Breakout Track I Wednesday, February 14, 2018 2:45 p.m.-3:45 p.m.				
Breakout Title	**Breakout Track**	**Description**	**Presenter(s)**	**Room Name**
1.1 Innovative Strategies for Engaging Residents in Participatory Planning Efforts that Drive Community Health Improvements	Community Health	Meaningful engagement of community members is often a desired goal of multi-sector collaborations working to improve community health though in reality, can be very difficult to achieve. Two representatives from public health departments in Seattle & King County, WA and Garrett County, MD will share how they developed and tailored processes and strategies for engaging residents in community health improvement planning as well as some of the barriers and opportunities encountered along the way. The role of local health systems in responding to the specific health needs identified by community members will also be discussed.	Nadine Chan, PhD, MPH, Public Health - Seattle & King County; Shelley Argbrite, MA, Garrett County Health Department	Ansley 1
1.2 Restoring the Community's Health, Spirit and Culture: Rethinking the Medieval Model of Communal Health	Community Health	The 14th century Medieval Model of Communal Health sought to view communal health from a trifold public health perspective: health, spirit and culture. Through the lens of generational determinants of health, the workshop will examined the 2015 Death of Freddie Gray and the Baltimore's civil unrest. I also introduce my Multigenerational Internationality to Communal Health conceptual framework. The conceptual framework directs any determinants of health process (i.e., planning, policy, programming, practice, etc.), to decisively utilize the looking backward-thinking forward method to explore the intersectionality of how generational determinants of health threaten communal health.	Sharon Jones-Eversley, Towson University	Ansley 2

1.3 Application of Advanced/Predictive Analytics to Adherence with Diabetic Patients.	Evaluation and Applied Research	Value-based reimbursement is driving healthcare enterprises to be more accountable for measuring benefit, and creating greater efficiencies while achieving improved clinical outcomes. This session presents an example of how to measure benefit and calculate ROI for Population Health Management initiative (PHM). Our example also includes the application of advanced/ predictive analytics using the CRISP-DM approach within a PHM initiative. This example has applied advanced/predictive analytics to improve adherence with diabetic patients at a California FQHC. Clinical results from insights gleaned through the application of advanced analytics will be shared before open discussion.	Mark Rivera, Managed Care Consulting, Inc. / MCC Analytics, Rick Wilk, Community Health Partnerships Ltd	Ansley 3
1.4 Accountable Communities of Health of Washington State: Multisector, Public-Private Partnerships Taking on the Medicaid Transformation Project	Multi-Sector Partnerships	ACHs in Washington State have been put in a unique role of implementing a DSRIP-style waiver from CMS. Because of their position as a multi-sector, public-private partnership, initiated to address health outcomes at a local level, ACHs have an opportunity to influence and change health systems, health disparities and how communities conceptualize health. This session will cover the history of ACHs, the establishment of Pierce County ACH and some of the successes and challenges we have experienced through the process we are going through to obtain health and address health disparities.	Kyle Davidson, Pierce County Accountable Community of Health	Ansley 4
1.5 Vision 2020: Planning, Implementing and Sustaining Successful School-based Health Centers	Multi Sector Partnerships	A large Federally-Qualified Health Center (FQHC) identified a critical need for two school-based health centers serving 20,000 students covering two large, suburban school districts including 14,000 students covered by Medicaid needing a medical home. The challenge was to raise $3.5M for primary care, dental, behavioral health, and vision services in both school districts SBHCs in a reasonable time. Partnering with	Francie Wolgin, Interact for Health; Stephen Roller, Primary	Ansley 5

		two school districts, SBHC champions and visionary funders enabled Primary Health Solutions (PHS) to develop two community SBHCs. One of these SBHCs includes the largest comprehensive suburban SBHC to include integrated medical, vision, dental and behavioral health services in one location.	Health Solutions	
1.6 Health in All Policies as a Collaborative Approach to Address Community Health	Multi Sector Partnerships	This session will introduce the foundational concepts of Health in All Policies (HiAP), an approach to trans-disciplinary collaboration on policy issues that are traditionally not inclusive of community health perspectives. Experts from the Georgia Health Policy Center will share their HiAP experiences working with affordable housing in Georgia and Alabama, community redevelopment in Wisconsin, and comprehensive planning in Kentucky. In each case, existing decision-making processes were enhanced by the inclusion of community health and equity perspectives that elevated concerns of stakeholders who may have otherwise not been a part of the process.	Jimmy Dills, Georgia Health Policy Center; Michelle Rushing, Georgia Health Policy Center	Ansley 6

