The
BUILD HEALTH
Challenge

Addressing Healthcare's Blindside in Albuquerque's South Side

Albuquerque, NM
2019

WHAT IS THE BUILD HEALTH CHALLENGE?

BUILD seeks to contribute to the creation of a new norm in the U.S., one that puts multisector, community-driven partnerships at the center of health in order to reduce health disparities caused by system-based or social inequity.

Awardees include community-based organizations, local health departments, and hospitals and health systems that developed partnerships to apply the BUILD principles.

To date, BUILD has supported 37 projects in 21 states and Washington, DC.

To learn more about the BUILD Health Challenge, see Appendix A.

The BUILD HEALTH Challenge

ACKNOWLEDGEMENTS

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* Denotes original founders and funders of the first cohort of the BUILD Health Challenge

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EXECUTIVE SUMMARY //

The BUILD Health Challenge (BUILD) is a national program designed to support partnerships that are working to address important community health issues.

BUILD followed seven sites that participated in its first cohort of awardees.

Over the course of 18 months, the three lead partners from each of these sites, representing community-based organizations (CBOs), hospitals and health systems, and local public health departments, were interviewed to not only track their progress, but also better understand how they applied the BUILD principles — Bold, Upstream, Integrated, Local, and Data-Driven — to their efforts to improve health in their communities. (See next page for more on the principles.)

The purpose of this analysis is to understand how each site conducted its work related to collaboration, data use, policy and advocacy, health equity, and sustainability. This report analyzes the results of the various core partner interviews and presents findings from their points of view in an effort to highlight lessons learned and share insights with others driving changes in population health.

This report highlights the efforts of the Albuquerque, NM, BUILD initiative: Addressing Healthcare's Blindside in Albuquerque's South Side (AHBASS). Through a series of interviews, the core partners of AHBASS shared how their collaboration interpreted and applied the BUILD principles, results of the initiative, and lessons learned over their two-year effort. For the BUILD principles described below, Data-Driven was considered a best practice for AHBASS (see Data-Driven in Section 3 for more detail).

To learn more about the BUILD program, see Appendix A. To learn how the other six implementation sites leveraged the BUILD model, **please reference the companion reports.**

THE BUILD PRINCIPLES: A FLEXIBLE MODEL

When applied in concert, the BUILD principles — Bold, Upstream, Integrated, Local, and Data-Driven — represent a powerful model that has the potential to transform community health. The principles are the engine that drives how BUILD operates.

The model reflects an innovative and flexible approach to population health that allows each site the opportunity to identify how to leverage the five principles most effectively. No one principle is more important than the other: they are neither mutually exclusive nor independent. They serve to guide BUILD sites as they start to design strategies and approaches within their respective communities.

BOLD

Interventions that have long-term influences over policy, regulation, and systems-level change

UPSTREAM

Solutions that focus on the social, environmental, and economic factors that have the greatest influence on the health of a community rather than access or care delivery

INTEGRATED

Programs that align the practices and perspectives of communities, health systems, and public health under a shared vision, establishing new roles while continuing to draw upon the strengths of each partner

LOCAL

Projects that engage with neighborhood residents and community leaders as key voices and thought leaders throughout all stages of planning and implementation

DATA-DRIVEN

Communities that use data from both clinical and community sources as a tool to identify key needs, measure meaningful changes, and facilitate transparency among stakeholders to generate actionable insights

HEALTH EQUITY

One of the goals of BUILD — although not a specific principle — is to promote health equity by creating the conditions that allow people to meet their optimal level of health.

AHBASS RESULTS

> **Because of BUILD we have cultivated a multi-sector collaboration that is working to change systems and improve health outcomes in Albuquerque's south side.**
>
> — The AHBASS Team

AHBASS addressed chronic disease and self-management through a multi-sector collaboration by establishing a referral tracking system and a Mobile Farmers Market.

In addition, the Healthy Here Wellness Referral Center, an integrated chronic disease management referral system, was designed and implemented to link clinics to community resources in order to improve health outcomes.

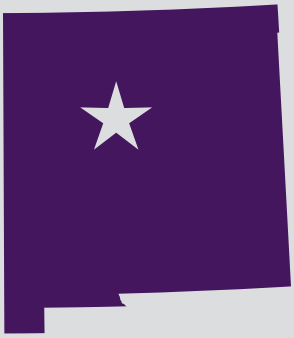
Highlights from the project include:

The Mobile Farmer's Market improved healthy food access by distributing food grown by local farmers in priority neighborhoods.

Over 1,700 people have gained access to healthy food grown by local farmers.

Over 1,500 referrals to 20 community resources, including: chronic disease management classes, healthy cooking classes, physical activity opportunities, and Mobile Farmer's Market.

Ultimately, there is now a cohesive collaboration of partners poised to continue advancing health and wellness in Albuquerque's south side.



THE ALBUQUERQUE BUILD INITIATIVE

The AHBASS initiative's primary goal was to "equip healthcare providers to act on the social drivers of poor health and to use feedback to measure the impact of non-medical interventions."

The partners worked to reduce high chronic disease rates and address barriers to health by improving the social, economic, and environmental factors that had the greatest impact on residents' access to a healthy lifestyle.

Specifically, in Albuquerque's South Side, "Latino and Native American populations have higher rates of heart disease mortality, high blood pressure, and childhood obesity relative to the white population as well as lower rates of health insurance coverage."

In order to address these health concerns, AHBASS was designed to support a "partnership of primary care providers and community development enterprises working collectively to address some of the non-medical factors that impact health." The main approach, which is described in detail on page 10, was to establish the Healthy Here Wellness Referral Center (WRC) as a means of connecting patients with necessary community resources.

AHBASS focused on two Albuquerque neighborhoods: Southeast (SE) Heights and South Valley. Both neighborhoods are within the metropolitan area of Bernalillo County. These two neighborhoods experience more barriers to health than their surrounding areas, resulting in poorer outcomes like higher levels of obesity and other chronic diseases. Some of the non-medical factors impacting residents' health include a lack of access to fresh and nutritious food, a lack of options for outside physical activity (e.g., few sidewalks, little open space), inadequate public transportation, and environmental injustice (e.g., some neighborhoods are adjacent to heavily polluted industrial zones).

A number of assessments identified the SE Heights and South Valley neighborhoods as being in need of innovative approaches to address community health concerns: the 2012 county health assessment conducted by the local health council resulted in a health improvement plan; the Community Need Index (Dignity Health) identified "the three zip codes in the South Valley and SE Heights in need of investment;" and the Community Risk Index (Joint Center for Political and Economic Studies) identified "the South Valley and SE Heights as having the highest risk and consequent poor health outcomes." The partners went on to describe in their application: "The areas' strengths are their strong identities, community organizations, and leaders committed to working together."

Prior to BUILD, these two neighborhoods had been the focus of a three-year Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (CDC REACH) grant, which grew from a two-year capacity-building Community Transformation Grant. They obtained a continuation of the CDC REACH grant for a fourth year, carrying it into September 2018. Applying for BUILD was part of AHBASS's sustainability plan for a larger initiative, the Healthy Here initiative, begun under the CDC

REACH grant. The BUILD award helped to catalyze a targeted portion of this project. The Healthy Here initiative"includes the mobile farmers market, the WRC, a number of physical activity initiatives,and the South Valley Community Commons (SVCC)." Several of these initiatives were core components of the BUILD initiative and are detailed in the next section.

Approach

To address high chronic disease rates in SE Heights and South Valley communities, AHBASS aimed to create an environment that, as one partner described, would make "the healthy choice the easy choice." By working to integrate key social determinants of health (economic stability, education, food, community, neighborhood and physical environment) within primary care services accessed by prioritized communities, AHBASS sought to reduce chronic disease rates in the focus communities by creating a wellness ecosystem where a healthy lifestyle was easy to access. The process involved connecting patients with a variety of services and community resources via the WRC, as well as a mobile farmers market and a community hub designed to provide additional support. Leveraging the technical expertise of the lead CBO partner and the unique history of collaboration between the two healthcare systems (more details provided in the Partners section on page 16), AHBASS partners developed a three-pronged approach to address the lack of nutritious foods, connect patients with health resources, and create a wellness ecosystem.

While funding from the BUILD award was not directly used for the SVCC expansion,

AHBASS FOCUS AREAS[1]

SE HEIGHTS DEMOGRAPHICS AS OF 2015

- Population: 27,000
- Area size: Two square miles
- Racial/ethnic makeup: 61% Hispanic, 7% Native American, 2% Asian
- Nativity: Home to many immigrant and first-generation families; some are refugees from Vietnam, Laos, Cuba, El Salvador, and African nations
- Healthcare shortage area: 100% of the Census Tracts within this area were classified as Primary Care Health Professional Shortage Areas
- Poverty: 39% of the population lives below the poverty level; 52% of youth live below the poverty level.
- Overweight/Obesity: Higher incidence among Native Americans versus Caucasians (66% versus 51%)

SOUTH VALLEY DEMOGRAPHICS AS OF 2015

- Population: 42,000
- Racial/ethnic makeup: 81.1% Hispanic
- Poverty: 30% of the population lives below the poverty level
- Insurance status: 23.7% are uninsured; 40.9% are publicly insured
- Diabetes: Death rate is three to four times higher than in affluent areas

it provided a space in which AHBASS-related initiatives took place. In addition, it was a key aspect of the long-term goal of the AHBASS partners' plan to create a wellness ecosystem for residents. Future plans for the SVCC include addressing:

- High school graduation rates — First Choice participated in the establishment of a Health Leadership High School that would reengage dropouts through project-based learning; the program would assist them with earning a diploma to support their advancement in the job marketplace.
- Jobs — by creating a workforce training center.
- Early childhood development — by creating a child development center.
- Healthy lifestyles — by creating a wellness center that provides services such as community health classes, fitness, and physical therapy aimed at removing barriers to access for uninsured and low-income patients and their families.
- Food access — by developing a four-acre farm with an indoor/outdoor growers market, food storage/packaging facilities and demonstration kitchen, a farm-to-table-style restaurant with catering and commissary, and space to be leased by a nonprofit accelerator.

1 BUILD Health Challenge application.

ADDRESSING HEALTHCARE'S BLINDSIDE STRATEGY

WRC: Connected patients with community health resources (many of which related to non-medical/social determinants of health) and created a feedback loop with providers related to patient health resource utilization.

- The WRC acts as the link between the healthcare system and community-based programs and provides patients with a customized list of appropriate resources in their area, based on the provider referral. The resources not only focus on better managing chronic disease, but all are free to the participants and do not require any form of insurance.

- Once a referral is received, a team member at the WRC contacts each referred patient (now participant) with a live call to explain the resources available and registers them in programs held at a time, location, and in a language that is most appropriate for their needs. After sending a welcome letter to the participant that includes the class/activity for which they are registered, and a list of other community resources they might be interested in for the future, the WRC makes reminder calls the day before each class to each participant. Once the series for a class/activity is completed, the WRC will make follow-up calls to learn the participant's satisfaction, any barriers they experienced and possibly sign up the participant for other classes, if desired.

