Thursday, February 16, 2017 **Breakouts I: 1-2:30pm** **TC Baker, 3rd Floor**	
Head Start Centers as "Hubs" of Community-Wide Obesity Prevention Thriving Communities, Thriving Children was a 3-year (2013-16) childhood obesity prevention project that served nearly 10,000 children ages 2-11 and their families in MS and LA. The project used easy-to-replicate interventions in schools, Head Starts and other community-based organizations where children spend time like health centers, afterschool programs, and summer camps. Results from Year 1 BMI and waist circumference data indicate statistically significant improvements in child health.	Michelle Lombardo, President, The OrganWise Guys, Inc.
Healthy Communities: Facilitating Cross-Sector Collaboration in a Rural Setting In September 2015, the LSU AgCenter was awarded the 1416 grant from Centers for Disease Control and Prevention (CDC) to increase physical activity and access to healthy foods in 3 rural parishes with obesity rates over 40%: St. Helena, Madison, and Tensas. Driven by community coalitions, the initiative, "Healthy Communities", uses the socio-ecological model and focuses on encouraging PSE changes to make the healthy choice the easy choice. The LSU AgCenter will present on the successes, best practices, and learned lessons in facilitating community forums, convening coalitions, and facilitating asset-mapping to help communities make lasting and equitable strides toward health.	Denise Holston-West, Instructor, LSU AgCenter; Elisabeth Altazan, Extension Associate, LSU AgCenter
Thursday, February 16, 2017 **Breakouts I: 1-2:30pm** **Quadrangle, 3rd Floor**	
Creating Healthy Communities Coalition: Making Cincinnati the Healthiest City in the Nation: Achieving Better Health Outcomes Through a Multidisciplinary Model The Cincinnati Health Department (CHD) created the Creating Healthy Communities Coalition (CHCC) to promote the health and well-being of people in Cincinnati. The CHCC works with many community partners and policy makers to address healthy eating, tobacco-free living, active living, and chronic disease management or prevention.	Denisha Porter, Director of Health Promotion and Worksite Wellness, Cincinnati Health Department
Building a Culture of Health in Communities The RWJF Culture of Health Prize recognizes communities that have placed a priority on health and are creating powerful partnerships and deep commitments that will enable everyone, especially those facing the greatest challenges, with the opportunity to live well. This session will be grounded in the six Prize criteria and will showcase how Prize-winner Brownsville, Texas is engaging leaders across sectors and community residents to improve local health outcomes, and working to ensure that everyone has the opportunity to live a longer, healthier, and more productive life.	Arturo Rodriguez, Director Health Department, City of Brownsville; Carrie Carroll, Deputy Director, RWJF Culture of Health Prize, University of Wisconsin Population Health Institute

Thursday, February 16, 2017	Breakouts I: 1-2:30pm	L. Mahncke, 3rd Floor
Understanding Community Health Worker Roles in Promoting Health Equity in US Communities Community Health Workers remain integral in the delivery of public health messages and prevention services. Since CHWs' work targets the individual, family, community, and system levels, much of their work promotes health equity. The Community Health Worker (CHW) Core Consensus (C3) Project Phase I offers recommendations for national consideration related to CHW core roles (scope of practice), core skills, and core qualities (C3 defines skills and qualities collectively as competencies). This presentation will include findings from C3's first consensus building phase—emphasizing CHW roles in community-based settings and efforts targeted to promote health equity.		Julie St. John, DrPH, MPH, MA, Associate Chair, Abilene Campus, Texas Tech University Health Science Center; Lex Hurley, Graduate Student Assistant, Texas Tech University Health Science Center
Bridging the Gap between Healthcare and the Community The movement of CHW integration among clinical teams is a much-needed innovative approach to mainstream health care. This session highlights the guiding framework utilizing CHWs to improve patient experience of care, patient health as well as reduce costs. Building cohesive health care teams to include suitable CHWs and supportive CHW nurse managers, plays an essential role in the overall program success. In theory, utilizing CHWs as a part of the health care team may seem simplistic; however, a structured and streamlined approach defining roles, responsibilities and scope of practice is warranted. Key components include stakeholder dialogue and engagement.		Kim Bush, Program Manager, University of Texas Health Science Center at Tyler/UT Health Northeast
