

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

Joining us as panelists, first up will be Tom Wolff. Tom is a young man but has spent many, many years working in the area of community collaboration and our paths have crossed many times over the years, and he will get us started. To be followed by Vondie Woodbury, who's the Director of Community Benefit for Trinity Health, which is based in Michigan, not California, and has been doing terrific work. And Peggy Honoré, who's the Director of Public Health System Finance and Quality Programming at the Office of healthcare Quality, office of the Assistant Secretary for Health and Human Services. Tom, would you like to kick us off?

[telephone dial tone] I hope you all didn't hang up. I'm a community psychologist, have spent 40 years leading collaboration on community engagement.

Some of that involved with community benefits, but not always with the kinds of wonderful possibilities and systems you've had presented to you over the last two days. I want to talk about two things. I've been asked to talk about two things. One is collaboration and what do we mean by that. It's been used all the way through this. And the second is priority setting and community engagement in that process. Collaboration, very simply for me, is doing together that which we can't do alone. If we sit in a room and talk at each other, that could also be done without purpose. And in my book, *The Power of Collaborative*

Solutions, I've listed six principles that have emerged for me over the many years of doing work in a huge number of settings and a huge number of groups. And it's really sort of practice informed and evidence based. The first is to engage a broad spectrum of the community. We've been talking about that, especially those most directly affected. And the key question could be look around the room. As you're making the properties, as you're doing this work, is the community in the room?

And so often, they're not. Well, we consulted with them, they're in our advisory group but we don't have them in the room, and I think they need to be in the room. The second, very critical, which is to encourage true collaboration is the form of exchange. That's the word we use all the time. And sometimes we fuss with whether it's coalition, collaboration, partnership. We'll never settle that issue. For me, Arthur Hilmberman has done it by saying, *What's happening in the room?*

And so, there are four possibilities of the exchanges. The first is networking. And we do this when we exchange cards. We tell each other what our services are. And it's the lowest level. It's a very important piece because we don't have the information, but it's a building block. And I see many coalitions that stop exactly at that point. They meet every month, they talk about after-school care in the community, they tell each other what's going on, and then a month later they come back and they do the same thing.

So we got to move further than that. The next is coordination, exchanging information, each build on each or they get more powerful, they get more complex, they get riskier. And now we're going to modify activities. Working in a rural area on hot meals for the homeless, we brought the churches together and said, *How many churches are providing warm meals?*

"And two churches raised their hands. And we said, *When do you do that?*

And the first church said, *Sunday*. And the second church all of a sudden turned red because they also did it on *Sunday*. Small community, 7,000 people, two churches on the same day. Because they're churches, one moved to *Wednesday*. If they were two hospitals in the same community, I don't know what the outcome would have been. Third, *cooperation*, exchanging information, modifying activities, now sharing resources. The resource word is on the table, and now things get a little heavier and a little riskier, but we have the chance of creating better change.

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

So first, an example, the Cambodian community is having a health fair. You can rent tables for \$75. Three agencies put in \$25 apiece, they share a table. More complicated, Springfield, Massachusetts wants to do door-to-door outreach in the Hispanic community. No one can afford to do it. Everybody has a little bit of outreach money. They pool it so I give my HIV money in, you give you teen pregnancy prevention money in, I put my tobacco money in. We have a full-time outreach worker and doors get knocked on. This is the example that matters because if we didn't pool the money, no doors get knocked on. This is doing together that which we can't do apart. Sitting together in a room with a diverse group of people doesn't get you here automatically. And Hilmerman defines the most important collaboration as enhancing the capacity of the other.

So here, the hospital is out in the community working with the neighborhood association, not as charity. They're trying to make the neighborhood association the best they can be. And the neighborhood association is trying to make the hospital the best it can be. When you see those true collaborations happen, and we saw or heard some with John, who was describing the bank in the basement. The bank is getting money, and he's getting some breaks for his employees.

So things are swapping two ways. When that happens, we're starting to change the system and transform the community. The third principle is practicing democracy. And here, we're really saying in our process, everybody's got a vote. And we use dotmocracy or whatever we need to do so that people feel empowered in the process. It's not that the powerful systems control the vote. And four is employing an ecological approach. And we've been starting to talk about that now over the last couple of presentations that employs both a deficit and an asset approach. McKnight has presented this so impressively analyzing our helping system as a deficit system. I've had four communities who say to me, We have the highest teen pregnancy rate in the state, Tom, yay, right. Why?

Because the first section of each grant is called the needs assessment. It's not a needs assessment, it's a deficit statement. God forbid our communities should read what we say about them. And when we approach it that way, it's very hard to partnership.

So we have to look at the assets. And this directly affects what happens in our assessments because our traditional assessment says two things, What are the problems and how do I, the hospital, fix them?

If you had two questions, what are the assets, and lead with that question, and then say, How can you contribute to helping us find a solution?

If all the assessments we've been talking about for the last couple of days started to do that, at the end of an assessment you'd have a lot of partners. And they would feel that maybe they had some value to you because you just weren't trying to figure out whether they were going to be the body on your waiting list. And so it's a very important, very subtle but very important, shift, and not too hard to make.

So, then next time you see only the first two questions being asked, don't let it happen. Five, take action. You need to address the issues of social change. And we've been talking about that and the whole push for policy is very encouraging because you're not going to be able to tackle obesity with nutrition programs until the hospital can join with the community in looking at the zoning changes that will be required to let the supermarket in. Now, when doing that, you're going to be tackling the same people who maybe wanting -- you're going to have to go to for your zoning changes for your hospital, or the mayor, who may not want to be doing this.

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

So these are just simply, oh this is going to be a piece of cake but it's inviting you into another arena. And then finally, encouraging, engaging your spirituality as a compass to social change. The people in this room, the people we work with in the community, the agencies, the hospital folks, the people who turn out didn't go in this business to count reimbursable hours. And yet, we're all kind of caught in that kind of world. They went into it for a higher purpose, for a compassionate view of the world, for a sense that we're all interconnected, we're all interdependent. That's really what healthy communities is all about. It's a spiritual principle but a very honorable one and one we know.

Social determinants of health are all saying, Hey, golly, where people live affects how they feel, so really a critical piece. The research comes out on what makes coalitions work, so we know this. We shouldn't be guessing at it. This is not a guessing game. We have the research and the bottom of it is that outcomes matter. And we also know a lot about the barriers. And again, at the end of this there will be some resources, the toolbox, my website, other things that really help you work through the barriers.