- Information on participation is sent back to the referring clinic to complete the feedback loop. This feedback serves as a way to continue the conversation about the patient's health, managing their chronic disease and their experience with the WRC.

Mobile Farmers Market: Expanded access to healthy food

- The local public health department provided a van that was retrofitted as a mobile farmers market. The mobile market delivered fresh produce to the SVCC, several clinics (UNM SE Heights clinic and First Nations Community HealthSource[2]; a federally qualified health center [FQHC] clinic; a hospital clinic), and other sites within the priority area including a Presbyterian Healthcare Services clinic.
- The mobile farmers market also offered cooking demonstrations, nutrition education, and benefits enrollment services.

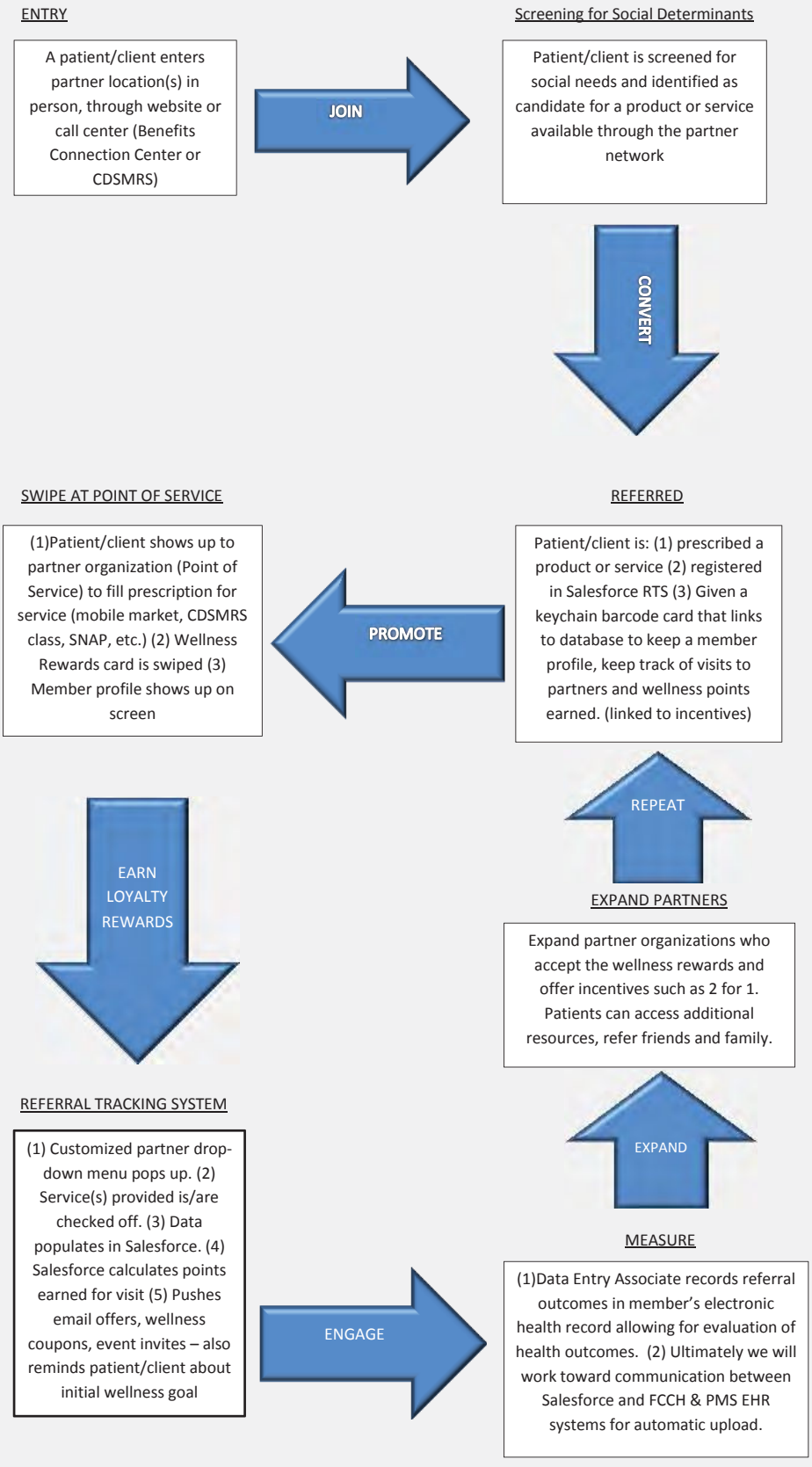
2 *Albuquerque Journal.* From farm to 'food deserts': Mobile Market provides local produce. August 5, 2015. https://www.abqjournal.com/623318/farm-to-food-deserts.html.

SVCC: As of late 2017, the SVCC was in the process of developing as an expansion to the existing South Valley Family Health Commons. Vacant property was purchased in 2010 by the Board of Directors of First Choice Community Healthcare (described later in this section) adjacent to its flagship South Valley Family Health Commons. Ultimately, SVCC will serve residents as a hub where "the healthy choice is the easy choice." Although not specific to AHBASS, the SVCC will include services that work in synergy with the WRC, mobile market, and other important community resources:

- A 20-acre service hub that provides health and community services for 20,000 individuals annually. Ten of the 20 acres will be slated for future development that would provide a "wellness ecosystem." (How the initiative defines wellness ecosystem is described in Section 3 under Upstream, page 27.)
- A half-mile walking trail, dubbed the "Wellness Trail," was opened in October of 2016 to SVCC patients and the public.[3] It was the first of several planned trails. Through the referral system, doctors from the hospital and the FQHC prescribed walking to patients. The WRC then connected these referred patients to volunteers who led walking groups three times a week.

3 First Choice Community Healthcare. (October 21, 2016) First Choice Launches Wellness Trail at South Valley Commons. http://www.fcch.com/news/92/20/First-Choice-Launches-Wellness-Trail-at-South-Valley-Commons.

REFERRAL TRACKING SYSTEM & WELLNESS REWARDS PROGRAM FLOWCHART



REFERRAL TOOL

PATIENT STICKER

Referral for Wellness

Individual's Name: **Preferred Name:** **Parent/Guardian Name:**	**Date:**
Wellness Program(s): ( ) Chronic Disease Self-Management Classes ( ) Diabetes Specific Classes ( ) Healthier Eating: Food Access & Cooking Classes ( ) Asthma Management ( ) Positive Self-Management Program (PSMP) - NM AIDS Services group ( ) *Physical Activity Referral* The person being referred for *Physical Activity* is healthy enough to participate in low to moderate intensity activity (ex: walking/light weights) Provider's Signature:_____ ( ) *Warm Water Aerobics Referral* The person being referred for *Warm Water Aerobics* is aware that all classes are self-regulated and should be done at their own pace. Provider's Signature _____	**Individual's Goals:** ( ) Complete Course ( ) Improve Eating Habits ( ) Pain Management ( ) Mental Health/Stress ( ) Quality of Life ( ) Physical Activity ____ xs/day week month ( ) Improving My Numbers _____ ( ) Other: _____
Comments:	

Individual's Demographics ( ) Known Transportation Issues

Address: _____ Zip Code:_____ Phone: _____
DOB:_____ Gender: _____

Race:
( ) Amer. Indian/Native Amer. ( ) White/Caucasian ( ) Asian/Pacific Isl. ( ) Black/African ( ) Other:_____

Hispanic, Latino, or of Spanish origin
( ) Yes ( ) No

Preferred Language
( ) Spanish ( ) English ( ) Other:

Spanish Speaking Class Requested
( ) Yes ( ) No

Insurance: (please mark **ALL** that apply)
( ) **Medicaid** ( ) **Medicare** ( ) **Self-Pay** ( ) **Other**:_____

( ) BlueCross BlueShield ( ) United Healthcare ( ) Molina Healthcare ( ) Presbyterian Health Plan

Individual's or Parent/Guardian Signed Consent - Persona o Padre/Guardián Firmaron un Consentimiento

I understand and agree that the Wellness Referral Center (WRC) will contact me about free community health programs, and the WRC will inform my doctor about my participation. - Entiendo y acepto que el Wellness Referral Center (WRC) se va a contactar conmigo acerca de programas de salud libres de costo en la comunidad, y el WRC le informará a mi doctor de mi participació.

Individual's Signature/Firma de Persona _____ Date/Fecha _____

Parent/Guardian Signature/ Firma de Padre/Guardián _____ Date/Fecha _____

Clinic Identification (alpha. order): ( ) Casa de Salud ( ) First Choice- Alamosa ( ) First Choice-S. Broadway ( ) First Choice- S. Valley ( ) First Nations- Truman ( ) First Nations-Zuni ( ) PHP-CHWs ( ) PMG-Atrisco ( ) PMG-Isleta ( ) PMG-Kaseman ( ) PMG-Paradise ( ) PMG-San Mateo ( ) Presbyterian Peds/Endo ( ) UNM FOCUS

Referring Provider:
Form Completed By: **Email:** **Phone:**

Wellness Referral Center (WRC) Information **Confirmation that WRC Received: YES NO**
Fax: 505-449-4472 Email: info@wellnessreferralcenter.com **Phone: 505-445-5332 Date Sent to WRC:**

Partner Organizations and AHBASS Roles

All BUILD sites are based upon a collaboration among three core partners in each community: a CBO, a hospital/health system, and a local health department. While the AHBASS application detailed the planned involvement of four core collaborators (CBO, health system, FQHC, county public health department), this report is based on interviews conducted with the following three partners:

Adelante Development Center:
Serving as the CBO and lead agency for AHBASS, Adelante is one of the largest human service agencies in New Mexico. It provides aid for people with developmental disabilities, seniors, and the low-income population. *AHBASS role:* Provided expertise in technological and programmatic innovation, specifically experience using the Salesforce platform to connect community members with resources, accept referrals from referring entities, and provide feedback on referral status to referring entities and registration information to resources.

The CBO partner described its role in AHBASS as the "hub," connecting community resources to healthcare providers through a streamlined and e fficient system. The CBO partner took the lead in the initiative's referral process, priding itself on "getting the operational piece of this off the ground." Adelante had the infrastructure to manage the information technology (IT) needs of the call center, referral process, and resource database that informed the patient rewards program. The agency's experience testing the data-tracking platform used for AHBASS paved the way for the data collection process to move forward effortlessly:

> *"When [AHBASS] came along, one of the major capabilities that we offered was to set up a tracking system for the mobile market and the Wellness Referral Center. That's really been our major role in setting up that entire system, all the configuration needed, all the reporting …. We have a dashboard that shows data, how to take referrals from different individuals, different clinics, and so on."*

Presbyterian Healthcare Services (PHS):
The healthcare system, New Mexico's only private, non-profit integrated healthcare system, was the backbone organization of the CDC REACH initiative. It is the state's largest provider of care, with 16 hospitals, 36 primary care clinics, a medical group, three community ambulance systems, and a statewide health plan. AHBASS role: Provided matching funds through cash and in-kind resources of staff, evaluation, marketing, and communications. Also provided cash support through its marketing and community benefits departments. Several hospital clinics were sites of WRC implementation. Presbyterian and its Community & Clinical Linkages Manager were key in getting clinics on-board for referring to the WRC; with initial meetings to hear the needs of the clinics, to facilitating the collective thinking processes for developing and refining the communication systems between the clinics, the WRC, the community resources and the feedback loops, as well as the creation and refinement of the referral form. The continual quality improvement oversight helped the

clinics not only feel comfortable with referring their patients to the WRC, but they also gained a sense of ownership with the project. This in-turn has made the WRC an integrated piece within the cultures of participating clinics; and the success of the WRC has caused an interest (and sometimes demand) from clinics outside of AHBASS to participate in its referral process.