Thursday, February 16, 2017	**Breakouts I: 1-2:30pm**	**Alamo, 3rd Floor**
A Data-driven Strategy for Improving Whole-Person Health MATCH is an innovative, community referral network that increases access to comprehensive care by providing participants with navigation to resources in order to alleviate socioeconomic barriers and improve well-being. The implementation of community-centered hubs in rural areas allows limited resources to be maximized and used efficiently, while reaching the most at-risk populations. A single entity cannot improve population health on its own, but through collaboration around priority health needs there is great potential for sustainable, deeply rooted change. MATCH decreases isolation from health services, maximizes limited resources in rural communities, and creates collaborative partnerships across health and social agencies.		Lanie Honeycutt, MATCH Program Manager, McDowell County Health Coalition; Matthew Son, President, Son Information Systems
Advancing Health Equity in Health Insurance Marketplaces: Perceptions of Progress and Challenges in Two Leading States With passage and implementation of the Affordable Care Act, rates of health insurance coverage have increased nationwide. Despite these gains, non-white, limited-English proficient, and LGBTQ populations continue to disproportionately experience lower rates of coverage. To better understand these disparities and spur equity-focused discussions, we engaged California and Connecticut's health insurance marketplaces and surveyed their stakeholders. Results provide an opportunity to compare and contrast perspectives of how marketplaces have worked to successfully advance health equity and identify perceived barriers to further achievement.		Anna Stelter, Health Policy Analyst, Texas Health Institute

Thursday, February 16, 2017	Breakouts I: 1-2:30pm	Frontier, 3rd Floor
Healthy Start Border Alliance: Aligning for Maximum Impact along the US/Mexico Border The federally funded Healthy Start Initiative is designed to eliminate disparities in perinatal health in communities with the poorest birth outcomes. In recognition of the barriers faced by families in U.S.-Mexico border communities, the Healthy Start Border Alliance was established in 2014 as a border-wide asset/resource network for peer learning and documentation of best practices across five grantees in California; Arizona; New Mexico (2); and Texas utilizing a collective impact approach to identify common measures of success and align programs strategies effective at overcoming barriers.		Maria Lourdes Reyes, Director of US and Border Programs, PCI
Engaging Vulnerable Maternal and Child Health Populations: The Texas Healthy Start Alliance Experience Over 100 Healthy Starts across US are funded by HRSA to eliminate perinatal health disparities through individual and community-level interventions. Most programs use home visiting to provide evidence-based screening, follow-up, education and support services to preconception, pregnant, and parenting women. Local health system, demographics and contextual factors guide local implementation. In Texas, several factors influence ability of programs to engage and serve vulnerable MCH populations and meet benchmarks. From a statewide perspective, we will provide an overview of most salient conditions affecting MCH populations, implementation challenges and strategies used to overcome barriers to engage and serve women and their families.		Misty Wilder, Program Manager, UNT Health Science Center Healthy Start Program; Kori Eberle, Project Director, San Antonio Metro Health - Healthy Start
Thursday, February 16, 2017	**Breakouts II: 2:45-4:15pm**	**TC Baker, 3rd Floor**
The ANCHOR National Implementation Model: Engaging Communities for Sustainable Policy, Systems, and Environment Change In 2014, the Centers for Disease Control and Prevention invested $10 million for national organizations to increase capacity to implement policy, systems, and environment (PSE) strategies addressing chronic disease risk factors. As a grantee, the American Heart Association (AHA) designed a national implementation model to develop and execute PSE initiatives. Thirty AHA field offices participated over three years. A national team directed program design, reporting, training and technical assistance, operations, and monitoring. The project built PSE changes to meet local needs to positively impact communities at greater risk. AHA's sustainability approach was to embed these local activities within AHA's infrastructure.		Laura King Hahn, Senior Program Manager, ANCHOR Partnership Program, American Heart Association