So that was item number one I was to cover, collaboration. Item number two has to do with priority setting and engaging the community not only in the assessment but in all the processes that follow.

So you have to ask yourself, what's your approach?

And there are two approaches that run on a continuum: agency based and community based. And we're very familiar with the agency based. It's focused on deficits, not assets. We define the problem, not the community. We're central to the decision making as opposed to being a resource. We're the primary decision makers throughout the process, as opposed to the community. And in the end, the potential for community ownership is low.

So we can do that but at the end of it we kind of wonder, oh I guess we're going to have to do this again next year because the community didn't buy it because it was ours. Oh that was the hospital's obesity program.

So we have to do this in a way that matters. And so, one of the benefits of involving the grassroots, why do we need them at the table as well as we need the mayor and the superintendent of schools. They know how to reach the yet to be reached. They work with both the formal and the informal leaders. They know what works in their community. We're guessing. They know. They're the community historians. They'll tell you, Hey Tom, that's a nice idea but we've tried that for the last three years and it doesn't work. They provide ownership and participation so at the end it's theirs. And they're the best architects of the solution. How often do we develop something that doesn't work. And they build the local leadership. If someone can come to the table and do that, why are we not spending a lot of time recruiting them?

And they create the positive norms in the community. When we're going to invite them into the room, we have to decide what's their role before they get there. And this ladder of participation is at least 30 years old, by Arenstein. Usually what we do is we take the bottom three roles and give them to the community, decoration, tokenism, manipulation. Yes, we have task force on youth and we have two youth. You know that the first two that are going to Harvard ever from our community, we're so proud of them. Oh yes, we have someone of color in on this. Oh, we're working on the Cambodian community and we found someone to be with us.

So we have to go up the line. Consultative and informed is what we've been talking about here, which is asking them for the information, getting the needs from them. But we have to go to the top levels, which are shared decision making where we go out into the community. That's been said and I'll skip that. The key

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

elements, I'm going to even skip this. Let me move to I have a wonderful example. What happens when we don't involve the community?

We're going to create programs that no one wants to come to. How many youth centers have even built that the youth don't go to?

We trap ourselves into always doing for, never can get to doing with. The community never owns the issue. And we have failed to respond to the diversity and culture of our communities. Let me give you an example of how this has been done in the grassroots level using social determinants of health and low-income youth. This is the Boston Reach Project. It started off working on issues of breast and cervical cancer. This wonderful poster was on the back of every bus in Boston for a year. And Barbara Ferrer, who's the Commissioner, states the role of the health department as follows. The role of a public health department -- and you can put hospital -- is to create a space for residents to come together to define a problem, to define the solutions and then enter into a dialog with us, not the other way around. You better figure out how you're going to get the people affected by the problem at the table, because if you can't do that and you can't support that work, somehow you're not going to get to the solutions you need to get to. And when we decide that we are outcome oriented, then this has to become our mantra. Not easy. This is their model, racism, social determinants of health, and health outcomes. We've talked a lot about health disparities in almost every talk but no one ever uses the word racism. The Boston Public Health Commission just puts it right out there. And let me tell you, the people in the community of color understand that and come to the table because they know you're talking turkey.

So in JP, which is a community that's 50% white and 50% black and Hispanic poor, the health center, which is part of a hospital but did not use benefit money for this, started a program looking at health equity. And their goal was to go down the social determinants of health where the youth would have high quality education, meaningful living wage jobs. And the question was, How do you involve youth in this complex model I just showed you?

So they did it very simply. They created what they called bucket meetings on each of the social determinants. And they would present a case study on how. On jobs, they said, Here's Carla. She's living in low-income housing with her mom, she can't find a job. And then we asked these kids, and they recruited 30 kids in the room, not the stars, kids right off the street. And they were asked, What's going to be the health impact on Carla?

And they could tell us. And they asked, What's the role of institutional racism?

And they could show that each of these systems are contributing. You can't get a job on Center Street if you're a kid of color. The stores never hire anybody. The schools never help you do a resume or learn how to do the jobs, and the only job placement service in town doesn't deal with youth.

So they then they laid out possible actions. And the kids could do this on each of the buckets. They went around and dotmocracy, as it was called, picked the top issue of the social determinants, which was jobs, came up with a strategy, went to advocacy because the governor and the legislature were going to cut summer jobs. And so they were 700 youth on the commons protesting that and asking, and noted by the media to be one of the best organized youth. And this was kids from all over the city, not just the JP kids. And they issued a wonderful report. And if you go to the Boston Public Health Commission Office of Health, Equity and Social Justice -- do you love that, I love that. You can get this report, which goes through each of the social determinants and tells you what the kids saw. On the cover it says, If you know what this is, this report is for you. You know what that is?

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

It's a teeny. A teeny is a junk drink with color and sugar. And it's only sold in the Hispanic and African-American part of JP. In the white part, they sell juice. This is not easy work, so I suggest the Dalai Lama has it right. There are a series of resources on the toolbox, on my website. And the JP Youth Repot is something you should go online and download. And finally, you can't leave without it. And here's my book. Next?

Okay, I'm challenged by technology, I'll say at the onset. Welcome to Muskegon. That's a lake up there. How many of you know where Muskegon is?

All right. I'm not from Los Angeles, I'm not from Boston, I'm not from a big city. But I am, I do have three job descriptions, with three job titles up there, which includes I'm the Director of Community Benefit for Trinity Health. And this is where -- ah ha, there, Trinity Health. Eileen said she was -- their system was the fifth-largest, and we're saying we're the fifth-largest.

So we will arm wrestle later, and you can all come and figure out how is really the fifth-largest Catholic health system. But suffice it to say, we are big. We are mostly clustered in the Midwest, as you can see. And we spend a lot on community benefit. Yes, now the first time we did a needs assessment in partnership, and I'm going to say "we" because I've recently come to Trinity after a few years, was -- we did a needs assessment back in 2009 and the first presentation that was made, I didn't get to make it. It was actually our Mission Director. And he stood up and he inserted this slide, and I've used this slide ever since. And one of the things about Catholic healthcare that you all ought to know is that we would do this anyway. John Bluford said that yesterday, we would it anyway because, by gosh, this is our mission, this is what we stand for. And I know a lot of people may say, Yeah, right. But it truly is our mission. All of us who are engaged in Catholic healthcare have a tremendous legacy to live up to in terms of the sisters and others who came before us who really began to establish that legacy. And this is a painting of the Ursuline nuns landing in New Orleans. And we're assuming that they didn't land and begin to lay out real estate and say, Here's where we're going to build a hospital. Instead, they looked around them, they say incredible community need. And they said, We are going to address these needs.