The health system partner described its role as the partner who *"propel[s] this work forward and create[s] more of a movement"* for community coalitions that otherwise would not benefit from the resources and support of major healthcare partners. The system was able to garner a grant from the CDC to aid in the cost associated with the WRC and mobile farmers market, which could not be financially supported by the FQHC or the nonprofit. The partner noted that, *"[We] are the backbone organizati on for the CDC grant, so it made sense for us to be at the table."* The healthcare system partner built upon the IT infrastructure, supplied matching grant funds in in-kind and monetary support, and provided access to a low-interest loan for its partners.

First Choice Community Healthcare and Agri-Cultura Network: This FQHC has worked with the community on wide-ranging projects such as early childhood development, workforce training, agricultural production, and health and wellness. *AHBASS role:* Helped design the referral and tracking system to be efficient and effective. Because of its history of working on health initiatives in the community, First Choice developed strong working relationships with organizations in the priority area and was a trusted resource. As a healthcare provider, the FQHC also assisted with implementing the referral system and referring patients to the WRC.

It chaired the council of community coalitions responsible for developing needs assessments and used data from these assessments to drive collaborations.

The unique collaboration among the three main partners — particularly between the FQHC and the healthcare system — allowed for two important healthcare providers to build upon each other's strengths and expertise. This synergy was critical in reaching the overall goals of the AHBASS initiative, which was to integrate key social determinants of health into primary care and practice. As stated in the partners' application, "The two health systems involved in this initiative have large primary care practices in the area, share a strong interest in improving chronic disease measures, and have committed to address non-medical factors that impact health."

While we were unable to interview the Bernalillo County Health Department partner during the process, the department provided the vehicle to be used for the mobile market. The partner also helped with start-up costs and supplied a public health specialist who was actively involved in the planning and implementation of the mobile farmers market. The county was also working on a land use agreement with the FQHC for the SVCC project.

Aside from the core AHBASS partners, there were a number of additional partners who contributed to the efforts to improve health in SE Heights and South Valley (see comprehensive diagram of the partners below). These groups comprised the team working on the CDC REACH Healthy Here initiative and local health council (Bernalillo County Community Health Council). The health council, while not a core partner, was nonetheless central to the success of

DID YOU KNOW?

A land use agreement is a contract between the land owner and another party. The contract allows for the non-owning party to use the property for specific uses stipulated in the contract. For Bernalillo County, this was one way of leveraging a partner's asset without having to purchase land themselves.

this initiative. The healthcare system partner was the chair of the health council and served as the backbone organization of the CDC REACH initiative that worked in tandem with AHBASS to support its strategies. Other members of the health council included the FQHC, community leaders and community members, health and social service providers, educators, and other private and public county employees. While not a member of the health council, the CBO, like its healthcare system counterparts, was a part of the Healthy Here lead team that managed AHBASS. The New Mexico Department of Health (NMDOH) became involved at the end of the final year of the funding period in order to provide some resources for community residents who needed support related to chronic disease diagnoses. Specifically,the NMDOH partnered with the WRC to refer pa. ents to the NMDOH for workshops and classes on chronic disease care and self-management of health. (See Diagram 1: Bernalillo County CDC REACH Initia. ve Org Chart on p. 21.)

Key Accomplishments

AHBASS had a long-term goal of improving the health of South Valley and SE Heights residents by applying innovative technology to connect residents to wellness resources, track utilization and create a feedback loop with

providers. The partners also envisioned creating a built environment for residents to make healthy lifestyle choices.

AHBASS has achieved a number of successes, some of which are described here, with additional details available in the body of the report.

By August 2017, AHBASS had:

Wellness Referral Center

- Reached its goal of establishing an electronic system that linked patients' WRC status and referral progress to their patient record. This enabled healthcare providers to see their patients' referral progress at the time of the clinic visit.
- Expanded the Salesforce platform to allow certain clinics to securely log onto the WRC portal and access referral information directly. The future goal is to enable all participating clinics to access patient referral information through the online portal.
- Successfully completed the planned expansion of the WRC beyond cooking and physical activity classes to include referrals for support managing chronic disease (i.e., Stanford-developed MyCD classes, Chronic Disease Self-Management Programs, and the Diabetes Self-Management Programs).
- Expanded the number of clinics participating in the WRC from a pilot program of two clinics to 12 clinics (there is the potential to expand to all 34 PHS clinics statewide). In the first three months of WRC implementation, the center had received 90 referrals. By the end of case study interviews, the WRC had received more than 1,000 patient referrals.

One partner stated that "the real progress has been in having consistent referrals now from the major providers in the BUILD prioritized area."

Mobile Farmers Market

- Successfully implemented the mobile farmers market and utilized a point-of-sale app tailored to track market utilization.

South Valley Community Commons

- Broke ground on the SVCC expansion.

AHBASS'S APPLICATION OF THE BUILD PRINCIPLES

While the five BUILD principles were actualized in different ways for each of the BUILD sites, the first cohort's application of the BUILD model was important in demonstrating its principles and understanding their impact. The application and evolution of the model can be helpful to other communities intending to replicate and sustain their upstream efforts as well as to the second cohort of BUILD sites.

AHBASS exemplified the BUILD principles in several ways as it sought to address food insecurity, chronic disease prevention, and self-management of health in its two priority neighborhoods. The intervention

BERNALILLO COUNTY CDC REACH INITIATIVE ORG CHART

LEAD TEAM GOVERNANCE, VISION AND STRATEGY

Adelante Development Center, Agri-Cultura Network, Albuquerque Public Schools, Bernalillo County Community Health Council, BernCo Office of Health & Social Services, BernCo Parks & Open Space, First Choice Community Healthcare/South Valley Community Commons, First Nations Community Healthsource, International District Healthy Communities Coalition, March of Dimes, MRCOG, MyCD, NM Community Data Collaborative, NMDOH, NM Health Connections, PLACE MATTERS, Presbyterian Healthcare Services, Roadrunner Food Bank, ShareNM, UNM College of Nursing, UNM Community Engagement Center, UNM Prevention Research Center

BACKBONE

Coalition/Convening Network, Engaging Partners & Community: **BCCHC**

Funding, Staffing, Offices, Engaging Partners & Community: **PHS**

Communication: **Soda Creek Consulting**

Data/Evaluation: **UNM/PRC**

Advocacy & Policy Change: **BCCHC & Partners**

HEALTHY EATING CONTRACTORS

- Agri-Cultura Network
- Farm to Table
- 1st Choice
- 1st Nations (FNCH)
- ShareNM
- APS
- Adelante
- Road-runner

ACTIVE LIVING CONTRACTORS

- MRCOG
- PLACE MATTERS
- IDHCC
- 1st Choice SVCC

CLINICAL/COMMUNITY LINKAGES CONTRACTORS

- 1st Choice (FCCH)
- 1st Nations (FNCH)
- IDHCC
- MyCD
- PHS
- NMCDC

The BUILD Health Challenge Partners are members of the Governing Lead Team

They are also subcontracted to implement parts of the health improvement plan with community

was ***Bold*** because of its innovative use of technology and data to address the ***Upstream*** factors that impacted health in the focus community. AHBASS brought together a collaborative, ***Integrated***, multi-sector partnership of two healthcare systems, a CBO, residents, and numerous other community organizations to create a wellness ecosystem. In their ***Local*** community, residents were engaged in the initiative in a variety of ways, from serving on boards of the healthcare partners to being part of the initiative's work groups and providing feedback on surveys. The Albuquerque initiative developed a ***Data*** system that could be used across sectors and to streamline data use and sharing in order to provide healthcare providers and organization leaders alike the information needed to create a wellness environment for the community. The application of these principles together in relation to their unique effort helped the partners to achieve their goals.

The following table depicts the sections throughout the report detailing how AHBASS specifically chose to apply the BUILD model to address its unique challenges. The first column highlights key components of the project that demonstrate how the site was able to bring the BUILD principles to life. Many of the examples cited touch upon one or more of the BUILD principles — reflecting how these principles are fundamentally flexible and inextricably linked to one another.

	Bold	Upstream	Integrated	Local	Data-Driven	Health Equity
Data Platform	✓	✓	✓	✓	✓	
Collaboration	✓		✓	✓		
Intervention	✓	✓	✓	✓	✓	✓
Sustainability	✓	✓		✓		
Community Engagement				✓		✓

Table 1: AHBASS Application of BUILD Principles

BOLD

The BUILD definition of “bold” emphasizes interventions that have long-term influences over policy, regulation, and systems-level change.

AHBASS applied bold strategies within its initiative in two key ways:

1. Innovative application of technology to track and address gaps in healthcare
2. Systems-level changes

BOLD: THE INNOVATIVE USE OF TECHNOLOGY TO TRACK AND ADDRESS GAPS IN HEALTHCARE

AHBASS's approach to addressing chronic disease in its community involved a pioneering combina. on of technology and data. The ini. ative applied technology to create a feedback loop between healthcare providers and patient resource u. lization. An online software platform called Salesforce was employed to track patient utilization of wellness resources provided by the initiative and to encourage utilization through a membership rewards program that incentivized healthy choices. The Referral Tracking System (RTS) allowed for use by multiple partners across sectors serving the same popul-ati on while integrating the non-medical resource data back into the health systems' electronic health record (EHR). Near the end of the BUILD funding period, the initiative was able to provide a portal to several clinics participating in the WRC so that providers were able to access a patient's medical history as well as data on their utilization of non-medical resources. In real time, providers were able to assess whether patients were following through on lifestyle changes they had "prescribed" them as well as make and look up referrals. This enabled providers to give more specific advice during follow-up visits and to determine the impact of healthier choices on participants' overall health outcomes. AHBASS's ongoing goal, as it relates to the portal, was to provide access to all clinics participating in the WRC initiative. For an overview of how Salesforce was utilized to monitor referrals and establish a feedback loop, see Appendix C for a presentation given by Adelante at a Salesforce convention.