Developing a Collective Impact from Grassroots Algoma is a rural community improving the health and well-being of our community and its members. Through empowerment, engagement and activation, we provide tools and resources, allowing people to achieve their own desired health outcomes. Our coalition (Live Algoma) is committed to developing equal opportunities for all through each of our five focal points Healthy Children, Healthy Individuals, Healthy Community, Healthy Employers, while ultimately contributing back to the Commons. We are dedicated to creating partnerships and teaching our community members to use their talents, assets and resources available so that we can live in a healthy, sustainable community.		Jody Anderson, Registered Nurse and Certified Health Coach, Bellin Health and Succeed Health, LLC; Claire Thompson, Associate Professor Community Development Educator, University of Wisconsin Cooperative Extension Kewaunee County

Thursday, February 16, 2017	Breakouts II: 2:45-4:15pm	Quadrangle, 3rd Floor
The Evolution of Crisis Care: A Community Solution What do you do when an extraordinary crisis threatens to disrupt countless lives in your own back yard? You pull together as never before, bridging the perceived distance and language barriers of mental healthcare, emergency services, law enforcement and politics to create a new alliance in the name of those among us who face the most critical need in our community. It may sound like the start of an action or thriller movie, but this was a very real dilemma faced by a community in Southeast Texas, and it brought out the very best in all of us.		Heather Champion, Business Development Director, Spindletop Center; Mark Severns Administrator, Crisis Stabilization Unit, Spindletop Center
Expanding the Reach and Success of Elder Abuse Prevention through Primary Care Partnerships The reach of Adult Protective Services can be expanded exponentially if primary care physicians around the country would routinely screen for abuse. Hear how one healthcare organization has embedded APS workers into their system and is screening seniors for the risk of elder abuse. Find out how this exciting program is creating new opportunities and potential new funding for Adult Protective Services.		Carol Zernial, Executive Director, WellMed Charitable Foundation; Ray Kirsch, Adult Protective Services Specialist V, Texas Department of Family and Protective Services
Thursday, February 16, 2017	**Breakouts II: 2:45-4:15pm**	**L Mahncke, 3rd Floor**
Impacting Communities from Our Doorstep Yale New Haven Health uses a risk stratification model to target individuals for disease management and prevention. This is done using a single source analytic software system that is able to interface with multiple data sources including medical, pharmacy, and our EMR system to risk adjust for targeted outreach and intervention.		Stacey Lane, Manager, Care Coordination, Yale New Haven Health; Carmela Valentino, Manager, Clinical Integration Population Health, Yale New Haven Health
Partnerships for Helping the Most Vulnerable Access their Medications The Trinity Health Prescription Safety Net Program brings together no cost and reduced rate prescriptions medication programs and makes them available to the patients we serve. Our staff is educated to help patients receive low or no cost medications at the point of service and in retail outlets. We have partnerships with pharma companies that provide medication samples and donations, and FamilyWize Community Service Partnership which provides educational materials and prescription savings tools. Together, we have built a Prescription Safety Net Program that benefits our patients. Other health systems and groups can learn from our experience and replicate our success.		Carrie Harnish, Clinical Director, Community Benefit, Trinity Health; Ken Majkowski, Pharm.D, Chief Pharmacy Officer, FamilyWize Community Service Partnership

Thursday, February 16, 2017	Breakouts II: 2:45-4:15pm	Alamo, 3rd Floor
Create Lasting Community Change How can collaborative action to address complex community change best honor community context, engage residents and lift equity? Active Living By Design's Community Action Model illustrates an evidence-based, field-tested process that incorporates key components for community change—multi-sector partnerships, ongoing preparation, and practical strategies—useful for guiding community/clinic integration efforts. These components incorporate six essential practices: health equity focus, community engagement, facilitative leadership, sustainable thinking, culture of learning, and strategic communication. Discover how community partnerships across the U.S. have achieved impressive and lasting results utilizing the model and gain tools to effectively incorporate this model into your current work.		Risa Wilkerson, Executive Director, Active Living by Design; Richard Bell, Senior Project Officer, Active Living by Design