Breakout Track II Thursday, February 15, 2018 10:00 a.m.-11:00 a.m.				
Breakout Title	**Breakout Track**	**Description**	**Presenter(s)**	**Room Name**
2.1 Combining Health Equity and Literacy Outcomes with an Evidence-based Childhood Obesity Prevention Program	Community Health	Through grant funding from the W.K. Kellogg Foundation, areas in Mississippi have received sustained, integrated, evidence-based programming on nutrition, physical activity and healthy living that is changing communities. By starting in the early years (Early Childcare and Head Start Centers), sound habits are being created in an effort to build a solid foundation on which a healthier future is built. Dr. Lombardo, Project Director of this initiative, will highlight the results of this previously funded success story that was recently expanded to include a focus on health equity and literacy outcomes	Michelle Lombardo, The OrganWise Guys, Inc.	Ansley 1
2.2 The Multiple Paths to Community Health Improvement	Community Health	All communities are different, just like every mountain. To reach the peak of improved community health, there are multiple considerations needing to be made to get to the top. Each community may need to take different trails, use different equipment, and go with different people to reach the peak. There isn't just one theory, method, or tactic which will get communities to the pinnacle of improved health. This session will examine a new way to examine the multiple tools available to communities to pursue improved health and choose the best path forward to community health.	Matt Guy, ReThink Health; Leigh Caswell, Presbyterian Healthcare Services	Ansley 2
2.3 Harnessing Clinical-Community Partnerships to Increasing Patient Physical: Implementing Exercise is Medicine in Two North Carolina Communities	Community Health	This presentation will demonstrate the importance of developing clinical-community linkages to increase physical activity for the subsequent reduction of obesity and chronic disease. Experts will share how Exercise is Medicine® (EIM), the signature initiative of the American College of Sports Medicine, attempts to forge these linkages through physical activity assessment, prescription and referral. Two community coalitions from Chatham and Catawba counties in North Carolina	Sarah Weller Pegna, Chatham Health Alliance; Zack King, LiveWell Catawba; Mark Stoutenberg, University of	Ansley 3

		will then share their challenges and lessons learned integrating EIM into their local health systems with the goal of providing attendees with concrete examples that can be applied within their own communities.	Tennessee Chattanooga	
2.4 Engaging Communities To Collect and Disseminate Data	Evaluation and Applied Research	During this session, we will share the unique methods we have utilized in our community to gather authentic community feedback about health status and barriers to good health. Attendees will participate in role playing scenarios to help make the session more interactive and engaging. A power point will also be used during the session and there will be time for questions and answers. We will also share the creative ways we have presented the data collected to and used this information as a starting point for conversation about community change.	Donyel Barber, Gaston Family Health Services; Abigail Newton, Department of Health and Human Services	Ansley 4
2.5 "Get Covered Carolina:" A Partnership to Navigate Change in Healthcare Law	Multi Sector Partnerships	The Session will be didactic and interactive. Participants will have an opportunity to hear about the Get Covered Carolina partnership members, political context, and outcomes. Questions will be encouraged. Participants will be divided into small groups to identify partners both traditional and non-traditional that may have an investment in a healthcare change that will be provided for them. They will be asked to describe how they would discuss what is important to a stakeholder and how they get them invested in the community work. The groups will be asked to report out both potential challenges and potential areas for success.	Sherry Hay, UNC-Family Medicine; Tim Smith, Carolina Health Net-FM	Ansley 5
2.6 Advancing Health Equity through Partnership	Multi Sector Partnerships	ARCHI, the Atlanta Regional Collaborative for Health Improvement traces its roots to 2011 when a group of community leaders recognized their shared frustration with a world class healthcare system that was still producing significant health inequities. This session will explore the formation of the Collaborative, and the particular roles that collective impact techniques, state of the art systems models and innovative community engagement have played in both the formation of ARCHI's 28 year strategy and its long term sustainability. Participants in this session will engage in dialogue about	Kathryn Lawler, ARCHI; Karen Minyard, Georgia Health Policy Center	Ansley 6