BOLD: SYSTEMS. LEVEL CHANGE

AHBASS's work involved systems-level changes in the ways in which medical and non-medical sectors worked together to address the health needs of the local community, with some focus on the ways in which regional/local policy could be enacted to sustain their work. AHBASS partners indicated that there was limited focus on policy or advocacy within their initiative. However, the CBO partner described potential changes in billing policy in their efforts to sustain their work:

"We don't want to necessarily lose the project because we lost the grant … so while we hope [grants] will be a good supplement, and for right now it is still

something that we're pursuing, we're looking long term toward something that won't end when the grant period ends, and that's why I think we're moving more towards billing through the healthcare system because … it doesn't have a … timeline that when it's over, it goes away."

Moving forward, the CBO planned to meet with the hospital partner, the health plan, and other potential medical payors to discuss policy-level changes that would enable billing for the services provided. This would be an avenue for sustainability and continuation of services post–grant period. The CBO partner was considering various options for revenue streams to sustain the WRC and ensure "that the project can go on" and was not dependent on external funding sources (e.g., time-limited grants). The CBO partner explained that there were potentially several avenues to tap into billable income to support the WRC:

1. Billing for time spent with clients with developmental disabilities (currently utilizing this income stream)
2. Investigating if physician referral of clients with developmental disabilities to the WRC was a billable service
3. Investigating if services (such as cooking and exercise classes) were billable

KEY TAKEAWAYS & LESSONS LEARNED // BOLD

The partners reflected on the major ways AHBASS made a difference for their organization, their partners, and the greater community, as well as the major outcomes of the project — particularly those related to the key areas described above in the section on bold. These reflections include:

- **Technology.** The initiative used technological approaches to address the upstream factors that impacted health in the priority community, focusing on food insecurity, chronic disease prevention, and self-management of health.

- **Systems-level change.** Changes in billing may result from the initiative's focus on long-term self-sustainability.

As described, this site exemplified bold in several core ways, many of which greatly align with the BUILD principles of upstream due to the focus on creating the infrastructure for a sustainable wellness ecosystem, integrated because of the multi ple partners and sectors needed to address the current health needs of the local community, and data-driven due to the applicati on of technology to manage and utilize patient data to continually inform these innovative ideas and processes. More details about these BUILD principles are included in subsequent sections.

DID YOU KNOW?

Billable services for Medicaid are determined by the Center for Medicaid Services at the state level. In order for a payor to be reimbursed for a service they provide to a Medicaid client, it must be a billable service. This might require a change in the Medicaid New Mexico state plan that is created to demonstrate compliance with the federal Medicaid program.

UPSTREAM

The Upstream principle emphasizes "solutions that focus on the social, environmental, and economic factors that have the greatest influence on the health of a community rather than access or care delivery."

Upstream solutions were explored to understand how the AHBASS partners conceptualized and implemented solutions as well as how the work was sustained and systemized.

The prioritized neighborhoods were low income, largely minority neighborhoods with disproportionately high mortality rates associated with diabetes and cancer. In response, AHBASS's upstream solutions targeted food insecurity, chronic disease prevention, and self-management of health through technological innovations in an effort to create an environment that made it easier to live a healthier lifestyle. To that end, the initiative worked upstream by:

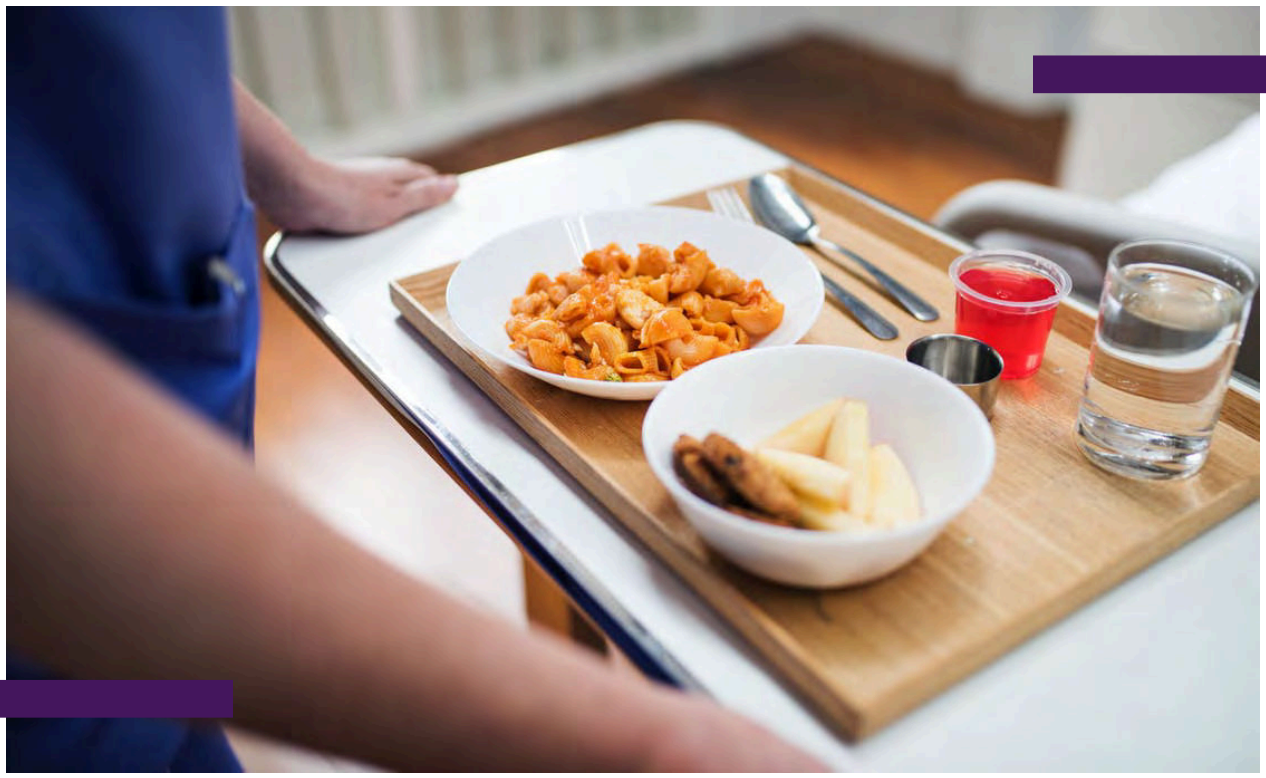
- **Expanding access to fresh and nutritious foods** through the mobile farmers market and mobile farmers market vouchers, which brought fresh, nutritious foods to areas where they were not available.
- **Equipping healthcare providers to address drivers of poor health** by combining patients' wellness information (e.g., participation in wellness classes) with their medical information in one online system that allowed healthcare providers to better understand drivers of poor health outcomes specific to their patients. This enabled providers to discuss, and thus address, factors related to their patients' poor health outcomes in clinic visits. (Further details about data integration can be found in Data-Driven, page 50.)
- **Providing a wellness ecosystem** that served as a service hub and catalyst for lasting change in the community. The goal of the SVCC project was to provide an environment that promoted health

in order to produce a "generation of social determinants of health–literate leaders" who would "think critically, work collaboratively, and become agents of their own destiny."[1] The SVCC aimed to "graduate students who were once dropouts, facilitate project-based learning that equips them to be successful in the growing health sector, the local food movement, child development, or whatever they choose to do. Their earning power will be greater, their health outcomes better, and their children's opportunities broader than they would be without such an ecosystem."

The following outlines steps that were taken to achieve these goals. Additional detail on the SVCC project was provided in the Introduction (page 8).

- PHS and UNM Health Sciences Center collaborated with the Democracy Collaborative to establish anchor institutions (https://democracycollaborative.org/democracycollaborative/anchorinstitutions/Anchor%20Institutions) that committed to local procurement of food and other supplies and services.
- PHS made tremendous investments in a local food hub/farm network initiative. As of 2017, First Choice would lease the building to house a food hub (community farm, teaching kitchen, etc.) to a local farm network to increase its capacity to supply hospital food service departments. The farm network will be "aggregating, washing, storing, distributing, and packaging produce and doing some value added production." In addition, PHS committed funds for components of the project.
- First Choice invested in land for a food hub facility that would greatly enhance the capacity to scale up production.

1 AHBASS BUILD application.



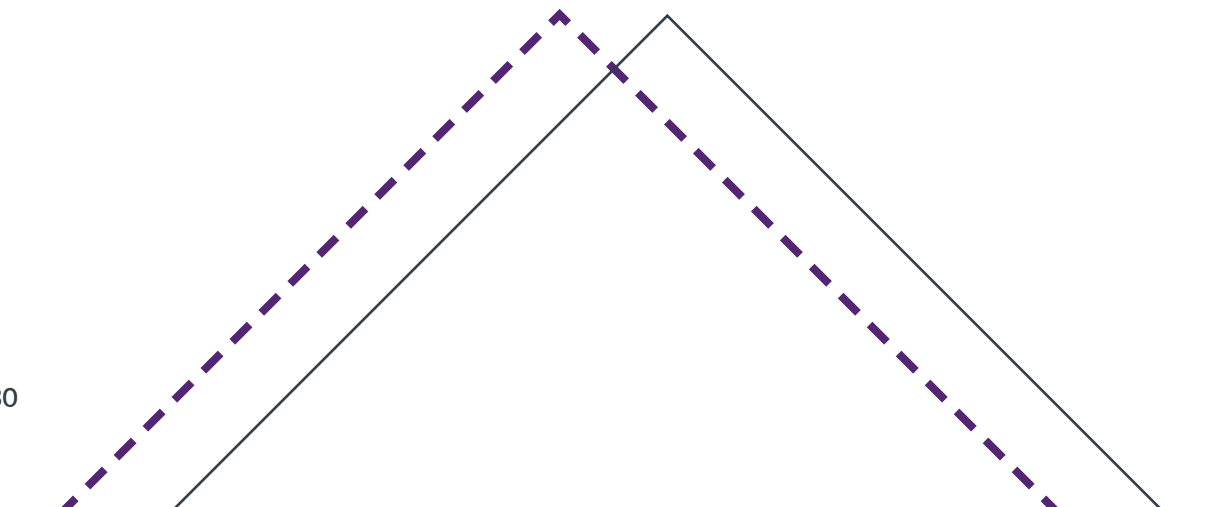
KEY TAKEAWAYS & LESSONS LEARNED // UPSTREAM

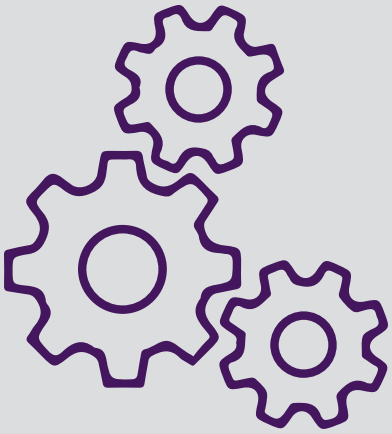
AHBASS aimed to "make the healthy choice the easy choice" by creating a wellness ecosystem.