And so, as my Mission Director said, this is the first community health needs assessment. Just thought you'd want to see it, ah ha. And now I'm going to take you to where I am, where I sit. I'm in one of these very unique positions where I am responsible, system-wide, for community benefit, but I actually work out of Muskegon, Michigan not out of Novi. Novi is a suburb of Detroit. And 15 years, it's probably more than 15 now, in 1995 I joined the Muskegon Community Health Project. And the Muskegon Community Health Project is a community health collaborative that really was, at that time and continues to be, a coalition-driven model that is invested in the engagement of community leaders and community members in terms of improving community health. And so, let me talk a little bit about the health project because it really has a lot to do with some of the work that we're doing at Trinity today, now that we have merged with Trinity. First of all, those of you who are familiar with some of the early work of the WK Kellogg Foundation, Kellogg came to Muskegon County in 1993. This was shortly after the attempts by the Clinton administration to reform health, reform -- we go through this a lot don't we -- had failed. And it was their belief at that time that one of the things that really did need to happen was that communities needed to become more directly invested in health and understand what was going on in healthcare, because in fact they had been left behind. And the easiest way to figure out that communities had been left behind was to watch the ads and sorts of things that really were used to defeat, if you will, health reform under the Clintons.

The other thing that was happening, environmentally, is that once people stepped away at the federal level from health reform that there was concern that the for-profit hospitals would begin to move into, and

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

particularly Michigan where we had not had a history of for-profit hospitals; and that in fact, community members needed to be in a position where they could be part of the solution, part of the discussions because these were in fact tax-exempt entities. And we wanted to make sure that if a hospital was going to become for-profit that we had some say in what was going to happen. And so the CCHMMs project, Comprehensive Community Health Models of Michigan project, was established, and we became a local grantee. We are the only remaining grantee, and one of the reasons -- or not grantee but the only surviving program if you will, the grant money left a long time ago. And one of the reasons that Kellogg said that we were successful is that we never let go of our community. We have always maintained their investment, and we've always had them involved. And in fact, it speaks to the kind of success that we've had in Muskegon in terms of keeping people engaged. The fun part now has been to engage them actively as a partner of the health system, as well as with public health. Not that we weren't doing that before, but it's a totally different game right now. I want to say about this model, which is very important to understand, is this is an inclusive model. Kellogg challenged us to engage everybody in our community as much as possible. They encouraged us to try things that no one had ever tried before. And it was okay to fail because through failure we would actually learn something, along with success. And we did a number of things, not the least of which was we created our own county health plan, called Access Health.

Some of you know it as the multi-share, or the three-share that has become nationally very successful. And in fact, it still exists in Muskegon. It's been there for 12 years. We sell health coverage to people for -- not we but the Access Health program does -- for \$46 a month. For \$46 a month, that's subsidized with DISH dollars. Try to get DISH dollars today. But we provide primary care hospitalization, pharmacy and all, and a very comprehensive prevention program with that.

So we've had some real success.

So, one of the things that happened was a couple of years ago, as we'd gone through all of this work in Muskegon, we started off with three hospitals. Oh my gosh, then it became two hospitals, and then it became one hospital, as was happening all over the country. And once it became one hospital, the issue that we represented sort of, if you will, a sort of neutral planning table went away. And we merged with first with Mercy Health Partners and later the acquisition with Trinity Health. And, in doing that, we took on responsibility at Trinity Health for some of the work that they initially sort of prioritized for us, not the least of which was could we create a program that, or if you will, a community health needs assessment book to begin to guide the rest of our ministry organization. We did that, and part of what we're to talk about, of course, is the way in which we've engaged community in that. And so we did quantitative and qualitative data. One of the things I want to say about qualitative data, it's highly recommended. I came out of a -- used to run political campaigns. A lot of times we look at the other types of data, and we think we know what we're talking about. But in fact, until you talk to people, you don't realize what they don't know.

Sometimes the best data that you can have is understanding what people in the community don't understand about what's going on there. We did a survey early on in the project, and we asked people, Do you think we're as healthy as the counties next door?

They all believed we were. And in fact, we were much -- we were very unhealthy community. We'd pay anywhere from, at that point it was \$10 to \$20 more per member per month because we had such unhealthy indices in Muskegon County. And so, part of what we needed to do really, was educate people about their role and responsibility in health. We have and there -- and there are a couple of books I've put out on the tables outside. We've used a couple of grids but we've used, in terms of meaningful engagement, we really have been directing through Trinity Health and working with our individual hospitals to encourage them to reach out of the cubicles, to get out of the hospital and to work with the groups that think are the most

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

meaningful in terms of this work, and including -- and we've had this discussion here already, we've talked about United Way, the 2-1-1 lines, the public health, obvious community mental health, a variety of groups that in fact are also doing needs assessments. And so why do it alone?

We asked them to identify who they working with, and gosh, who knew the IRS would come out with the requirement that we're going to have to include names now in our 990 report, so we got names. We've included Julie's work. And I've got to say, I mean hats off to the work that has been done, and she has done some work for us with Trinity. We've put her on an affinity call, what we call affinity calls, to talk to all of our hospitals about the need to begin to think in terms of this context that has been developed in terms of the county indicators project. And we've also then given -- and again, I'm only picking some things out of the book in terms of how we've asked our people to engage with community; but we've asked them to report, very specifically, the kinds of things they did in their needs assessment planning. Post-planning, as far as prioritization is going, I don't want to go through the process that we went through. Obviously, it's a lot of stuff that we've already talked about in terms of do you do with dots, do you do it with people sitting down?

I will tell you, at the community level, as far as I'm concerned, is there a community out there that hasn't identified diabetes, childhood obesity, disparities, I mean you know, some of these things it doesn't take any kind of a process. You know it's bad, it's bad all over the country. It just depends on where you sit. And where I sit, it's pretty bad.