		their own collaborative work sharing their lessons learned and future goals.		
2.7 From Grass Roots to Statewide Change: A Collective Impact Approach to Addressing Childhood Obesity	Multi Sector Partnerships	This session will review successes and challenges experienced when implementing a childhood obesity effort at the local, regional and state level. Participating stakeholders and their roles in addressing childhood obesity will be described including state departments of public health, education and early care along with public, private, county and district public health partners. A systems modeling tool used to educate legislators about childhood obesity will provide audience interaction. Finally, a discussion of how partnerships, professional development, technical assistance, and community interventions have been applied in targeted geographic locations to build capacity throughout the state in addressing childhood obesity.	Emily Ann Vall, Georgia Department of Public Health; Debra Kibbe, Georgia Health Policy Center	Ansley 7
Breakout Track III Thursday, February 15, 2018 11:15 a.m.-12:15 p.m.				
Breakout Title	**Breakout Track**	**Description**	**Presenter(s)**	**Room Name**
3.1 Pierce County Accountable Communities of Health: Community Voice Engagement for Community Health in the Medicaid Transformation Project	Community Health	The ACH's of Washington State are focusing on creating a more inclusive health care system that not only focuses on the medical aspect of a person's well-being but also focuses on other dimensions that can implicate or support a person. We are partnering with local Managed Care Organizations, local coalitions, schools, Behavior health, and faith-based groups so that the new Medicaid Transformation project can deliver services to bigger ranges of community sectors that were underrepresented. Specifically, the Pierce County ACH is working towards increasing transparency by opening council participation to the community to partake in discussion and decision-making processes.	Liszet Chavez-Avila, Pierce County Accountable Community of Health	Ansley 1
3.2 "TRIP (Transporting Residents with Innovative Practices) Case Study- Collaborating	Community Health	People who have low-incomes and health challenges must prioritize paying for transportation over other	Weyling White,	Ansley 2

Locally to Improve Transportation Access in Two Rural Communities"		necessities like medication. Without reliable and affordable transportation, many are unable to manage their health. Transporting Residents with Innovative Practices (TRIP) is a pilot designed by a local collaborative, Hertford Health Maintenance Alliance (HHMA) that serves Hertford and Bertie, two rural counties located in northeastern North Carolina. TRIP works to improve the health of each participant by implementing a patient-centered model. HHMA developed the pilot after learning how other rural communities are addressing transportation. TRIP is a cross-sector collaboration that includes local transportation providers.	Roanoke Chowan Community Health Center; Shelisa Howard-Martinez, Care Share Health Alliance	
3.3 Population Health and Transformational Initiatives in Texas as Evidenced Based Incubators for Delivery System Reform	Community Health	The 1115 Medicaid Waiver in Texas provides organizations the opportunity to implement innovative models of care for targeted populations in an effort to drive toward better care experience and better outcomes at a lower cost. The more than 1400 projects implemented across the state provide the opportunity to explore the health outcomes of specific groups of individuals and utilize the data in order to identify best practices and scale programs that advance population health. Waiver projects serve as an incubator for population health initiatives in a variety of ways.	Craig Kovacevich, University of Texas Medical Branch	Ansley 3
3.4 Documenting Collaborative Networks as Community Connectors – Network Clients & Social Determinants of Health	Evaluation and Applied Research	North Carolina's collaborative networks have begun systematically documenting their work related to social determinants of health and clients' needs. This session describes that process, associated tools, and how both can be adapted by other communities. How to leverage this data at multiple levels will be discussed. One network's experience is spotlighted – Care Ring Physicians Reach Out recognized an opportunity in collecting social determinants of health data to identify and triage patients for targeted case management. Their new process streamlined existing	Andrea Radford, DrPH, MHA; Care Share Health Alliance, Rebecca Palmer, Care Ring	Ansley 4