To do so, the initiative worked to provide not only access to a healthy lifestyle, but also the infrastructure in the local community that would make it easy to choose a healthy lifestyle.

By identifying and targeting the root causes of the community's health issues, including food insecurity, chronic disease prevention, and self-management of health, AHBASS demonstrated a long-term and sustainable path forward. In order for this upstream approach to be effective, it was necessary for the collaborative to act as an integrated network of partners and have an integrated data system to help guide its work.

Finally, AHBASS's attention to upstream solutions was brought to bear with the support of the local hospital, FQHC, CBO, community members, and other stakeholders. Subsequent sections describe how AHBASS exemplified the BUILD principles of integrated, local, and data-driven.





INTEGRATED

The Integrated principle focuses on whether programs "align the practices and perspectives of communities, health systems, and public health under a shared vision."

This principle can be observed in the AHBASS initiative by examining how the partners came together and the various structures implemented to sustain the partnership.

A major goal of BUILD was to help develop, support, and sustain strong collaborations among partners in order for their work to be effective in addressing community health needs and achieving health equity. Integration, whether in relation to the partnership or to data, was a critical element of the AHBASS' success. The partners developed, over the course of the project implementation period, a successful process of collaboration; effectively utilized their history of working together on community health engagement projects; and jointly developed a user-friendly, cross-sector data system.

This section explores the following areas with respect to integration:

1. Integration of a Multi-sector Partnership and Multilevel Intervention
2. Collaboration in Sustainability Conversations
3. Data Integration (Note: All information related to data is provided in the Data-Driven section.)

INTEGRATION OF A MULTI-SECTOR PARTNERSHIP AND MULTILEVEL INTERVENTION

Both of the healthcare partners learned of BUILD through their decade-long partnership with the community health council. They were motivated to collaborate on the BUILD grant by the opportunity to expand their current work and noted that the BUILD grant *"connect[ed] us even deeper with one another."* The CBO partner, in contrast, was not a member of the local health council and did not have prior experience collaborating with the other healthcare partners. Despite the CBO being the newest addition to an existing collaboration, all three main partners felt that the project was strengthened by the addition of new assets, especially the IT expertise of the CBO.

For the AHBASS partners, the BUILD grant provided an attractive funding opportunity because there were few restrictions on how the funds could be used. The hospital partner explained that the advantage of BUILD funding was that it provided a way to support the infrastructure in ways that their existing grants did not:

> ***"I think it was looking at projects that were a part of our larger initiative. We have a CDC REACH grant that only pays for policy systems, environment … . We identified [the BUILD Health Challenge] as a way to help [bridge]***

some gaps and a way to leverage the financial support that Presbyterian wanted to put into the work as well. We are looking at the specific project of the Wellness Referral Center and mobile farmers market, and it made sense to focus on the IT piece of that… . Then, looking at the partners that you all were requiring to have at the table, like the local health department, the nonprofit… . The nonprofit we had identified would be a good partner for the referrals center, and they were also helping a lot with the mobile farmers market. And we ended up with two health system partners because of the partnership and their interest in the work and the low-interest loans. ”

Partners shared several of the primary motives for their collaboration:

- The CBO partner was excited to offer their unique IT resources to expand the impact of the preexisting collaboration.
- The hospital partner shared that their investment in the community made them more competitive for future grant opportunities and created a model for other health systems to follow. The healthcare partners also appreciated that their collaboration allowed them to expand their community reach in many ways, including engaging directly in community service.
- The FQHC's motivation to participate in the collaboration was specifically connected to its mission and approach, which emphasized addressing the social determinants of health. Its

leadership recognized the long-term benefits of contributing to a community needs assessment, gap analysis, and program planning, especially as they related to securing grant funds.

Formal Agreements in Collaboration

AHBASS did not have any formal written agreements (e.g., Memoranda of Understanding [MOUs]) between the core partners outlining roles and responsibilities in the collaboration for BUILD. However, the partners defined each of their roles through their application for BUILD funding, and, through the process of working together, ultimately kept each other accountable to their shared goals as well as each partner's responsibilities. Without formal agreements in place, however, all three partners felt they risked negative consequences from the lack of well-defined roles and accounting for how resources within the collaboration would be allocated.

The CBO partner felt that in absence of an MOU, it was still possible to build and maintain trust among partners:

"I think you do what you say you're going to do. That is to me the bottom line. You can sign all the agreements you want."

The CBO also felt that there was some accountability through the minutes taken at higher-level meetings.

In September of 2017, the partnership added a major new member, the NMDOH. The CBO partner developed an MOU with the NMDOH that focused on the confidentiality of the material and the process of contacting patients.

Key points of the MOU included:

- Establishing logistics and workflow for the processing of the referrals and enrollments between partners.
- Detailing informa. on on maintaining Health Insurance Portability and Accountability Act (HIPAA) protection guidelines, namely through minimizing the HIPAA-related information to be shared.
- Establishing that the contracting organization would provide training to the nonprofit staff.
- Establishing follow-up procedures for participants who do not show up to their appointments.

The full MOU document can be found in Appendix B.

Best Practices for Collaboration

Despite a lack of formal agreement on the process of collaboration, the partners had an advantage in that both healthcare organizations (as well as many supporting groups) had worked together on projects previously as members of the local health council. All three main partners agreed that one of the key elements for building and sustaining a partnership included leveraging "structure[s] and coalitions that already exist[ed]." For this collaboration, that included valuing and tapping into the community health council. AHBASS partners had a strong council infrastructure in place that facilitated a system of accountability and shared ownership of the work, resulting in trust and transparency among partner organizations.

COLLABORATION IN SUSTAINABILITY CONVERSATIONS

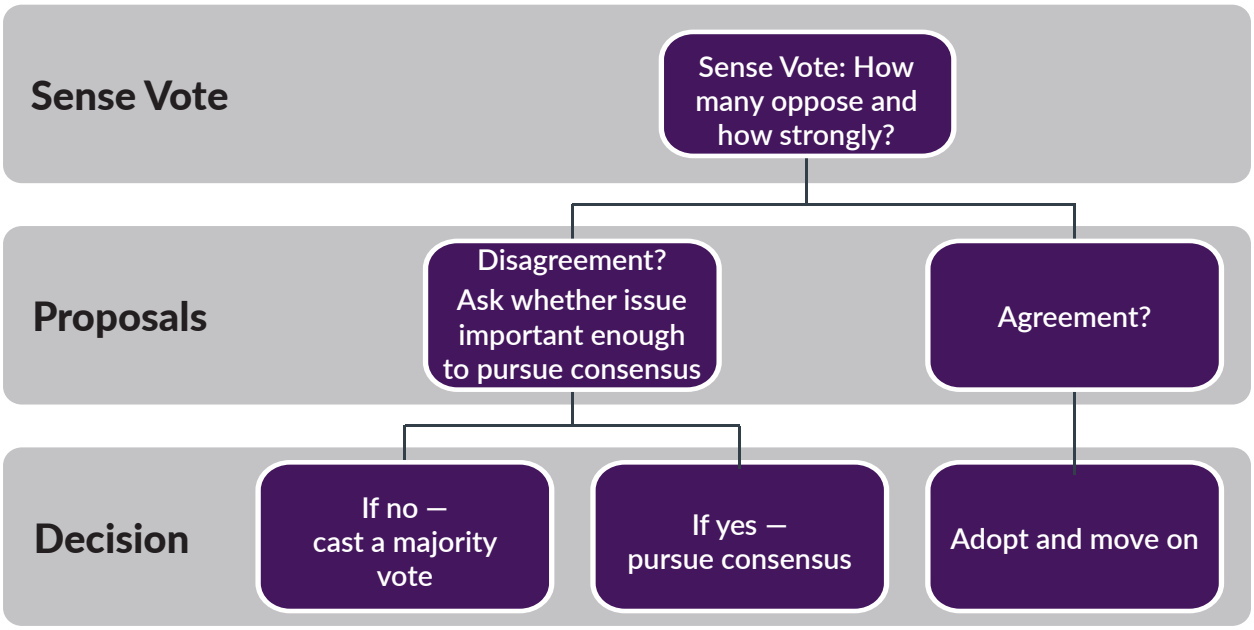
BUILD grant funding was one component of the sustainability plan for a larger project initiated under the CDC REACH grant. Sustainability and funding discussions occurred "at least every month but multiple times a month usually," and "all these partners are definitely part of this conversation." Partners came together under the Healthy Here lead team (within the local health council) to discuss funding and sustainability; these conversations also occurred within different project sub-workgroups. And while the CBO was not a member of the local health council, it was part of the Healthy Here lead team.

The CBO partner described the AHBASS partners' involvement in sustainability discussions:

> ***"This big-picture Healthy Here initiative has 30 partners or something, and it's a very consensus-based group. So all these partners are definitely part of this conversation. We have monthly meetings. And recently it all revolved around sustainability because we are entering this transition in CDC REACH funding years …. I would say every single partner that's involved in this project has been invited to offer input into the sustainability planning …. For our specific project, our hospital partner has been probably our closest collaborator as far as***

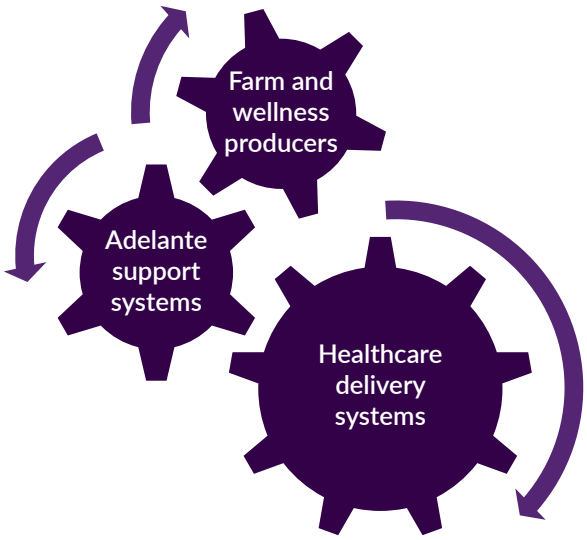
BERNALILLO COUNTY CDC REACH INITIATIVE DECISION-MAKING FLOWCHART

Decision Making Approach — Modified Consensus Process



From Martha's Rules: A Basic Adaptation of an Effective Alternative Decision-Making Process

Vision of Our Partnership



coming up with the sustainability plan. And then also our … health council, which is our government partner, has also been a pretty big stakeholder. I think that they're planning on facilitating our discussion on sustainability so it's definitely a very partner-driven conversation. ”

Given the vast number of partner organizations, the health council used a specific process to reach consensus. A flowchart for this decision-making process is provided left. This flowchart was genera ted from AHBASS's parallel work on their CDC REACH initiative based on "Martha's Rules." They used a modified consensus process that involved a "Sense Vote" to determine how many opposed and how strongly, a review of "Proposals" to determine the level of disagreement or agreement, and finally a "Decision" to vote if consensus is necessary.