So, within the Action strategy, I'm going to skip this. This is a picture of our community benefit program, or actually our community benefit organization, the Muskegon Community Health Project in Muskegon, Michigan. And this is a robust, if you will, approach to the work of community benefit. And it's one that I have to say we're very, very proud of. We have, and I don't know how to put the -- if you go up just -- there's the board of trustees at the top. Right below that is what we have, which is a policy-related board. There's 17 members of that board, including people who really can drive policy through our community. We're talking about people, the county administrator, the county treasurer, the Chamber of Commerce president, the largest employers in town, the small business people, a very robust group of people. We stayed with something that Kellogg taught us, that we wanted equal representation of payers, the businesses, providers and consumers at that table who were in a position to act on behalf of the community and help us make decisions. Below that you see there's an array of programs that we deliver directly as Mercy Health partners through the health project. The health project, by the way, is located street level in the community. We are not on the actual campus of the hospital.

We're very accessible. We're on the bus lines, the whole bit. But we have nine community health workers who then work with a variety of our community partners throughout Muskegon County. If you -- the left hand side here, these are stand-alone community coalitions with community members embedded in them as volunteers. We have about 400 community volunteers who then work within these areas that we've identified as priorities in Muskegon County. And they help us, not just seek solutions, but to move beyond the solution to implementation. Kellogg said to us, one of the reasons we were successful is we didn't disband the community, once we figured out what we wanted to do. And we've never disbanded the community. They truly are full partners in this. Not only are they partners in terms of the decision making and I will say that these are fairly autonomous coalitions. We provide staff to them. We will help them write grants if they want to do grants. We help walk them through processes. We provide the back room organization. They don't have to become stand-alone separate 501(c)(3)s. In fact, we will do the fiduciary work for them, everything else for them as well. But they make the decisions. These people as community members then bring their solutions back to that board, that is the board of the community benefit office. And I will say also never in the years that I have worked there has anyone brought something back and had somebody sitting there saying, Well, we're not going to do this. We're very respectful of the work of our

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

community. You'll see, going down that, there's a variety of different things that we're working on but there's a separate African-American group. And I wanted to touch on this because of things that were said earlier. One of the things I noticed early on when I first came to the health project is that you would go to a meeting and you would have one or two people there who were from communities of color. They were generally quiet, did not feel that they were being taken seriously. We decided that not only -- I mean first of all we've worked very hard to make all of these groups inclusive.

But we also wanted to create a table where people would feel that they really could oversee many, a variety of different functions and could give us really excellent kinds of input on the things that needed to happen. We saw way too many collaboratives, or what were intended to be collaboratives, they weren't ours but other groups in the community where people were coming together and they were so disrespectful of community. There was one I remember early on where I went to a meeting. Health department called it. There were over 50 people there to talk about teen pregnancy. And the solution was we were going to address teen pregnancy in the African-American community. There was one African-American in the room. There's way too much community planning that goes on like this. On your right-hand side there over there, those are internal collaboratives. And this is the other nifty thing about being an outsider who actually then gets to become part of an insider in terms of a hospital system, is the ability to call meetings with people that normally would not have picked up the phone and talked to me because I was running an outside collaborative.

One of the boxes I want to talk about very briefly, and I know I'm over my time, but I really want to impress on you the strength of this kind of a structure, if there is an enrollment team. When we -- I mentioned I have community health workers. They're all cross-trained on how to do Medicaid applications, food stamp applications, those sorts of things. When we sat down as an enrollment team with the people in the inside of the hospital who were actually doing enrollment, people were sitting there taking about the fact of how difficult it is, that patients would leave. They wouldn't have their Medicaid forms filled out, or they didn't respond to phone calls, they didn't respond to letters. We put the community health workers on that, and they did the follow-up. And in following up, first of all, were able to complete those applications, so we have had a very measurable shift away from bad debt into financial assistance, which is where those folks needed to be in most cases. We've been able to clear up a number of Medicaid forms that were kind of out there and no one was dealing with them. But even more importantly, we went to a single form enrollment, and then we asked them additional questions that the hospital never used to ask.

So we're co-enrolling people. We're helping them get into food stamps, we're getting them into the Alliance vision programs. We're doing things internally at the hospital that helps to stabilize their lives. We're also, as we've done the work at Muskegon as we've also been pushing out in terms of using social media. This is our website. I hope you'll visit our website. It gives you an idea of some of the things we're doing. We did not want to create -- there is a community benefits site for Mercy Health partners that's out there on the web but it's a fairly typical hospital-centric kind of an approach. It's got a picture of a hospital on it and, you know, you can go in and you can look at the report. We wanted to create something that was visual. As the people that I work with in marketing say, you want something that looks like, you know, the USA Today on the front page as opposed to something that looks institutional. You want people using it. You want them to figure out where they can go for information. But using this website, you can go in and you can look at anything that's there on the hospital side as well.

So, the process wins. We've had a bunch of them in terms of the utility and the use of community collaboratives. For those of you who want to learn more about collaboratives, I would invite you to also look at Communities Joined in Action. Communities Joined in Action is a national organization that basically those of us who run collaboratives got together some years back and formed so that we could work with each other and share best practices. There are hundreds of community-based health collaboratives around

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

this country. They haven't really come up. We haven't talked about them much in these meetings, but by gosh don't reinvent the wheel. And on the challenges, one of the first challenges, gosh coalitions are not considered for community benefit reporting. They are considered community building. I would challenge my friend there from the IRS to figure out how you're going to fix things with community if you can't convene them and count that in some way. I really would challenge you to think about how we might do that because otherwise we are going to continue to work in silos. And the true integration of community requires that. The other thing I want to point out on this, and there are a number of, I think, barrier issues that we can get into a bit later. But local public health has also been an issue, not because they don't want to be there but because they are so desperately underfunded at this point that you really find that your ability to lean on them for some of the things that you need for needs assessments, etc., it's almost impossible to get from them because they just don't have the personnel to do it.

So in mid-size counties like mine, it's very difficult. And Muskegon County, by the way is 178,000 people. We are a small county. I've gone, I've done presentations that are collaborative, a lot of places around the country, many of them much larger, who said, Well, we can't do that. We can't figure out how to do that. It's very easy to do and I can certainly tell people how to do it. That's how to find me.

Thank you. Good afternoon. My task this afternoon is to introduce you to the HHS quality principles and to demonstrate how those could be incorporated into principles for community building -- community benefit and community-building activities of tax-exempt hospitals. I'm going to try to do this within my ten minutes of allotted time, but I probably won't make it. I will talk very fast, so I apologize in advance for that.