		case management protocols for high-risk patients, improving patient care and maximizing case management staff resources.		
3.5 Creative Collaborations: Using Social Determinants of Health to Spark Innovative Partnerships Across Multiple Community Service Sectors	Multi Sector Partnerships	Through utilization of interactive storytelling based on lived, professional experiences, attendees will learn about successes and challenges associated with community-wide, multisector partnerships. Attendees will consider how specific community organizations address various social determinants of health while brainstorming who they could partner with to create holistic and equitable health improvements for their entire community. Attendees will become familiarized with models of successful multisector partnerships and then be given an interactive, small group assignment to source local, creative collaborations that may fit with their own agency/organization. Attendees will leave the session with three next steps to begin a multisector partnership.	Gregory Dent, Northwest Georgia Healthcare Partnership; Gayle Brannon, Whitfield County Health Department	Ansley 5
3.6 A Coordinated Response to Opioid Addiction	Multi Sector Partnership	Rio Arriba County is modifying the Pathways Care Coordination model to meet the needs of rural and frontier communities struggling to respond to the opioid epidemic. In past years the national response to addiction has been weighted towards law enforcement. The switch to a public health model requires involvement of police, corrections and the judicial system, all of whom speak a language alien to health care. Rio Arriba was the first county in the US to be impacted and has brought providers and justice together to create outreach and jail diversion.	Lauren Reichelt, Rio Arriba Health and Human Services Department	Ansley 6
3.7 Pathway to Health Equity: Interprofessional Collaboration	Multi Sector Partnerships	The presentation, through the use of case studies and a toolkit, will explain how a collaboration among a large, urban-based health system, state university law school, and an urban-based legal services organization, implemented, funds, evaluates and integrates patient-focused legal services into the	Sylvia Caley, Health Law Partnership; Robert Pettignano,	Ansley 7

		hospital setting. It will show how this integration has improved the patient health and well-being and the healthcare organization financial well-being, and created interdisciplinary educational opportunities for professionals. Participants will learn key attributes required to develop their own MLP, including identifying and formalizing partner roles and responsibilities, developing funding strategies, and developing a process evaluate success.	Health Law Partnership	
Breakout Track IV Thursday, February 15, 2018 2:15 p.m.-3:15 p.m.				
Breakout Title	**Breakout Track**	**Description**	**Presenter(s)**	**Room Name**
4.1 A Hospital & TimeBank Partner to Meet Patient and Community Health Needs	Community Health	St Joseph Mercy Oakland and the Pontiac SUN (Strong United Neighbors) TimeBank share a vision that healing doesn't stop at the hospital door, and that we all need each other. Creating community is an important part of health and healing. Building on work of Lehigh Valley, Pennsylvania, we launched an innovative collaboration to utilize TimeBanking to address loneliness, social determinants of health, and gaps in care for patients recently discharged from the hospital. It has been an extraordinary journey, and we will share the challenges, obstacles, learnings and hands-on resources and tools created over this two year journey.	Kim Hodge, Pontiac SUN TimeBank; Beverly Beltramo, St Joseph Mercy Oakland	Ansley 1
4.2 Transportation and Health: An Overview of the Rides to Wellness Initiative in the Atlanta Metro Region	Community Health	The Transportation and Health: An Overview of the Rides to Wellness Initiative in the Atlanta Metro Region session will provide participants with information about the Rides to Wellness Program and how it is improving the lives of participants in the Atlanta Metro Region. The presenter will go over why partnerships between health and transportation providers are important in Atlanta and how Rides to	Amanda Tyler, Atlanta Regional Commission;	Ansley 2

