on our third cycle of doing our community benefit needs and assets assessment together.

So it will get us through nine years of working together. And we chose this framework in our last cycle as a way to look at the information that we're gathering from the community, identify some best practices at these different levels of intervention to help guide the individual community benefit plans that we make.

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So the community organizing process in our organization is very much relationship-based. We don't organize around issues; we don't build relationships to complete activities. It's very much a partnership in recognizing that there's a lot of wisdom in the community.

Some of it has initials after its name, and some of it doesn't.

Some of it wears the suits and some of it wears jeans and flip-flops. But this is a multi-directional shift for all of us. And so if we're coming in and working with the community to help the community understand its own power, its own place and how to use it, and then we move on.

So, our organizers really focus, again, very much on building relationships and helping to inform community processes of dialog and learning how to be partners, be at the table, as well as working with the agencies and local governments to learn how to work with residents. We're members of a community health coalition in our county called Health Action. And we are really the driving force behind the community engagement strategy throughout that. And that coalition has representation of business leadership, healthcare leadership, political leadership, and different ethnic and cultural communities. And we recently did a presentation on some strategies and projects that have worked. And we had a four hour session with them in which they reflected on what changes for them personally in their organizations from policies and practices when the community learns how to use its power. And how is that going to make them look at what they're doing and what do they need to do differently.

So it was fascinating, and I think a lot of courageous conversations happened in the room. We've got our training program, which really is just a way to systemize the leadership development work that we do with the residents. And we also recognize that leadership is a continuum, and it's all necessary and it's all good.

Sometimes when you use the term "community leader" it can be intimidating to someone.

So, as one of my colleagues mentioned before, people are struggling to meet their basic needs, and they're committed to also being part of making their community stronger and better. And it can be very intimidating because they assume it means a lot of meetings. And so, we need to recognize that there's people that are concerned about what's going on, and they may really want to give their input on a community need assessment and a focus group. And that may be all they're really wanting to do. And then, there's others who are activists. They're willing to get involved and do something. And then there's folks -- there's those leaders who really want to grapple with the problems, and then they feel good and they've solved the problem and they move on. And then there are those more visionary community-building activist leaders. And those are the one this we're focusing on so they can help build those different levels of leaders along the continuum. And so it's -- accountability has come up a lot. And for us, it's very important. And I drive my team crazy all the time when they tell me that they had 30 residents come to a meeting and half of them were there for the first time. And, of course, I respond with "Well, so what?"

Then they were able to decide what to do and they decided to write a letter to the City Council about this traffic problems. And I go, Cool and so what happened with the letter?

And we go on and on. And so, accountability is important and so we are a very humble crew and we are anxious to learn from anyone we can. And so we look at what processes and tools are out there working. And if they're not working for what we're doing, can we adapt them?

And so, we've developed our own sort of continuum of leadership indicators that our organizers focus on with the residents they work with. We've also adapted a model that was developed by woman's funding network, called Indicators of

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Social Change. Because if something's not changed in the community, you're not doing your job. And then looking at results based accountability also helped us.

So again, moving through the continuum of being involved to being in charge, and then looking what's changing. How do people redefine the problem?

What change is happening in their behavior, what's the change in the quality of their engagement and their leadership in the community, what policies are changing and how are we sustaining those changes?

So, for example, if our community organizers go in and start talking to people, find out what's important to them, help bring them together with others who can help them address those problems, be actively involved in making decisions about what's important and about what to do about it. And then they'll decide we work with day laborers who decided they wanted to do a community garden because they were hungry. But they also decided that part of what they grow needs to go back to the food bank because they've been receiving services from the food bank so long. And then they decided, well gee, we're out there looking for work and if we had a stable economy here in our community then we'd all be healthier.

So they took the idea of their community garden and they've turned it into a co-op farm. And the school up the street is contracting with them to bring in fresh produce. The community clinic has asked them, Can they load up a pickup and come and sell produce at the clinic?

So it's opening up all kinds of opportunities because we acknowledged that they had the wisdom of what they need to do and then that they also had the wisdom to tell us what they needed from us. And so, when we look at the work that we do in community building and community organizing, health protection, and we have to look at is this group that we're mentoring making a difference in the community, and if so, how?

And how are they relating to, and being related to differently, by the officials in their community, by the businesses, and is the community any healthier at the end of it?