Bringing Sectors Together to Improve Health Through Data Sharing As catalysts for health equity, data-driven community collaborations help decision-makers understand and address social, economic, behavioral, and environmental factors that influence health. This presentation will highlight two initiatives transforming community health through multi-sector data sharing. The Baltimore City Health Department will share progress engaging city government, community-based organizations and a Health Information Exchange to create a real-time data surveillance system to track and reduce falls-related ED visits and hospitalizations. The Cincinnati Children's Hospital Medical Center will discuss work identifying hotspots of poor child health and working to understand social determinants of health by integrating inpatient hospitalization records and GIS.		Andrew Beck, Assistant Professor and Attending Pediatrician, Cincinnati Children's Hospital Medical Center; Grace Mandel, Project Manager, Baltimore City Health Department
Friday, February 17, 2017	**Breakouts III: 9:15-10:45am**	**Alamo, 3rd Floor**
Coordinating Care in the ED: CHWs and Patients Navigator in a Hospital ED Setting There is emerging interest in using Patient Navigators (PN) and Community Health Workers (CHW) to improve health outcomes. As financial incentives and payment models change, healthcare organizations are searching for evidence-based approaches to keeping patients healthy. Innovative healthcare projects have demonstrated promising results in health outcomes and costs. Our presentation gives an overview of CHW's/PN's, and includes a systematic review of CHWs/PN's, including definitions, roles, and examples of how they can be incorporated into complex healthcare systems. We also discuss a unique pilot study conducted in the Yale-New Haven Hospital Emergency Department using PN's to engage frequent ED users.		Peter Ellis, Associate Professor, Yale School of Medicine; Juan Carmona, Patient Navigator, Project Access of New Haven
Developing a Community Health Worker Training Model for Underserved Latino Residents in Rural Texas This session describes the development of a community health worker (CHW) training model to increase access to health services among underserved Latino residents in a rural Texas community. The Latino population in Madisonville, Texas is predominately underinsured/uninsured, non-English speaking, and served by non-culturally competent healthcare providers. In this model, trained volunteers will immediately be prepared to connect disadvantaged Latinos to available resources, increase access to care, and improve health outcomes in their home communities.		Katharine Nimmons, Director, National CHW Training Center, Center for Community Health Development; Angie Alaniz, Associate Director, Center for Community Health Development

Friday, February 17, 2017	Breakouts III: 9:15-10:45am	Frontier, 3rd Floor
Improving Access to Specialty Care for the Uninsured The Specialty Access for the Uninsured Program (SAUP) is a unique collaboration across health systems and safety net clinics that offers barrier-free access to specialty health care screenings, diagnostics and treatment for low-income, uninsured residents in Milwaukee. Building on a patient-centered medical home model, each participating safety net clinic is matched with one or more hospital/health system to coordinate access to specialty care services. By working together to also resolve other barriers, such as transportation and language needs, the SAUP has guided 9,196 specialty referrals for the uninsured since 2012.		Betty Ragalie, Project Director, Milwaukee Health Care Partnership
Implementation of eConsults with Patient Navigation at a Federally Qualified Health Center Project Access-New Haven (PA-NH) launched an innovative eConsult program that allows primary care providers at a community-based federally-qualified health center to obtain electronic consultations for Medicaid-insured patients from specialists at a nearby academic medical center. Patients referred for specialist office visits or testing via the eConsult process are also offered intensive patient navigation through PA-NH to coordinate care, facilitate timely appointments, and remove access barriers. Incorporation of navigation is essential and unique to our eConsult model. The program was developed through collaboration with multiple community partners and stakeholders and incorporates rigorous evaluation to measure patient-reported outcomes and healthcare utilization/cost metrics.		Lauren Kelley, Director, Research & Evaluation, Project Access-New Haven; Sanket Dhruva, Robert Wood Johnson Foundation Clinical Scholar, Yale University School of Medicine
Friday, February 17, 2017	**Breakouts III: 9:15-10:45am**	**L Mahncke, 3rd Floor**