		Wellness is increasing health care access for its participants.		
4.3 Using a Comprehensive Risk Reduction Lens to Transform Service Delivery and Payment, Pathways Community HUBs as an Example	Evaluation and Applied Research	A risk reduction lens is used to understand program and payment approaches within health and social services. Community based programs serve as the intervention center of research. Risk factors are the addressable source and impactable variable to improve outcomes and reduce cost. Science is needed to determine the critical weights and interlinkages of factors such as housing, medical care, medication access. We will present published research and future research approaches. A national research network approach can produce quantitative relative values of physical, behavioral and social determinant factors and serve to strategically improve programmatic and payment approaches to care.	Mark Redding, Akron Children's Hospital Rebecca D. Considine Research Center;	Ansley 3
4.4 Achieving Sprints of Change within the Marathon of Health System Transformation: A Technical Assistance Model aimed at Supporting the Development of Policy Strategies to Address Upstream Determinants of Health among Hospital-Community Partners	Multi Sector Partnerships	Within the marathon of health care transformation, there's a need for “sprints of change”- short-term strategies that support health systems and partners in implementing evidence-informed institutional and local health policy. This presentation summarizes results from a pilot model for supporting health systems and community partners through these sprints of change. The Learning Labs are a series of virtual meetings separated by short action periods to drive: increased knowledge of resources to inform their work; increased skills for identifying appropriate policy strategies for their community and creating associated policy tools; increased connection to experts who can inform and accelerate their work.	Allison Gertel-Rosenberg, Nemours Children's Health System Stephanie Walsh, Children's Healthcare of Atlanta	Ansley 4
4.5 Making Multi-Sectoral Teams Work: Policies, Procedures, and Tools for Success	Multi Sector Partnerships	Community Food Strategies (CFS) is an intentionally multi-organizational initiative actively using and modeling policies and practices that reflect our collaborative approach and value in trusted relationships as essential to creating the greatest	Megan Bolejack, Care Share Health Alliance, Gini Knight, Center	Ansley 5

		impact for systems change. We will highlight how our practices have been essential in creating a successful and sustainable team with members across four different organizations and six different sectors. The session will highlight local council examples modeling similar practices to work across sectors, engage community voice and influence leaders to improve health, food access, natural resource protection, economic development, and production agriculture for all its community's residents.	for Environmental Farming Systems	
4.6 Collaborative Cottage Grove: Aligning Health and Housing	Multi Sector Partnerships	Cottage Grove neighborhood leaders with their organizational partners Collaborative Cottage Grove will share the story of building shared leadership, sustainable and authentic community engagement practices for upstream health. Through shared decision making processes, planning and capacity building, they align health and housing to create positive and measurable impact within the community and its surrounding area.	Josie Williams, Greensboro Housing Coalition; Brett Byerly, Greensboro Housing Coalition	Ansley 6

Breakout Track V Friday, February 16, 2018 9:25 a.m.-10:25 a.m.				
Breakout Title	**Breakout Track**	**Description**	**Presenter(s)**	**Room Name**
5.1 Building and Applying Medication Access Programs in Health systems and Communities	Community Health	The growing problem of medication costs affects our most vulnerable populations. As this problem continues to get larger, Trinity Health is increasing medication access across their communities. Starting within their health systems and expanding across community groups, Trinity Health has increased access to both prescription medication and low and no cost flu vaccines. This presentation will discuss how the first year of the program went, what we've learned and how we continue to evolve the program. We will also discuss how other communities can benefit from we have learned.	Carrie Harnish, Trinity Health; Joann Fisher, FamilyWize	Ansley 1
5.2 Improving our FOCUS: How Community Health Improvements Lead to Increased Hepatitis C Screenings and Further Linkage-to-Care	Community Health	In April 2016, Gaston Family Health Services (GFHS) was approved for a FOCUS Award via Gilead Sciences in order to develop a replicable model program that embodies best practices in HIV and/or Hepatitis screenings and linkage-to-care. FOCUS - Frontlines of Communities in the United States - is a program to address systemic and institutional barriers to routine HIV and HCV screening and access to care by building innovative partnerships for the creation of sustainable testing models. GFHS and Catawba Co. Public Health will present on the successes, best practices and learned lessons in program development, while facilitating discussion around barriers and potential solutions.	Erin Hultgren, Gaston Family Health Services, Inc.; Jennifer McCracken, Catawba County Public Health	Ansley 2
5.3 Collaborative Efforts to Reduce Health Inequities in Rural Communities	Community Health	In this interactive presentation, Tanner Get Healthy, Live Well will describe its efforts focused on eliminating health disparities and addressing the social determinants of health. Tanner will highlight is successes in engaging a robust faith-based coalition to	Denise Taylor, Tanner Health System; Patricia Mitchell,	Ansley 3