So I know you can't see this, but this was just the flow of what happens, the kind of the logic model of our organizing. The organizers began engaging folks. They identify who are the leaders. They focus on building that small leadership team so that then the leaders go out and make a difference.

So they engage in direct advocacy but they're really peer educators as well. And then they engage the residents and they decide what they want to address and how they want to address it. And then we look at those social change indicators. What's happened?

We've got one group who was doing a lot of community gardens as organizing tools, teaching tools, access to affordable fresh produce, physical activity, and also policy change.

So we just had our first -- County Regional Park has allocated land for a community garden, first one in the county. They're excited about it. They want it in all of our regional parks. We've got cities who have made land use changes. One city had public pools they had close for lack of resources. The residents said, Hey, you got the water infrastructure, can we have a garden?

It's already fenced.

So they made land use changes.

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So the residents see the changes. Women who were limited English speakers participating in meetings at their schools not happy about what their kids are getting to eat but not feeling like they had any power. And when our community organizer said, Would you like to meet the food service director?

I can set up a meeting for you, and you go from there. Six meetings later, they changed the school menus for the entire school district and not just the kids of those five women.

So, those are the things that we need to look for to see if something's actually changing.

So, I've left my presentation in packets with some other information on the table so you could actually read what these teeny letters say.

Thank you. Oh, thank you. Wow, great set of presentations I think to queue up the kind of give and take we want to move into. Let me start off. I want to go to Jessica first. Got, I think, a great framework that Dory gave us on the different kinds of roles of community. And often we have sort of put a frame around the engagement of community in the context of the assessment and even within the context of that as consumers, as often as past recipients of services.

So we hold a focus group and say, Tell us what kinds of medical care are most important to you. Obviously, there are a range of other roles that we talk about of moving from consumer, or patient, to informant, to adviser, as some would frame it, as watchdog. And then ultimately I think much of what both Dory and Michelle were talking about as partner with shared accountability for those results. Could you say a little bit about how Community Catalyst approaches this issue as you engage folks around the country on this?

I know I've had conversations with both you and your Director Rob Restuccia over the years about some of the learnings from what some might frame as scorched earth approaches to advocacy versus how you really do build the kinds of mutually accountable and beneficial partnerships. Such a big question. I think what our experience has been, and certainly the framework that we've always used with groups, even when they decide and we leave it to them to decide what sort of approach they need to use, whether it's scorched earth or more collaborative is that the goal at the end of the day is to move more towards that collaborative framework as well. And the groups that we tend to work with tend to be, I would say, more at the grass tops level. And so one of the projects that we're just finishing up in 15 states is focused more on the financial assistance component of community benefit. That, I think, is where you tend to see more of the scorched earth tactics. People feel really ignored in that aspect of community benefit. And one of the experiences that we've had is we required in that project for there to be legal service organizations, advocacy organizations, and grassroots organizations as well because we felt like those were three spheres of advocacy and organizing that needed to be brought together. Each had something different to bring to the table. And that approach, I think, has worked really well to have advocates who are more aware of how systems work, how power works when you're making these decisions. But then, having people from the community directly affected to say how they were affected and to learn this is how power works, this is how I can use it. And one of things that I think we've really seen -- we've certainly seen it in Massachusetts, we've seen it in other states -- is that really getting people into the room and having change come from the conversation that they're having, it doesn't stop at this issue.

So we've seen groups move very quickly from working on more contentious issues to saying, Well now this is interesting because the real issue here is access to coverage. For example, we've seen a lot of groups pivot and move from talking about financial assistance to working on expanding Medicaid or other programs together. And then even beyond that, you know I think people are now talking more about what does quality mean to a community, to a community member who has never thought about quality before. And so I think it does -- the skill set is the same, regardless of the issue that you're working on. But it's really identifying all the different spheres that need to be in play. And one more thing that I would say also that I think is a

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challenge for everyone is recognizing the amount of work it takes. And I really like the way Dory laid out the framework. Not everybody is going to want to move from addressing their individual problem to systems change.

So part of it is also understanding where people are on that continuum and how identifying who can move forward with you and then supporting them in that. Great. Michelle, I'm not going to ask you to address this at length, but you have raised this issue and we will discuss it, and I know in particular we'll hear from Paul Hattis in the next panel on the unique contributions of academic health centers. But if you could say a couple of words on this, as you've raised it, the role and the linkage to training the next generation of healthcare providers in how we build cultural competence, address health disparities, really build the understanding of how we address these complex problems in our communities. Sure, and I think it happens across all of our programs. And as we have evolved as a healthcare delivery system, as I mentioned earlier, thinking outside of our own box, thinking outside of the box of the hospital, outside the box of the clinics, outside of the barriers that we inadvertently put up by being so facility-bound often in our previous way of thinking of delivering healthcare, that it becomes imperative that, as we work with our learners, all of our health professional learners, that we begin to think about all aspects of health, all factors that impact health.