So what drove HHS to delve into the world of public health quality?

Well, quite simply it was gaps in national guidance for public health quality and the absence of a focus on public health quality in national reports. Going as far back as 2001, the IOM published, Crossing the Quality Chasm where they established six aims serving as characteristics of quality for patient care. They acknowledge the relevance of public health to improving health of our communities; but for various reasons they did not include public health in that discussion, leaving a void. In April of this year, a paper was published in Health Affairs by the Office of the Assistant Secretary of Health, which is the office where I'm housed also, in collaboration with Don Berwick at CMS, Carolyn Clancy at ARC, Peter Lee at the Office of Healthcare Reform, to document the accomplishments and the work that had been done by HHS over the last several years to build concepts and principles for quality in the public health system. And I would just, very quickly, walk you through some of those.

The HHS, the first response that HHS had to this was in 2008 where a public health quality forum was established through the Office of the Assistant Secretary for Health. That public health quality forum consisted of agency and office directors from across all sectors of HHS; Director of CDC, Director of ARC, SAMHSA, NIH, the Office of the Assistant Secretary for Preparedness and Response, and designees of theirs as well. To the first charge was to develop a consensus statement on quality in the public health system. And that consensus statement represented uniform concepts and principles to bring synergy across all sectors of the public health system. What also happened in that doing that consensus statement development process was to develop a definition of public health quality. Believe it or not, prior to this time, in 2008, there was no definition of public health quality. And the team that worked on this was very insistent that quality in the public health system was not only, should not focused only on governmental public health agencies; but should stretch across the entire spectrum of those involved in fulfilling public health admission or public health activities. What emerged during that process that stretched over about a six month period of time, it was a very iterative, a very dynamic process. I literally, for the six month period of going through this, I had hives off and on for six months. It was such a dynamic process and included so many people. And

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

I neglected to say that it did include external participants as well, representing the major public health organizations.

So it was quite a dynamic process. But what emerged first, well following the establishment of a definition of public health quality, were nine aims that serve as characteristics of quality in the public health system. We called these characteristics of quality because, based on the definition of quality from the International Organization of Standards, they defined quality as a set of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs.

So in essence, when fulfilling a public health mission, what should be characteristics that are present in that system, and as you begin to build, design and implement programs?

This is very similar in concept to what the IOM did when they developed the six characteristics and aims for patient care as well. Following that process, a year later, we embarked on a similar process with the same team of agency directors and external stakeholders to actually identify priority areas needing improvement in the public health system. And I do have materials in the back in the hallway about all of these processes and copies of the reports. But these were the six priority areas that were identified by the group. And the first one, population health metrics and IT is certainly one that has been getting a lot of discussion over the last two days, and I suspect will continue to be discussed. Don Berwick's contribution to this is that he saw these priority areas as actually drivers of quality in the public health system. And if you pick up a copy of the report in the back of the room, you will see some of the illustrations that we developed with Don to show why these actually are drivers. What I want to do next is to actually illustrate how to link these quality principles to community building and community benefit activities in tax-exempt hospitals, and address also the issue of community building and what we see as being very important. First of all, linking the public health concepts to address IRS objectives primarily of relieving or reducing the burden on government and activities to improve community health.

So how can these principles aid with addressing all four of the items listed, but in particular the first two. And also to illustrate a connection to a document that I read from Catholic Healthcare West, a research that they did showing that communities with the highest community need index were twice as likely to be hospitalized for ambulatory-sensitive conditions, including heart disease.

So, what our illustration shows, and I hope I get the pointer right, from the perspective of Medicare costs in that in the Medicare cost to treat cardiovascular disease in men over age 65 is twice as high if the individual had risk factors at age 45, compared to one who had no risk factors.

So the bottom line here is, if you have risk factors at an early age, you're going to increase the burden on government twice as much as opposed to if you did not have those risk factors.

So the question becomes well, what are some of these risk factors and what are some of the root causes of why we have these risk factors?

So I just pulled together, and I'm probably preaching to the choir because I'm sure everybody in the room is aware of this already; but here are some of the risk factors associated with cardiovascular disease. And then we have here some of the root causes of why we acquire these risk factors.

Some of them related to environment or neighborhood type factors such as limited access to recreation, lack of counseling, inadequate nutrition, lack of exercise, all of those underlying community factors that aid in the development of these risk factors. You can't see this very well but I merely included this to show; and

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

I'm preaching to the choir again, the relevance of the multiple determinants of health on the risk factors, but also on health overall. And we can see that this is only three of many, many models that address in various ways the multiple determinants of health. We see that the Wisconsin Match model, which actually shows, I think it's like only 20% of health can be attributed to clinical care. The rest is on socio and economic factors and physical environment. Here's a county planning module that was developed based on decision science modeling where a community or a county can go in and set their own weights, identify their own indicators within specific to the needs within their community.

So there's many, many models to address this. The relevance of this is that healthcare within the healthcare system plays a much lesser role in reducing these risk factors.

So what I want to illustrate now is how we can take HHS concepts such as the public health quality principles, the guide to community preventive services, recommendations from that document, which one of the presenters earlier gave a very good overview of that. And also, Healthy People 2020 objectives, which is the nation's blueprint for health; how we can use those documents in selecting activities, setting priorities to build community benefit and community building activities to improve community health. This is just a matrix showing how we aligned all of these concepts by using the aims for quality improvement, and we have them listed here in the left side. We also linked it to community benefit and community building activities based on evidence within the community guide and linking it to Healthy People 2020 objectives. I'm not going to read all of these because I know I'm about to get a three minute -- a two minute warning.

Okay, so the first population-centered, we can see educational prevention programs in primary schools and other learning environments, a community building activity, participating in programs to reduce the density of alcohol outlets, definitely a contributor to risk factors from a neighborhood or environmental perspective, equitable placing educational kiosks about mammography, breast cancer in low-income African-American neighborhoods, I'm not going to be able -- I'll have to turn to my notes to read the next one. I really like this, and this was -- definitely came out of the comment guide, providing or subsidizing neighborhood early childcare development programs for at-risk children and low-income families. The last one here proactive, being part of community-wide efforts to increase vaccination rates for new immigrant populations. I'll just go to the next slide and read one these right quick. Oh, I really like this one, health promoting, offering free or low-cost smoking cessation programs; and then community building, working with community parents to create walking and bike paths to encourage exercise. And we documented all of the nine aims with community building and community benefit activities tied to healthy people and also to the community guide. Not saying that that's the only thing that you have to tie to a link to, but it just shows how you can bring synergy of quality within the public health system if you use the quality concepts and HHS documents as well.