KEY TAKEAWAYS & LESSONS LEARNED // INTEGRATED

AHBASS was successful in bringing together a diverse group of partners with a shared vision and goal.

The partners built upon a history of collaboration and an existing structure of governance and communication through the local health council, which was critical to their success. They created an intervention with multiple components and multiple organizations working together to coordinate and implement an upstream intervention.

Perhaps the greatest success of this integrated effort was the development of a data-driven approach that included a shared database enabling healthcare providers to see nonclinical contributors to their patients' health outcomes and the resources available to them. Through the process of negotiation and development of agreements, AHBASS was successful in integrating multiple systems.

Additionally, collaboration was strengthened by recognizing the unique contributions of each partner and identifying ways in which those contributions could be maximized. More details about how the Albuquerque initiative instituted the BUILD principles of local and data-driven follow.

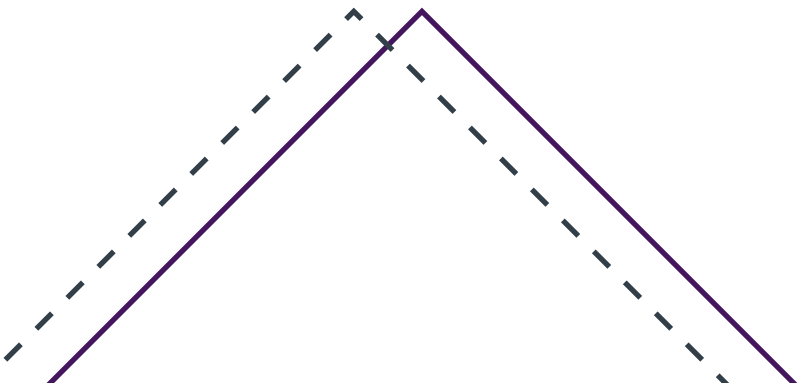
LOCAL

The Local principle stresses that initiatives "incorporate a commitment to community engagement so that neighborhood residents and community leaders are key voices and thought leaders throughout all stages of planning and implementation."

This principle can be understood by examining how the local community was involved in the project, overall community engagement efforts, and the processes that were implemented to ensure residents and stakeholders were involved in various aspects of the BUILD initiative.

"Local" is described by the following:

1. History of Community Engagement and Community Engagement Strategies and Efforts
2. The Role of the Community in Identifying Goals, Priorities, and Concerns



HISTORY OF COMMUNITY ENGAGEMENT AND COMMUNITY ENGAGEMENT STRATEGIES AND EFFORTS

Both healthcare partners had an extensive history of community engagement, which included serving on boards of local organizations, engaging directly with residents, and working with partner organizations in the communities in which they provided clinical care. This longstanding involvement with the community helped to lay the groundwork for a robust level of community engagement that benefited the AHBASS initiative. Regarding the CBO, it was the combination of its nonprofit status (a requirement for BUILD) and extensive IT and data system expertise, rather than any history of extensive community engagement, that was the primary reason the healthcare partners sought it as a partner. The CBO partner's previous engagement with the community was primarily in the form of interaction with their client base through the services they provided. The AHBASS initiative was their first community health-based endeavor.

The FQHC engaged the community at both the county and local levels. At the county level, the FQHC collaborated with community partners who were involved in the local health council, high school education, and childcare services. At the local level, a Community Commons coordinator at the FQHC

engaged neighborhood residents and organizations. This coordinator convened quarterly meetings with organizational partners, conducted neighborhood and school outreach, informed social service agencies about the work of the FQHC, and invited various agencies to participate in AHBASS. The FQHC was involved in community health and received input from residents in various ways:

- The board of the FQHC consisted of people from the community: "We have a community-based board of directors who are consumers of care, so they're patients of ours and we get a lot of guidance from them. "
- Since 2008, the FQHC convened quarterly meetings involving partner organizations and immediate neighbors of the clinic. This provided opportunities for both the organizations and residents to interact with the FQHC doctors in areas outside the scope of clinical or medical care. This provided one pathway for the FQHC to be aware of community health needs:

"That's how our doctors get a lot of information about what the major concerns are in the community, such as environmental health, and other kinds of projects that are going on in the community that would have an impact on health. And basically asking our provider to step in and play a role in some way, whether it's testifying at a county commission meeting or writing a letter of support or something like that. That's another example of how we've engaged with our community."

- Several FQHC staff members were members of their neighborhood associations as private citizens, not FQHC employees. While not a formal pathway of information, this nonetheless enabled the FQHC to stay abreast of the important issues that affected health in their community. Here the FQHC partner discussed the information gathered by the staff members:

"They share information with the organization about what neighborhood associations are concerned about …. There's not a formal way for those to be taken into consideration, but it does become another piece of information that we as an organization take into consideration when we think about opening a new clinic, moving a clinic, changing hours, opening up a planning process when community members should get involved, and those sorts of things."

As a member of the local health council, the FQHC also used results from the community needs assessments conducted by the council to modify their clinical approach:

> *"As an organization, we're not a hospital, but we're also required to do a community needs assessment or to take one into consideration as we apply for our federal 330 grant as a federally qualified health center system. So our organization has always relied upon the Bernalillo County Community Health Council and state epidemiology reports on what the major health needs are of our community. And that really … helps guide our clinical approach and why we have such a heavy focus on diabetes prevention, obesity, chronic disease of all types."*

As with the FQHC, community members are also on the boards of the health system. Additionally, hospital staff and leadership sit on community boards:

> *"Our staff sit on community boards [of] different nonprofits and service providers … so we're engaging in that way. We have strong relationships with community health councils in our state, so oftentimes our … leadership of hospitals sits on the community health councils where they really … learn a lot about community needs."*

The hospital partner cited several ways that community members helped identify goals and priorities in AHBASS: community members were on the board of the health system and community health councils; there were health system staff positions specific to community engagement; and the community provided feedback through community forums and patient satisfaction surveys. The health system partner engaged the community primarily in the following three ways:

- **Conversations with residents who hold positions on various boards and work groups.** Community residents provided input in their roles as members of the local health council and different council work groups that were part of implementing AHBASS. However, once they were hired, the health system partner felt that a position working on AHBASS altered their role and status as a community member:

> *"On the health council we have community members … We don't ask community members to show up to our regular meetings and not be paid while the rest of the partners are. That is not what I've determined is an appropriate way to engage community. So we really work more with community at events … and we've hired community members, but then they're no longer considered community."*

- **Health system staff positions** that specifically involved community engagement for AHBASS:

"[There's] … the community and clinical linkages coordinator who does a lot of work with the wellness referral center and the associated services we provide in the clinics. And a community engagement specialist who also does a lot of work. We also have a community food projects coordinator who is doing a lot of the work in getting the mobile farmers market up and operating."

- **Through informal conversations with community members.** The health system partner also underscored the value of informal conversations with community members. These conversations inspired new opportunities for community investment and programming. One example relates to the farm network. Conversations with local farmers encouraged opportunities for the health system to invest in local agriculture and improve community access to nutritious food:

"This farm network was a prime opportunity to tap into. You know, they're trying to create jobs and bring back the agricultural economy, and the health system is in need of food … it wasn't just a need for nutrition. There was also thought given to how to invest in those entrepreneurs who are poised to lead us. A demand that matches the needs assessment."

The health system partner also acknowledged the importance of working closely with organizations that

have more expertise and experience in community engagement efforts:

Community Input for Land Development and the SVCC

Community input on land development was central to the development of the SVCC project. The FQHC partner shared that the community was involved in the planning process for the SVCC through six-month charrettes. These were "community design sessions," a series of seven workshops in which a total of 107 people participated over the six-month period. Through these sessions, the community provided input on how the actual campus should look, "on where does the parking go, how do the buildings relate to each other — all kinds of elements of what the physical place should look like, feel like, sound like, etc."

AHBASS highlighted key results of the design workshops it developed in seeking community input for its initiatives(see "Results of Design Charreties for the SVCC Community Development Project" on p. 47). Community Input in the Development of the WRC The CBO partner shared that community input guided resource development for the WRC. In addition to participant questionnaires soliciting feedback for the WRC and the mobile farmers market, the partner described how community members led class development at the WRC. For the WRC Zumba class, the CBO did not bring in an outside group to run the class; rather, it engaged a qualified resident from the focus community. Residents also approached the nonprofit with suggestions for new classes that they thought would do well in the WRC. The nonprofit described this community-led resource development:

> *"We work with partners who are really engaged with the people that they're serving in their community and … it's not appropriate to invite community to a coalition meeting of organizations … but those organizations that hire community, that train community and … do a lot of work engaging community."*

> *"What we're doing is referring patients that are getting referred from the clinic to community resources. So all of the resources have really been community led in these different neighborhoods that we're working in. So it's not like we're going in and putting on a Zumba class, bringing in an outside group. It's actually the community that's leading this resource development. And we're kind of to the point now where the community's coming to us and saying, we're hosting this diabetes class here and we think this would be great for you. I would say the resource development, where we're sending people to get healthy, that's been probably 90 percent community led. Not only community led, but community led within the community we're trying to work with as far as improving community health."*

Demographic Comparison

When speaking with the AHBASS partners, we discussed how the partner organizations, at the leadership level, reflected the communities they served. Partners were asked to compare the demographic background of key organizational players doing the AHBASS work with the demographics of the focus get community. They described how key players involved in AHBASS did not refl ect the racial and socioeconomic background of the communities they served. One partner said:

> *"I think for our organization I would say ... it probably mimics the inequity that we see played out in the community. That ... we don't necessarily reflect the community .... We're engaging [in] an initiative ... to look at equity, but I would say we're typically white in the leadership and in the lower-paid positions, we ... have more people of color, which sort of reflects our poverty makeup in our community so ... we're not helping."*

One partner also mentioned the effect of these demographic differences and their relationship to power and oppression:

> *"... we have to be a part of conversations about privilege and oppression. Who we are, as individuals, in those relationships really matters because we're a part of this organization that does perpetuate the inequities that are happening in our community."*

RESULTS OF DESIGN CHARRETTES FOR THE SVCC COMMUNITY DEVELOPMENT PROJECT

First Choice conducted a series of seven design workshops with a total of 107 participants. Each workshop focused on a different component of the overall master plan for the SVCC Expansion Project, including:

- Health Leadership High School
- Wellness Referral Center
- Community Farm
- Child Development Center

The final workshop focused on putting all the pieces together into a master plan for the entire 10-acre site. One of the key points that emerged from this community design process was the idea that the SVCC Expansion Project should help create a healthy “heart” of the community. Community members felt that the proposed project has the potential for creating a healthy community focal point for the South Valley — truly a wellness ecosystem where the health of people and the planet are cared for in a sustainable manner.

Other significant changes that came from the community planning process included a recognition that the farmers preferred a single farm stand, where produce from different farms could be sold all year long, as opposed to an outdoor farmers market with separate stands for each farmer during the harvest season. The need for a food hub, where local farmers can aggregate, wash, store, and distribute their produce, was prioritized, as well as a teaching center for beginning farmers.