And it's about providing experiences throughout their entire learning continuum so that they can begin to have that first-hand knowledge of the kinds of analysis we should be doing, the kinds of ways we should be thinking about designing services and delivering services and the ways in which we should be measuring them. Most importantly, we've often educated our health professional students in isolation of one another. And we've come a long way, I think, in trying to break down those silos in terms of true team training. It's not enough to just put people together and say, Now you're a team, but to actually give them those experiences and ensure that they also see the patient and their families and the community, the population as a member of that team as well. And what does that really mean for them. It's for us, of course, it's meant a good deal of changing in terms of the way that we run our educational programs. All of those scheduling nightmares and all of those kinds of logistical things that you have to work through as an institution takes time, but it's worth it to do it to ensure that the students receive that kind of experience. We've also put together a process by which learners who would like to experience community engaged work outside of the traditional educational program that they may be in, very often our community would tell us that they've been getting any number of calls from eager learners to come help to come help show the way or perhaps something they learned in the community they came from. But now they're here in Durham and they want to do it just exactly like they did in Boston where they grew up.

So, in response to our community partners, we actually put together a process by which learners could engage in a structured manner that they would go through training in the principles of community engagement and the ethics of community engagement. And that they would actually be accompanied by credentialed faculty members in community health in those experiences. And it's worked well. Our partner agencies now can call us. And they know that they have a portal to come through when they are indeed looking to engage learners outside of a more traditional curriculum and that learners can use as a matching one. Last quick question to you, Dory. We've had conversations over the years about some of the challenges. As you do this terrific work, given changes, turnover in leadership, but what sort of organizational support is needed to be able to sustain this kind of work?

Well, I think that it has to be -- there has to be commitment from the most senior level of the organization, governing boards as well as administration. We have a community benefit committee of our hospital board of trustees that includes representatives of the board of trustees as well as community representatives. And we also have representation on our executive management team. I'm a member of the hospital's operating budget steering committee, which was a little mind boggling. I'm a community organizer and I now need to understand the budget of the surgical services.

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So that principle of community capacity building is internal as well. But there has to be a commitment at every level. We're integrated with our strategic services processes, our strategic budgeting processes. And every year when the executive management team selects quality metrics to track, there is at least one from community benefit, often more. And everything, the maximum authority actually comes from the community. And so, it's getting our governing boards, our executive management to embrace that and work with those community representatives as full partners. Great, thank you. I want to now go to questions. Please raise your hand or stand up so we can get to you quickly. Please, folks that haven't spoken up yet, we want to hear from you. Hi, my name is Dorothy Cilenti. I'm at the School of Public Health in Chapel Hill, and I'm also interim Health Director in Orange County, which is next door to Durham County.

So my comment is more from a public health practitioner perspective. I think -- I just want to provide just kind of some context. I think meetings like this, we tend to hear from the best in class. And we've certainly heard these last two panels just very vibrant healthcare systems doing a lot of great work in the community. And I think for a large part of our nation; and I know particularly in North Carolina which is a largely poor state, I'd like to think about how some of the activities we've heard about might be relevant to communities that aren't served by these very large, lots of resource healthcare systems. And we do have 3,000 health departments in this country with a core function of community health assessment as well as assurance and policy development and a fair amount of expertise in the area of community engagement, and in many communities may be the only resource in that community. And so I'd like to hear from the panel about how they might think about communities that don't have these large systems, how either the public health department or other resources in those communities might be able to move the community health improvement process forward. And particularly in our state, we have a public health hospital collaborative steering committee. And as a point of example, Kevin was able come and talk with that committee. And one of the reactions was, Oh, well we wish we were California but we're not.

So I'd like to just offer that as perspective. Sure, in due response I would note that some of the best collaboration between public health and hospitals is occurring in North Carolina. And I suspect in part because the resources are so tight and you have a good model for a lot of us to look at. Next person?