The value of this to us, and we really had a passion about this. It demonstrates how IRS Schedule 8 community building activities can be aligned with the public health quality concepts, the national objectives such as Healthy People; and evidence -- meaning science -- to build activities that advance improvements in health of the community, while reducing and avoiding Medicare costs. And I think that's very, very important to show why this is relevant with the community building activities because it does seem like it can help reduce, or even avoid, cost to the government. The last slide, the value of alignment, with the Affordable Care Act, in that quality is a central theme of the Affordable Care Act, goes for addressing the underlying causes of poor health, meaning root causes is a major component of the Affordable Care Act; the emphasis on prevention and community-based initiatives to promote improvements in population health such as some of the grants that we've already seen released under the Affordable Care Act. And also for strengthening the intersection between public health and healthcare to forge a coordinated approach to improving quality and population health across all sectors. And, in closing, one of the very important things

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

that emerged from our latest effort in this was the vision of the Assistant Secretary of Health, Dr. Howard Koh, his vision for public health quality or quality throughout the entire public health system, is building better systems to give all people what they need to reach their full potential for health. And I thank you.

Thank you, all three, for a great, great set of presentations.

So Tom helped us understand what a truly collaborative approach to shared ownership and priority setting is all about. Vondie shared both the challenges and processes in how you build capacity in hospitals and health systems for a collaborative approach to setting priorities and taking action. And Peggy helped us understand how the federal public health quality aims are in fact aligned with what we're trying to do in community benefit and really also inform our thinking on how we do -- how we set priorities in collaboration with communities. I'm going to do, what is it they say, Vondie, in congressional committees, I'm going to defer my time to the senator from Massachusetts. I'm going to defer my time to the questions from the audience.

So let's go right to questions. Hi, I'm Mark Huber, Vice President of

Social Responsibility with Aurora Healthcare in Milwaukee, Wisconsin. My comment is related to a provision in the new IRS guidelines that I don't think has been raised yet in this conference, so I guess it's directed directly at you, Chris. And it's one that speaks to collaboration. I think if there's one thing that's a common theme in all of the sessions we've had today is that there's consensus around the importance, the value, the necessity of collaborative approaches to community health assessment or community health improvement planning. And the provision that I'm referring to is the provision that requires hospitals to complete and adopt their community benefit plan or strategy in the same taxable year as they conduct their community health assessment.

So, let me give you an example how that might be a barrier to collaboration. Right now I'm chairing a collaborative group in southeastern Wisconsin that includes all six health systems and 19 different local public health officers among many other organizations. And anyone who has been involved in a broad collaborative knows that you don't always control the timeframe of that process. I like to use the term you can't use the word control in the same sentence as the word collaboration. And so, one of the things we're at the mercy of everyone's schedule that's involved in that collaborative planning process. Another thing is, if anyone has ever used the MAPP process, or worked with local public health and planning, they know it can be a very involved and time-consuming process. But thoroughly and most directly tied to this provision in the guidelines is that among the six health systems, we have different tax years.

So some of our partners have a tax year in July, others have a tax year in January. We've just narrowed down the window for us to be compliant with that provision, just six months to do both the assessment and the development of our community health improvement plan. And I think it's an easy fix to come to a different solution for that need. And that may be to develop a guideline instead that says, Within X period of time after the completion of the community health assessment, the community benefit plan would be adopted.

So that's my comment.

Thank you. Mark, thanks for both identifying the problem and offering a solution. Next point, next question, next comment. Hi, Julie Willems Van Dijk from the University of Wisconsin. I just want to reiterate around the community building piece. When Peggy put those examples up of what we count under community health improvement and under community building, the policy-based and systems-based strategies that going to be most sustainable in changing the environment in the community were falling under community building.

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

So there's one more reason we really need reconsideration of this community building piece. Second thought, I have three quick things here. I'm not sure where they fit. But this is about accountability. And it has struck me today, it struck me in the earlier conversation about accountability for other nonprofits. But it also strikes me in terms of accountability for local public health agencies who are leading community health assessment processes that we, and I still consider myself one of those -- we need to have that same accountability for public transparency. And even though the IRS is not regulating us, local public health departments need to be required to post and share those community health assessments in the same way. I mean, hopefully they're collaborative and they're the same assessment that's on the hospital website. But we all need to share that kind of transparency and accountability. And the third piece Vondie noted, but others have too about this tragic state of funding for local public health. We need the rest of you to support that because what I hear from hospitals a lot is, I can't count on the health department. They don't have any resources. They don't have enough skills. Well, you can help change that because public health saying, We need to develop these skills and be there, is a noisy gong. And we need others to support us. And in this changing healthcare environment where we need public health systems to be part of the transformation, we need our other partners to support that.

Thank you, one more question/comments?

Thanks, Kevin. Nancy Clifton-Hawkins. Again, I'm a health educator in private practice in southern California. There is a vibration going on in this room, especially for those of us who work at the grassroots level. I'm hearing a lot of theoretical type of applications of these community based community building concepts that aren't reaching down to the rest of us who actually work at the grassroots and deal with community building and coalitions and things like that. And so I'm so glad I came after Julie because she brought up some of those things that I've been thinking about in these two pages of notes that I've been holding back on. Okay, the first thing is, we need to get rid of the us and them when we're working on our collaborative environments with people trying to build community and create sustainable solutions. It's not an us and them it's a we. And we, together, can build those solutions to make changes in the community. The second thing is when I work in hospitals -- and again I have an MPH, I'm a health educator, a certified health education specialist -- when I go work in the hospitals, I'm not always respected by nurses and doctors because I'm not a clinical person. Well, how the heck am I going to get work done to build community when I can't even break through the sorority and fraternity that's going on in the hospital system.

So we need to break that down again, because again we're working together. It's us together to make those changes. And then the third thing is, is -- and Julie you brought it up again, it's that you're right. I used to work at the Health Department. And we didn't have resources to go out, but we did have people like me that have passion who want to make change in the community in a very collaborative way. Why don't the hospitals either hire someone like me or go to that one health educator that's working in the community health department, and go in and work in the hospital and have a space there and train the staff to do it, and then recommend to their non-profit hospitals, or any hospital anywhere else?