Forming Partnerships to Address Obesity in Texas Border Rural School Districts The Texas Department of State Health Services (DSHS) Health Service Region (HSR) 8, Office of Border Services (OBS) has partnered with different school districts along the Texas-Mexico border to launch a Border Obesity Prevention (BOP) - Independent School District (ISD) Program to address child and adolescent obesity. The goal of the Nutrition Ambassador and 100 Mile Club Initiative is to develop a program to empower students to actively participate in learning about healthy eating habits, to stimulate change within their schools. Nutrition Ambassador Programs have been implemented in various Texas counties along the US-Mexico border and is in its third year of implementation in Maverick County.		Rosy De Los Santos, Office of Border Services Binational Program Coordinator, Texas Department of State Health Services
Greater with WIC: Moving Beyond the Clinic Walls to Bridge the Rural Food Access Gap The Community Partnerships for Healthy Mothers and Children (CPHMC) project has given local WIC agencies around the United States the opportunity to implement community-level public health projects and address local health disparities. Over the course of 15 months, six local WIC agencies combatted rural food deserts in Texas, Virginia, Louisiana, Michigan and New Mexico by establishing and strengthening coalitions and implementing policy, systems, and environmental (PSE) improvements at convenience stores, food banks, mobile grocers, grocery stores, farm stands, elementary schools, and a day care center. The interventions collectively reached approximately 126,988 people.		Quinney Harris, Senior Program Manager, National WIC Association,

Friday, February 17, 2017	Breakouts III: 9:15-10:45am	Quadrangle, 3rd Floor
Social Impact Bonds 2.0 – A New Way to Get Resources and Results Social Impact Bonds 2.0 is a new approach for funding today's ounce of prevention based on saving tomorrow's pound of cure. First generation social impact bonds were primarily designed to monetize future savings in the social sector for the benefit of financial investors. That approach bets on isolated, evidence-based interventions rather than collaborating to tackle social issues with communities joined together for action. The SIB 2.0 model leverages value creation and the harnessing of underutilized community assets along with innovative financing to creates value that stays in the community rather than going to financial investors.		Bill Barberg, President, Insightformation, Inc.; Scott Cole, CEO/Co-Founder, Collectivity
Community-Based Health Reform: Braiding Data, Coalitions, Community Engagement Regional Population Health Improvement: Data, Coalitions, Community Engagement: How partners are improving population health through coalition building, building and supporting integrated data systems, authentically engaging the community and aligning community funding priorities.		Kathleen Burgoyne, Senior Director, Foundation for Healthier Generations; Robbi Kay Norman, Principal, Uncommon Solutions

Friday, February 17, 2017	Breakouts III: 9:15-10:45am	TC Baker, 3rd Floor
People, Policy, and Place: A Model for Organizational Transformation to Health Equity in Harris County, Texas Harris County, Texas is one of the largest, fastest growing, and diverse areas, facing multiple upstream challenges: 19% poverty, 78% HS graduation, and 11 zip codes on a pollution watch list. All are correlated with poor health, and some are avoidable and reversible (health inequities). As the county health department, Harris County Public Health adopted a health equity goal in its Strategic Plan; and then designed and is implementing an evidence-informed model and five-step process for health equity agency transformation with tangible impacts. We believe our model is replicable by other local health departments, healthcare/clinics, and community-based organizations.		Umair Shah, Executive Director, Harris County Public Health; Jennifer Hadayia, Health Equity Coordinator, Harris County Public Health
Keeping Them Ambulatory: Care Navigation for the At-Risk Population The University of Texas Medical Branch's Community Health Program/Chronic Disease Education project has helped over 700 patients navigate the next phase of their healthcare, with the goal of remaining ambulatory. The project uses a team of Community Health Workers, Social Workers, and Registered Nurses. The work being done in the Galveston and Brazoria County communities has been made possible with the Texas 1115 Medicaid Waiver. The measurement of metrics such as hypertension and readmissions have advanced the triple aim of healthcare (Access, Cost, and Outcomes) demonstrating how innovative programs, like this, are advancing population health.		Craig Kovacevich, Associate Vice President Waiver Operations & Community Health Plans, The University of Texas Medical Branch at Galveston; Katrina Lambrecht, Vice President & Administrator for the Angleton Danbury Campus and Vice President, Institutional Strategic Initiatives, The University of Texas Medical Branch at Galveston