Thank you. My name is Abbey Cofsky, I'm from the Robert Wood Johnson Foundation. And two quick points, maybe one building on the previous commenter. In thinking perhaps a little bit in the context of yesterday's presentations as well, in communities where there are multiple assessments happening, where the health department is doing an assessment and the hospital, I'm thinking of myself as a community member and really wanting to know that the leaders in my community, whether it's government, whether it's a hospital, are listening to me and are working strategically together. Because I think if you're looking to me to speak on behalf of the community what my needs are, I don't want to feel like I'm being used in various different contexts. I want to know that there's a bigger plan, and I want to know that my community leaders are working together.

So how is that happening?

Is that happening and what are the mechanisms to make sure that it's happening?

My second comment is, you know the definition of community here has seemed to be patients, residents, citizens. And I guess I want to know is there an opportunity here, and I would think there is, to expand that definition of community so it gets more to that two-directional, multi-directional? Who are the other stakeholders? If we want to be addressing violence, you know is the police department at the table? If we're addressing education, is the school district at the table? If we're really moving in that direction to address the root causes of how poor health in our community, are those people that can help solve those problems at the table from the very beginning as well?

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Great point. One more?

A comment and a question. I just want to assure my colleague that there's a lot of people in California who'd like to be in North Carolina. The question is for Dory and you spoke about - Could I ask you to identify yourself?

Oh, Larry Prybil with the University of Kentucky, Kevin. Dory, you talked about the community organizing work and other programs at St. Joseph system. Does that take place at the system level or at the hospital level or both?

If you perhaps could comment on that. In multi-level systems, there's a lot of different ways to get from here to there. Great question.

So we have one exhortation to the panel. Let's make sure we're looking at how we do this in smaller systems that are smaller hospitals that are not tied to large systems where there are significant resource constraints. How do we build confidence, given that there's a lot of fragmentation in the engagement of community members that there's actually a plan and a commitment to follow through on it?

And a question I think initially to Dory, but I think more broadly is from whence does this innovation come?

And how, to what extent is this a function of local drivers versus system drivers?

Take them in whatever order you'd like, panel. I scribbled without my glasses so I don't know if these will help. I might not have written anything that makes sense. I think in response to I guess all three questions, a similar response. And I would say that I go back to the importance of relationship for us. That we invest very heavily in time and resources and relationship building. Because from there we can move in a lot of directions. If we go to a city council member and ask for something and don't have a relationship, it's going to be a lot harder to get it. And that's when the scorched earth tactics are more required. And so, for us, community is much broader than a sector of the community. And so, we really understand that if there's something that's working for us, the community organizing strategy is working for us. When we became part of the ASACB cohort and we helped to develop and learn from those core principles of community benefit and how that was working for us, we bring that to others.

So we are in ongoing relationships.

So we work very closely with our public health team, with again, the other -- we have a few surviving district hospitals as well as the Kaiser Hospital and Sutter Hospital. And so, we look at the community that we are part of and serve together. And we identify who has the right skill sets, who has the right resources, who has the right talents to address which aspect of the problem. And so, in the area of community engagement and grassroots leadership development and partnership and collaboration in general, it's recognized that have developed a certain skill set.

So, that's something that we usually contribute the coalitions. We actually are a subcontractor of the HEAL project in our area. And we are responsible for that piece of this really great initiative.

So we understand our role to educate and influence others. And it happens somewhat throughout our health system but really in Sonoma County, because of the leaders and folks who have been involved and because of the culture of Sonoma County, we're the only ministry in St. Joseph Health Association that has an ongoing, permanent organizing team. Our organizers started in 1996, and we've got a half dozen of them out there. But at the system level, we have developed a community building initiative in our system's foundation that funds local partners in all of the ministry's service areas to do this kind of work. I think a couple of

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things, and as Dory said, to try to answer in a cohesive manner. I actually started my relationship with Duke as a community partner. I was with the school system in Durham. And our students at our particular school weren't healthy enough to learn. And it didn't take much data to show us that. It took looking at our classrooms and talking with our students and talking with their parents. It took asking them why they were sleeping in first period and weren't feeling well and why they couldn't go see the doctor. I had no healthcare background whatsoever when I was asking those questions. But it was those answers that led us, as a school, to write a grant that was for academic performance but incorporated the building of a school-based health center. We didn't have one in Durham. They were not a new concept -- nationally of course -- but we didn't have them in Durham.