Send someone to the Michigan Public Health Training Center for an online certificate program in public health so they understand what it is that we're talking about, or reach out to your other local schools of public health to train the hospital staff to move from clinical into more community-based public health programming that will create those sustainable solutions that will create healthier communities. Okay.

So we have the issue, the practical issue on the -- or I should say the impracticality of expecting hospitals to be in often situations and collaborative situations, to compete the assessment and the implementation plan in the same year. How do we match support for community benefit or for community building, or I should say

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

the Match program, supports community building as part of community health improvement, fundamentally -- a fundamental part of it. How do we get these parallel expectations of public health agencies. On the issue of transparency, how in fact do we support public health departments often faced with obstacles?

I'm going to ask you address that in particular, Vondie, an issue that you were sharing with me. This notion of professional exclusionism among clinicians as it related to folk and outside of the clinical arena and having some legitimacy. And in general, the need to begin to build professionalism, we know that it is taking place, but some of us are more impatient with that than others about how we get to where we need to go because we know kind of capacities that we need. Panel?

Okay. Vondie, I've just -- I'm referencing the political dynamic you cited. Yes, no, I knew what you were talking about. I mentioned one of the issues being, of course, that public health is dramatically underfunded. The other issue that I didn't have a chance to talk about is also the fact that public health staff are staff of basically people who are political office-holders and county boards of commissioners. And one of the issues that we ran into repeatedly was, even when the Health Department staff felt strongly about something, let's say you're going to reduce the amount of smoking in public buildings or something like that, they ran headlong into having to confront the people who basically pay their salary who were active smokers; and who, in most cases, would say, We're not going to hear it and we're unwilling to move an agenda for them.

So that when you're working in close collaboration with your Health Department, they may quietly say, We want to do this, but they're unable to move an agenda because of political realities of the people who sit on those county boards. And so there's also need, I think, for NACCHO and others to come forward to begin to do a better level of education about how you leave some of your own agenda at the door if you're going to sit on a county board and you're really going to look and get engaged in public health and in health improvement. Because it is a serious issue at a local level and one that's very difficult. I know they're paying my salary. It's tough to get there and say, Well, you're wrong. And in some cases, they are quite adamant about it. We do have a number of people have been elected recently who are extremely conservative, believe that government belongs in nothing. And these are new emergent voices in the political atmosphere and they're not necessarily nice voices. And so, we've run into that as well in terms of moving our agenda. Just a comment on the us and them. I'm very conscious of how many times we're turning to Chris and saying, We want community building put into this. It feels a little us and them. And I think if there's any way in which at some point Chins wants to address the group in terms of what would be helpful to make that argument. I know these are still guidelines where there's some chance for feedback. I think that might be very helpful.

So because we're thrilled that he's here. And I think people feel passionately about this piece of community action not being included in the guidelines and there may some more productive way than talking at Chris to address that.

So using my coalition-building process, I just observed that. I wanted to address that also what Julie mentioned is one of the driving factors, why I'm here today representing the Office of the Assistant Secretary for Health is because we feel very passionate about this. I mean it is very difficult to look at one side of the ledger with community benefit and then community building in most cases. And the ashes first reaction to this was what's the difference between -- so I mean it's very difficult to explain a difference to somebody who understands health, how health happens, what the underlying -- as Rob Bialek said, the underlying causes, the root causes of poor health.

So we feel very adamant about making this case for community building. The next set of questions or comments?

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

Yes. Howard Fishbein. I think it's great and I think you're absolutely right, there are a lot of public health folks who are extremely enthusiastic and have a lot of passion and would be in their position, would work in their position whether they're getting paid \$5,000 or \$50,000. And then there are others who are public health workers who just like to be there and do the same thing year after year after year. And if you go with them with an idea, and there's a mix of these folks in all health departments, if you go to them with an idea that's going to add burden to what they're doing. For those who are passionate, they're going to run with it. For those who are not passionate, they're going to resist it.

So I think what CDC could do in the end here or other organizations who are funding the health departments, would be to align their requirements, that is their reporting requirements, their performance goals, objectives that the states are responsible for doing with funds so that individuals at the health departments then understand these are great things, and yet they're also things that we need to do because we're going to be funded for them. If this entity, this program, these standards, whatever comes out of these kinds of meetings, stand alone in the woods. It's going to stand alone in the woods. Those who are extremely passionate, those who are in Boston and California and Michigan and others who are here today will run with it. The other 45 states won't. Great next?

Dory Escobar, St. Joseph Health System. I wanted to build on the comment you just made, Tom. We've been talking community engagement a lot today. And community engagement, if we look at it as an activity that we're going to do to get a needs assessment done, it's not going to get us as far as it could if we really embrace it as a core philosophy and what strategies do we need to integrate throughout what we do. And I think in the conversations here today I've heard opportunities to look at things through that lens of those same community engagement principles. And just as we do community health improvement plans based on current asset needs assessments, I think this narrative of this transformation needs to also be continually updated. And I don't think it's helpful to keep talking about what nobody's doing when clearly we have a lot of evidence in this room and in many other rooms that there's a lot of things changing. And needles may not have been moved, but they're clearly wiggled. And I think that we need to be able to acknowledge that, celebrate that, and build on that and to invite others in who might be a little more hesitant. Great, next?

Jessica Curtis, Community Catalyst. And I think I'm going to ask what's a fairly narrow question, so Kevin I'm really interested to see how you fit this into your synthesis of our questions. But I don't think it's something that others, or other panels will address. And something that you said, Vondie, about the role of the hospital and enrollment in public programs. I'm really curious what the panel thinks too, looking prospectively to the incoming class, as it were, of the newly insured and the role of hospitals in enrolling those individuals or helping to screen them for subsidies for enrollment in Medicaid, certainly for financial assistance. What role do you see?

How are you preparing for that?

That's sort of the other wave of Affordable Care Act provisions that are coming online soon. And then what do you need, or what would be helpful from those in positions of authority, possibly not the IRS but folks at HHS, who are looking more closely at those provisions to help you do that?

And then finally, Tom and Peggy, if you have ideas also about what are the roles of community workers and examples you may have seen of how hospitals or others have been useful in those enrollment tactics?