		implement evidence-based policy, systems and environmental strategies in west Georgia, along with its efforts to enhance access to care for medically underserved populations through an innovative community-clinical linkages model and a community paramedicine program in partnership with the Haralson County-based ambulance service Ambucare.	Tanner Health System	
5.4 Creating a Community of Solutions: Technology Tools & Resources to Accelerate the Journey	Evaluation and Applied Research	This session will provide an overview of the tools and resources that are available to communities as part of the 100 Million Healthier Lives movement that can help accelerate community health improvement for equity, health, and wellbeing. 100 Million Healthier Lives has created a suite of tools based on a six-part strategy that was developed in co-design with communities. This session will demonstrate four of the tools providing steps for practical application.	Laura Howell, Institute for Healthcare Improvement	Ansley 4
5.5 Using Photovoice as an Evaluation Tool to Engage Stakeholders	Evaluation and Applied Research	Since 2008, the Money Follows the Person (MFP) rebalancing demonstration program has sought to shift Medicaid long term care spending by transitioning individuals from institutional to community settings. Georgia's MFP program targets individuals with developmental disabilities, physical disabilities, traumatic brain injuries, older adults, and youth with a mental health diagnosis. Photovoice is a participatory action research method that encourages participants to document their experience and share it with stakeholders through photography and storytelling. Photovoice was added to an existing evaluation of MFP in Georgia to better understand participants' perceptions of the impact of the program on their quality of life.	Chandrika Derricho, Georgia Health Policy Center, Kristi Fuller; Georgia Health Policy Center	Ansley 5
5.6 Building a Healthy Dan River Region by Addressing Health Disparities	Multi Sector Partnerships	How do you build a sense of community and camaraderie across a region to address health disparities? With a nearly 18-year difference in healthy life expectancy between neighborhoods and no common goals between sectors, The Health	Tim Schwantes, Active Living by Design; Annie Martinie, Danville	Ansley 6

		Collaborative (THC) in the Dan River Region (bordering NC and VA) utilized data mapping to create community-identified priorities and developed a community health worker program to address many issues, including poverty, excess emergency department visits, and access to health care. By bringing siloed conversations together across urban and rural communities, THC bridges disparate efforts into shared goals that are meeting a variety of needs.	Regional Foundation	
5.7 The Three Legs of Community Health: Public, Behavioral, and Safety Net Hospital	Multi Sector Partnerships	The University of Texas (UTMB), the Galveston County Health District (GCHD), and the Gulf Coast Behavioral Health Center (GCC) all serve either Galveston and/or Brazoria counties through charter or mission. All three participated in the initial Texas 1115 Medicaid Healthcare Transformation Waiver, where they collaborated on waiver projects. With the initial waiver ending and expected renewal from CMS, all three organizations look forward to collaborating further as Texas moves forward. Areas of current collaboration have been mobile clinics, integrated care, maternal care, and telehealth work. The health of the community has greatly improved with these partnerships.	Craig Kovacevich, University of Texas Medical Branch; Melissa Tucker, Gulf Coast Center	Ansley 7