So I do remember how daunting it was to take that grant that we wrote without partners per se and go knocking on doors at Duke to say, Hi. We have a grant. Would you all like to build a healthcare service with us?

And it took a few doors. A door finally opened. But it is about relationships. And in the four years that we worked together, not just in building that clinic but in running that clinic together, school system and Duke, more clinics opened. The thought process about how do we deliver healthcare in nontraditional facilities, for us that was nontraditional and may not have been in other parts of the country -- but led to the initial definition of our whole division. Over the years, though, those relationships with not just Duke but obviously with the health department, Department of

Social Services, the school system itself, the police department, and all of our community entities takes a constant nurturing. There is turnover. There are competing priorities within all of their organizations. And we, as an institution, also had to be respectful of that, just as we would ask them to compartmentalize perhaps their relationships with us as a large institution sometimes that goes so well or don't so well on any given day. And I think about the way we've approached the development of our collaborative community engaged services. We how share staff. I've got folks in clinics that we perhaps operate from an administrative standpoint that are actually employees of the Health Department. They're employees of the FQHC. My folks that perhaps are Duke clinicians are also credentialed at the FQHC. We look to see who can we actually maximize all of our resources when we work collaboratively. And instead of starting from the standpoint of what resources we need in comparison to the traditional model of delivery; or what resources we don't have in comparison to the traditional model of delivery, we actually would ask the question of, What do we actually need?

Is it a facility?

Is it a clinician?

Could we look at ways to build capacity within a community, with a community, based on where the community wants to start, what their priority is. And I think we go from there in thinking about -- again, I keep using the term healthcare delivery that makes sense for people in the content of their lives. And it's usually not found, I think, in the traditional ways that we've delivered healthcare. I think we still see outcomes across our entire nation that shows it's not working so well for us. Just a quick comment. I want to get to some more questions, please. Sure.

So, I would just add to that that in addition to relationship, a lot of it for us tends to be about communication as well and transparency.

So the community to your point, to your question, Abbey, about I want to know that there's a bigger plan. Well, a very simple thing to do for, I think hospitals and others is to just be transparent about what they're

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doing and how, and lead the community in their reporting. And whether it's required or whether it's optional, how do they arrive at their decisions?

And that was certainly what we were hopeful that the Affordable Care Act would accomplish. To the other point about we're talking about the best students in the class, I think part of our hope was there are a set of good practices that are out there among those best students. It's very clear from our work, which happens in Mississippi as well as Massachusetts, that part of our goal is to bring the other students along. And so, I think that to the question about how do you work when you don't have a lot of resources, I would say to start where you are and to also broaden the definition of resources. When we're working with advocates who are trying to change to effect system change, we're not using Massachusetts as a model in most of the states that we're working.

So map where you are, think about where you are, think about your political reality, the other realities that affect your work. And then also monetary resources are not the only thing that hospitals or others have to give. I think it really does come down to sharing knowledge, sharing skill sets as well, sharing the relationships you already have. Relationships are also an asset and I think it's really easy for people to forget that.

So that's what I would add to that. Great, thank you. Question, comment?

Hi. My name is Claudia Lennhoff and I work with the Champaign County healthcare consumers in Champaign, Illinois. I appreciated the panel and your presentations. Dory, one of the things that you said is that healthcare providers also have to be willing to be engaged by the community. And one of the experiences that we have in our community is so many times when we do try to engage, the perception is that we're just at the door knocking and asking for money as opposed to trying to work on a more, you know, on a different kind of process. But my question for you all was, I was wondering if you all had any experience working in communities where there is a competitive dynamic between healthcare providers and whether that constitutes a barrier for real community engagement and just what your experiences are with that?

Great question. Next. Hi, I'm Judy Darnell, and I'm with United Ways of California. And I love the panel. I appreciated all of your points and discussions. A lot of it saves me time tomorrow on a panel I'm going to be on. One of the questions I had, a couple of comments and a question. You were talking about having some community convenings at the hospitals and the hospital's role in the community. And what we have found in the work that we've done in the area where I'm from in California, unfortunately -- not unfortunately but a lot of California examples, is that we find it very successful to go to the community; in other words, get out of the hospital get away from that big building that intimidates people and go to where they're comfortable, whether it's churches or some community room. Also, looking at somebody asked what other organizations do you partner with. How do you -- and this is something I'd like to hear addressed, is who are the trusted leaders in other organizations that you partner with?

Do the hospitals see that they need to be out there leading the way or do you co-lead?