Okay, so we need more alignment of public health priorities with actual funds, i.e., let's put our money where our mouth is. We need to acknowledge and build on what we're doing well. Let's make sure that we are taking an assets approach to this issue and not just identifying what's wrong. And last, this preparation

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

for 2014, I've spoken with an increasing number of hospital and health system leaders that understand that a significant proportion, if not the majority of the people that will be coming on the rolls in 2014 live in communities which present obstacles to the health behaviors they want to engage them in.

So and we know that what we do in terms of medical care only contributes 10% to 15% of what creates health.

So how do we build the capacity in our organizations to effectively care for these individuals and bend the cost curve?

I'm going to focus, of course, on the enrollment piece. And a little bit of background, in my community, 10% of the people are identified as unemployed and another 18% are underemployed. And one of the qualitative surveys that we did when we did our last needs assessment was we went out to where people were basically waiting in line to get into Michigan Works. And we had them fill out some summary information. And by the end of that process, we had gotten over 1,000 people. And one of the big issues that emerged was the barrier ration of medical debt, that many of the people had lost their jobs, full of credit cards with medical debt on it, and as a result, that had created yet another issue in terms of their access to care.

So even they were afraid to go to their primary care physician. I say that because, then once we got into looking at the issue of enrollment processes in the hospitals. And hospitals have very distinct ways of doing these things and you sort of move along a continuum from the moment at which you get your forms and you're filling them out or you've not filled them out. And then over time if you've not responded to phone calls or something, then suddenly you drop into bad debt. And of course, that's been something we've been called to account for certainly with the new Affordable Care Act in terms of things that we need to change. And so we've spend a lot of time on this issue. And what's occurred as we've begun to look at it closely is that, you know, I've had a ton of people and I know where they live, who received financial assistance from my health systems. Now, why in the world would somebody not pick up the phone, whether it's with the Michigan Department of Public Health or somebody and say, You know what, you know who these people are, you know where they're at.

You can shortcut this process by letting them know that potentially they are eligible now for their expansion and to be there and help them fill out those forms. There's no reason in creating the wheel. Instead, what I have heard, and I've heard this off the record, was that the State of Michigan was about to take some significant cuts in terms of their enrollment staff because they're assuming everybody's going to go on a website or use a 1-800 number. I would suggest from the position of healthcare, whether you're sitting in a hospital or you're out in the community, if we're going to help people stay well and access care, then one of the first things we can do, if we do it right, is the front end, which is the enrollment process. And you're quite correct. That is something we need to focus on. It's certainly something that I'm talking about in Michigan with our Medicaid department and others, is being we ought to be full partners in that. We ought to make an effort to reach out to people that we know, especially if they're on my list, they're people already sick. We can remove a lot of stress from their life by moving in and helping them complete those applications. Let me address the enrollment issue because many years ago when Massachusetts passed the bill that covered all kids, we got involved in creating health access networks, my organization, Community Partners. And we had six meetings a month around the state, 60 meetings a year, bringing together everybody who was engaged in enrollment. And hospitals were only one of the players. We actually had lobbied the state with healthcare for all to get \$1 million worth of outreach grants. And they were outreach grants at a every small immigrant non-profit. There were some in rural areas and we had an army of outreach workers trying everything imaginable to get people enrolled. And we had to change huge attitudes

Panel 7: Setting Priorities: Selection Processes, Collaboration, and Accountability

because up to then, Mass Health, Medicare, Medicaid had decided that to keep the legislature happy, they were going to keep their roles down as far as possible. Now, all of a sudden they had to get the roles up. And so we got them into the room and we started having these exchanges. And there were a lot of hostile feelings on all ends, but that settled down.

So we used essentially a community-building approach, to bring the players. And they're just like in coalitions and other things, there are multiple players in enrollment to get them in the room. We had people who were doing raffles for chainsaws at town dumps in the rural areas. We had people who were putting the most effective thing, being tear-offs in laundromats to get to single moms. It was a wide range of approaches. And of course, as we all know, Massachusetts enrolled huge numbers of these kids. It became the model for CHIP. But the first word that we had gotten was very similar to this, which was, Oh, Medicare is just going to run some ads in English. That will do it. And we really had to say, This is a hands-on basis. Now the next issue that's going to happen is you're going to -- because we put out a workbook called Moving Beyond enrollment is you get them enrolled and then you got to get them to get the healthcare. And let me tell you, this is a population that has not had good experiences going to healthcare. And so, then you need to get these same outreach workers to go back and encourage them to actually set up an appointment and follow-up. And so, it's not going to be as simple as passing a piece of legislation to get this to happen. Let me just also quickly address the question that Howard raised about resistant health departments. If you're building coalitions, just replace the word health department with anybody else in your community at any given time it can be anybody can be resistant. And the question is, how do you deal with them?

And so it's about a common vision, get people excited about the direction you're going to go in, bring them in and you're going to at least lure some part of those resistant health departments who all of a sudden say, Oh, maybe this job could be a little bit more fun. And maybe I could work with people, pardon me, a little bit more interesting than the people who are in my office. And you know, and you start to get some people out. In the experience we had with the enrollment, the Mass health workers, we had some who retired from their jobs and kept coming to the Health Access Network meetings because they liked them so much.

So if you build environments where people have a passion about what they're doing, and people who have been in passion-less organizations, you can really keep them coming to the table. Peggy, you get the last word. Yes, I'd like to address the enrollment issue as well. And I had a similar experience in the state of Missouri years ago when the CHIP program was first being implemented. And it was very difficult to get people to enroll because it was a perception that it was welfare and they didn't want to be associated with a welfare program.

So that was definitely a barrier. Another thing I would like to say is that it's important to educate the community in a language that they understand. And I think somebody brought that up either yesterday or today. But I think we have to start educating them about the social determinants but maybe not in the context of using language of social determinants but something that they can understand so they'll know that the reason why they're having these health problems is not just because they're getting old and it's something that's going to happen to them, but it's something within their environment, something under their control that they can alter. Another thing, observation that I would just like to offer about community and how to engage them. When we have processes such like this, I mean we're a wonderful group of very knowledgeable, educated people. But perhaps if we get some of the non-institutional grassroots people to come and comment and participate in the dialog, that might be helpful for engaging them in the long term as well.

So that's just one observation. Great. Please join me in thanking panel seven.