Do you look to who are the trusted leaders in the community or the region that you can bring in?

And then finally too, another comments in the audience about who are the other stakeholders the woman from Robert Wood Johnson about the schools and police. I think that is very, very crucial and it's needed and we need to address that every time we engage. Great, one more?

Here you go right here. I think right here. I'm Joan Quinlan from Massachusetts General Hospital and thank you to the whole panel. You raised a lot of interesting issues. I think one of the other side of the coin on

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community engagement is that we, as hospitals, can easily go into the community and work with all the key stakeholders, the police, the schools, and I'm thinking of a very specific example of a local community around violence. But suddenly we woke up and realized, well, we're a member of the community too and we can convene everybody but we actually have to change ourselves as well. And that's one of the factors I think we have to stay mindful of.

So what were we doing when people experiencing domestic violence were our patients?

We were just doing all this great work out in the community. But it actually has to affect us as well. Great point, so very quickly, and I'm going to ask the panelists to limit themselves to one minute each in responding to these questions and issues raised. The impression referenced that when community knocks on the door all they want is money. How to engage in the context of competition among hospitals within a community. Who are trusted leaders and organizations?

Who can help co-lead these efforts and how do we change ourselves in the process of engaging communities. One minute each, please.

So I'll start and I'll only partially address the questions. But to the question about competition, I think one thing that I've started to hear and I think makes sense is that hospitals aren't necessary -- they may be competing but they're probably not competing over the populations that should be the target of a community benefit program.

So, I don't know that hospitals have necessarily recognized that or made that shift across the board; but certainly in the example I gave from Camden, you know there's a collaborative now of hospitals and other providers there. It's social service providers, mental health providers, the police are involved also. Homeless service providers are also involved in that. And that's a very intentional collaboration over a specific population to really bring down admissions, the avoidable admissions, etc.

So I think that's also a transformational shift. I would imagine that to start to look at your patient population and to realize community benefit targets are probably not necessarily the ones that hospitals are trying to court to come into their doors.

So that's one thing. And then to the question about trusted leaders, I'm interested in hearing what my co-panelists have to say, but I just want to flag that I think working with established community leaders will get you different data than it will if you look beyond trusted leaders as well.

So I think we should identify and go to them, but recognize that those who are established leaders in the community, that's one segment of the community. And I think we will get different data, we'll empower, that question of empowerment also comes from moving beyond that circle into the next layer down. Yeah, I would agree. I can tell you that the business end of healthcare in Sonoma County is extraordinarily competitive for a lot of reasons. And, as it began to heat up, the community and benefit leadership came together. And that's when we decided nine years ago to do our needs assessments together and to identify -- agree on priority populations, priority community health needs that we would be addressing.

Some of those activities we would be doing together, some of them we would be doing on our own but in coordination. But that this was one area that we could not compete on if we had any hope of moving the needle and improving things for the most vulnerable members of our community and a lot of leadership from our local public health staff as well. And so in order to do that, you have to work closely with authentic community and that involves recognized leaders and the as-yet unrecognized leaders. And so after every needs assessment, before it's finalized, before it's posted on anybody's website, we go back and we ask everyone we can what they think about what we've gathered and what they think about our interpretation of

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it. And that all goes back into the needs assessment before it's done. Okay, Michelle, you get the last word. The last word. In Durham, we actually do provide the overwhelming majority of healthcare services within our county in terms of both hospitals are part of the Duke Health System in Durham County. In relation though to developing services that are outside of the facilities and that actually, again, I keep saying that term over and over. It makes sense in the context of people's lives. We co-lead all of that work. All of it's collaborative because we are looking to each other to see where does it make the most sense in terms of who's delivering what services. As I mentioned, we're all touching the same people within our community. Let's make sure we're coordinated in that effort. And so we have very candid conversations with our community partners and partner entities to ensure that the services are constructed in such a way that make sense for people. In addition though, we can't just test it with each other. You can't sit within your office or within your conference rooms and test it. We actually do, at every step of the way, talk with and work with our community members in designing those services and evaluating those services. And that includes everything from neighborhood organizations to literally going door-to-door in the neighborhoods where services are being delivered to ensure that this may have been the need three years ago, are we still meeting the right need?

Communities are dynamic. We have to keep that relationship going at every single level within our community. Please join me in thanking our panel. We are now officially on our first break. We will begin again at promptly at 11:00.

Thank you.