Another major change from the original conceptual plans was to connect all the buildings around a central plaza, with permeable pavers and places to sit outdoors and enjoy entertainment, as opposed to locating all parking and the center of the campus.

The parking was moved to the periphery. The full charrette report and the new renderings inside plan can be viewed at: https://bit.ly/2qwXTrf.

This fostered community buy-in on the project:

> *"... it has made the project better. Number one, it has raised a lot of awareness and support. So, it's a way of getting a whole lot of buy-in real early in the process so that the community wants to make sure that this happens. This isn't just a development that one day will appear. Now there's a whole community that wants to make sure that it happens even if it takes years."*

The success of community engagement in the SVCC project inspired executives at the hospital organization to consider the benefits of community input in their new projects:

> *"I don't want to overstate this because it's not all about what we've done, but it has inspired even Presbyterian a little bit. It's about to build a new clinic and ... one of their vice presidents said we want to do something like you guys did and get community input on the building. So, they've seen how it can be successful and you end up with a better product by involving the community."*

TAKEAWAYS & LESSONS LEARNED // LOCAL

Over the past several decades, AHBASS partners and community residents recognized that they must work together to create sustainable improvements in their community's health and wellbeing. Relative to the BUILD project, AHBASS focused their engagement with the community in several key ways that helped advance not only their own team's programmatic efforts, but also deepen the BUILD stakeholders' and residents' shared investment in SE Heights and South Valley.

The AHBASS team relied heavily on its vast network of community and resident leaders from the area to inform and shape its original strategy. By intentionally working with and for the community at every step of the project—including leveraging patient satisfaction surveys and hosting community design meetings that informed their needs assessment processes and strategies for the health coalition—the AHBASS team was able to realize widespread community support that helped the team achieve a number of their goals.

First Nations Community Healthsource is an FQHC that serves predominately urban Indians, although their services are open to all people. They have been in operation for more than 43 years, and they are best known for their wraparound approach to an individual's wellbeing. They integrate culturally competent health care that addresses the physical, social, emotional, and spiritual needs of our community members.

AHBASS's decision to invite First Nations Community Healthsource (FNCH) as a partner to the project proved to be very beneficial for all involved. As with most working relationships, effective team work is built on trust. Staff at Presbyterian Healthcare Services had worked with FNCH in the past, and that made it relatively easier to extend this opportunity to one of the most utilized FQHCs in the Albuquerque area for Native Americans, outside of the federal agency for Indian Health Services (IHS). FNHC fully adopted the AHBASS project into their system, and even integrated the referral process into their electronic health records. They have been the highest referring clinic several times during the time of the project, and there have even been patients from FNHC that have won activity trackers and laptops, from the quarterly drawings of participants.

The long term commitment made by AHBASS partners to maintain and sustain these engagement structures is yet another indicator of the significant investment the partners and community members made in their relationships and this project. From the creation of health system staff positions dedicated to community engagement to compensating community members as board members of their own organizations, the AHBASS partners have consciously created a framework that values and fosters the development of relationships with other organizations that advance community engagement.

DATA-DRIVEN

The Data-Driven principle elevates the "use of data from both clinical and community sources as a tool to identify key needs, measure meaningful changes, and facilitate transparency among stakeholders to generate actionable insights."

This section will explore AHBASS's data management process, how the partners used data to inform and develop their initiative, and how data was shared across partners.

The Albuquerque collaborators relied on data from the early planning stages of their work, using it for a variety of purposes ranging from identifying the neighborhoods to designing and modifying the interventions.

This section will detail the following data-related topics:

1. Data management
2. Data collection: Data sources and metrics (including referral process data collection)
3. Data integration
4. Data sharing
5. Data usage to inform the initiative

DATA MANAGEMENT

The CBO partner and Health Prevention Institute at the University of New Mexico handled the majority of the data. The university collaborator provided data evaluation services while the CBO partner received all of the patient data. The CBO was also a key leader in establishing the overall data system being used for the initiative's mobile market and WRC. The Salesforce platform was used to create an online data system to collect data, track clients, and report out data: "We have a dashboard that shows data, how to take referrals in from different individuals, different clinics, and so on." Adelante had experience with Salesforce through a previous grant project in which the CBO built a call center (the Benefits Connection Center that utilized Salesforce for tracking, reporting, and dashboards. Since Salesforce worked well for the previous undertaking, Adelante used the platform for the BUILD initiative to create an AHBASS-specific RTS to collect data from both the social determinants screening tool (page 15) and utilization of the wellness resources at the point of service and input this information into the EHRs. The goal of integrating this non-medical data into a medical database was to enable healthcare providers "to act on and be held accountable for addressing the non-medical risk factors — just as they are held accountable for counseling patients about tobacco cessation."

DID YOU KNOW?

Salesforce is a cloud-based application platform for sales, service, and marketing (www.salesforce.com).

The health system partner did not work directly with data, but provided guidance:

> *"I don't work directly with the data necessarily except to look at what our evaluation team gives to us. And I'm not working directly with patients so I don't have any patient data but as far as guidance on how we deal with the data and what data we need, I'm certainly at the table there."*

The FQHC had a more hands-on role with data, compiling "monthly data specifi c to the patient referred to the wellness referral center from [the FQHC] listing various diagnoses and comorbiditi es and coming up with a total." There data were analyzed by the WRC and showed the number of referrals that had been made as well as the number of patients who followed through on those referrals.

DATA COLLECTION

AHBASS had several types of data sources and metrics:

- Clinic-level data, such as chronic disease information and type of insurance, was provided by healthcare partners at participating clinics in the priority neighborhoods.
- Individual data collected included:—

  Demographic information, such as age, date of birth, number of people in household, gender, income levels.

  — Dietary habits, based on participation in the market as well as

what patients purchased (collected through the mobile market).

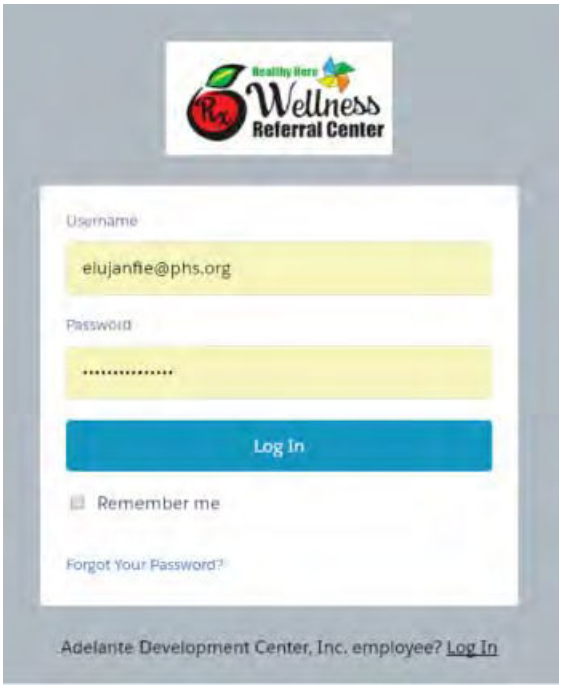
  - Physical activity feedback. The healthcare and university partners were exploring how to collect pre- and post-physical activity data for a walking trail that is in the neighborhood around the clinic. Participants self-assess how they feel after a walk using a walking log.
  - Referral information. Referrals made to patients, barriers patients identified to participating in various wellness programs, and whether the patient followed through on the referral were all tracked (see flowchart on p. 14).
- Geographical data such as zip code and Census Tract was collected to explore social determinants and the influence of factors like income and poverty levels.

AHBASS tracked several key metrics longitudinally. One partner described tracking wellness center resource utilization over time in order to ensure "the system is set and working and [people are] utilizing those systems." The initiative also tracked chronic disease outcomes longitudinally through the CDC REACH grant, with initial data collection focused on data such as "number of people being served, the number of clinics participating, the number of sites for the mobile market, the number of farmers." Here, one partner stated that these metrics were important because "that actually is along the pathway to some chronic disease outcome or reduced food insecurity or increased consumption."

Partners collected and used data gained from community initiatives unrelated to AHBASS. For example, in a non-AHBASS study, patients were given an 11-question screening tool for social determinants of health (page 15) at each clinic visit. The answers to those questions would "trigger an offer of help from the community health worker and resource navigation. It can be very involved or as simple as providing a phone number or access to some resource." The screening tool was an additional source of information "about what the community needs in terms of healthy foods, access to jobs, access to legal services — all the non-medical factors that influence health." While that data was collected for a different study, AHBASS used it to identify gaps and "where we're going to need to push for expanded resources to address those upstream barriers."

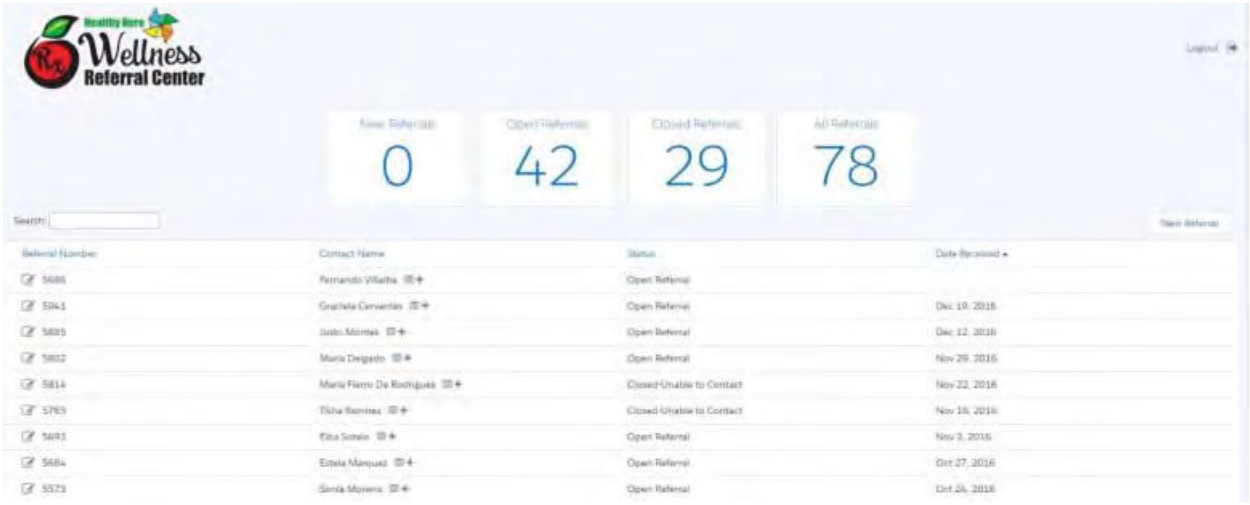
Referral Process Data Collection

Data collection for the referral process (see the Referral Tracking System and Wellness Rewards Program Flowchart on p. 14) begins with clinic healthcare providers referring the patients to the WRC when they discover their patient has a chronic disease:



Screenshot of portal plugin

> *"So the data part starts at the initial process with the doctor level. What typically happens is that the doctor will use the form-based system where they complete a huge demographic data point for each patient. This person needs to attend, say, a chronic disease management class, which is a standard class that is put on here in New Mexico. They want that person to attend that class so we get that referral into our system. Right now, they fax it or email the system referral to us. And in our data-tracking system, we extract that patient."*



Screenshot of portal dashboard

Wellness Event Registrations

Show Registration After Opened Date: [12/28/2016] Apply

Date/Time Opened	Contact Name	Event Location	Event Name	Course Type	Registration Status
6/22/2016 11:17 AM	[redacted]	Compadres Senior Center, 5411 Osuna Rd NE, Albuquerque	Creaciones de Cocina (Compadres)	Healthy Cooking for Diabetics	Completed
6/22/2016 11:17 AM			Healthy Eating Open Referral	Healthier Eating Education	Interested - No Match
6/22/2016 11:17 AM			DSMP Spanish Self Mgmt Diabetes - Open for Referral	Diabetes Specific Classes	Not Interested
6/22/2016 11:17 AM		First Choice Community Healthcare (2001 N. El Centro Familiar Blvd. SW, Albuquerque, NM 87105)	Cooking For Health (Bilingual)	Healthier Eating Education	Completed
6/22/2016 11:17 AM		First Choice Community Health Care - 2001 El Centro Familiar Blvd SW	Mobile Market - First Choice Community Healthcare SW Clinic	Food Access	Dropped

Screenshot of one participant's details

Initially in the data-tracking process, AHBASS partners had to transfer patient referral information from a paper form to the electronic database. These referrals — to classes such as cooking, healthy eating, and exercise at the WRC — were integral to achieving the goals of their initiative, while encouraging people to live healthier lifestyles. One partner explained that by tracking the referrals, they were able to close the gap between the chronic disease diagnosis and the referral. Prior to AHBASS, when referrals were not tracked, it was unknown whether a patient heeded their doctor's advice on healthy behaviors such as "you really need to get more exercise. You need to start working on healthy eating. You need to attend these classes, the wellness classes."

DATA INTEGRATION

While data integration was initially a challenge, the partners were ultimately able to integrate over the course of the BUILD timeline the disparate sources of data collected by each constituent organization. Near the end of the BUILD grant period, there were several data integration–related accomplishments such as cross-clinic utilization of a data portal and EHR systems integration.

The CBO partner, which brought their IT expertise to the AHBASS team, explained that each clinic used a portal to access referrals specific to that clinic only. This additional functionality was achieved through the purchase of an app on Salesforce's app exchange.

Initially, EHR systems integration was a challenge because there were multiple EHR platforms being used by clinics. At

the time of this project, there were two major EHR systems nationally, and clinics tailored the systems to fit their needs. For instance, a clinic making referrals for AHBASS wrote its own open-source EHR platform. This made integrating referral data into the EHR platform even more difficult. However, the partners developed a relatively simple solution that involved attaching a PDF of referral information to the patient's medical record. The CBO partner described the process:

DID YOU KNOW?

Attaching a PDF form to disparate EHR platforms could help solve the issue of data collection from separate EHR platforms.

" One of our solutions that seems to be working well is to send individual PDFs — one page per referral in a zipped file so that those individual PDFs could be attached to the electronic health record. And that has now crossed the two big [EHR] systems; the people that work with Cerner and the people that work with Epic, those two different medical record systems. They both asked for that and it can be done. So, from their point of view, that's interesting that [it] can sort of fit into their processes …. So that has been, I think to me, an unexpected outcome, that's an integration of the two systems because they sent us a referral and the wellness referral sends them back something that gets attached directly to the patient's electronic medical record. "

While the EHR systems were not directly connected with the WRC data, "from the user perspective, it's accessible in the same way." The healthcare provider could access referral information and use it in a follow-up clinic visit. In this way, healthcare providers could, theoretically, better understand and, thus, address the non-medical factors or social determinants of health related to their patients' poor health outcomes in clinic visits.

DATA SHARING

There were several work groups involved in data analysis and interpretation: a mobile market work group, referral center work group, and an evaluation team (local university collaborators). While each of the work groups was "involved in their respective project," the evaluation team "really pulls it all together and then reports back to our larger advisory group."

Partners communicated about data access, management, and interpretation at their monthly meetings; the separate work groups then met to discuss further details. As one partner stated, some of the data-sharing process was simply a matter of trial and error to see what would be most effective:

" And we've been working on a variety of techniques. What way

of sharing and reporting of data is going to be most effective for each partner, whether that's just getting reports from [a partner] at a certain frequency or creating an online portal that other partners would be able to log into and access in a secure fashion to review the data."

The healthcare partners frequently created learning opportunities in their mobile market and referral center work groups. The partners electronically shared tools and resources such as published research articles about best practices for their specific programs and interventions. They also shared resources and details on evaluation practices. Partners felt that a key asset to these work groups was "the different expertise that we bring to the table."

The CBO partner, who handled the majority of the data for the initiative, had work group meetings composed of "six or seven of us" who met every month. In these meetings, the work group members discussed all data-related matters (e.g., number of referrals achieved) and provided feedback to the clinic:

"*Part of the meeting is that we go over dashboards together from Salesforce ... and we go over that data with the revised number of referrals. We meet about [every] two to three weeks. The data is pretty much real-time, and that is what makes it pretty cool. And we get feedback information*

back to the clinic …. The clinic wants to know if the person gets the referral, and the person gets to the courses that they referred them to … so all that information gets sent back to the person who made this referral …. In most cases, it's the community health worker …. So the doctors … they may want some points. But truly, they are typically handed off to a nurse or to a community health worker so we give them back reports, weekly reports, on of all their referrals. ”

USING DATA TO INFORM THE INITIATIVE

Partners used data to inform decisions throughout their process:

1. Data helped to identify gaps in the referral process at the clinic level:

> “*Having data showing you that most of our referrals come from Presbyterian, that's a real obvious data point. You can look at that and say: 'How come they don't have more [of those people coming] from this source?'* ”

2. Data also identified gaps at the referral center. Based on class utilization data, the CBO partner realized that “50% of the people who say they are going to come are not going to come.” They then developed a successful strategy to over-enroll people in the program.
3. Participant survey data also helped them develop new programming by “working with new partners that can provide the courses that the patients want, when they want them, and working with existing partners to make sure that their programming is responsive to their needs.” One partner explained the process:

> “*As we look at who came and what classes were successful, and then we talk to the people after the class and we put all that together … it seemed like, for instance, the walking groups were very popular and people attended those at a good rate. And the classes that were on Saturday mornings did better than the [other] classes, so we just looked at people voting with their feet, I guess you could say partly, and with follow-up interviews too, to develop those resources.* ”

KEY TAKEAWAYS & LESSONS LEARNED // DATA-DRIVEN

The Albuquerque initiative worked to develop a system that could be used across sectors and to streamline data use and sharing in order to provide healthcare providers and organization leaders alike the information needed to create a wellness environment for the community.

It is worth noting the data-related challenges the initiative faced and how the partners overcame those challenges:

1. Remaining HIPAA-compliant by protecting patients' confidential information while sharing data was a challenge. The initiative overcame the challenge in two ways: (1) by not sharing information that was diagnostic and (2) by getting secure email accounts. One partner discussed their intentional goal of eliminating the need for protected data:

> *"What we try to do at our end is not have that information available to anyone except at the wellness referral center, and there is special training here for HIPAA. But really, our idea is to not have any HIPAA data …. Our main thing is we just try to keep a firewall between anything that could be considered HIPAA, any diagnostic … we don't ask anybody what their sickness is or anything like that. We simply say, 'We see you've been referred for a physical activity. What one would you like to do?'"*

2. Tracking participants who were lost to follow-up was a challenge. Because the CBO partner was not receiving patient utilization data for chronic disease classes, they were unable to know how many patients were actually following through on their referrals. However, once a new nonprofit (the Consortium for Older Adult Wellness, based in Colorado) came in to manage the chronic disease classes, detailed information began to be shared with the CBO partner, who then entered it into Salesforce. Receiving that information from the class managers "was just a process change that's a little more work and took a little while to get integrated."

AHBASS partners shared two key lessons learned during implementation of the initiative. The first piece of advice was to "start the conversation about data early." And the second point, relatedly, was that it is vital to think about EHRs early in the process because it may take more time than expected to integrate with them. The partners had been slow to consider the role of the EHR in data because of the challenges in integrating data with, or linking it to, patient records:

> *"…it is a cumbersome endeavor to link into any EHR. We know that that's going to take a lot of resources, money, and people's time and, I would say that funding is going to be a big issue in terms of paying for people's time and then the capacity to make our EHR do things that it can't do right now."*

HEALTH EQUITY

A BUILD goal was to address health disparities — that is, reduce differences in core health outcomes — caused by systems-based or social inequity.

There was no requirement for sites to address health equity, although many sites saw this as an opportunity to further develop their equity-based work. BUILD National is learning from each of the BUILD sites' efforts as they develop their plans and progress toward achieving health equity.

In this section, we explore health equity and the AHBASS initiative as it relates to:

1. The process used to assess the initiative's approach to health equity.
2. Its definition and shared vision for health equity.
3. Lessons learned from applying the R4P framework, a tool to understand the various components of AHBASS's work with respect to health equity.

PROCESS FOR ASSESSING SITES' APPROACH TO HEALTH EQUITY

Multiple sources of information were used to assess each site's understanding, approach, and commitment to health equity:

1. BUILD grant applications were reviewed. While not asked to describe health equity issues specifically, sites were asked to detail the health disparities affecting their community.
2. Partners participated in individual interviews and a follow-up group interview and completed a self-assessment tool related to equity in order to give researchers an understanding of the ways in which they understood and instituted health equity throughout their initiative.
3. And finally, an equity framework called R4P (described further below) was applied to understand how partners defined and approached health equity in their initiative.

The Hogan and Rowley R4P Framework, a theory of change for designing an equity approach to reversing the unfair and avoidable consequences of inequity, was utilized. This framework was used to query partners about the ways they attempted to achieve equity though the five domains of R4P:

1. Repair past or historical damage/harm/setbacks

2. Remediate, or reduce the impact of existing stressors that diminish outcome goals
3. Restructure policies, procedures, job descriptions, meeting agendas, and other institutional structures to remove the production and sources of inequity
4. Remove the institutional sources and vestiges of racism, classism, sexism, and other "-isms"
5. Provide culturally and socioeconomically relevant health/education/clinical services to all populations so that they can achieve equity in outcomes, and further provide structural supports to ensure that all populations have the tools and resources to carry out educational/clinical recommendations

The online self-assessment portion of the health equity interview was designed to guide partners in reflecting on their initiative and their organizati on with respect to health equity.

DEFINITION AND SHARED VISION OF HEALTH EQUITY

While AHBASS partners did not have an explicit definition or shared vision for health equity, the partners expressed their desire to promote equity across the partner organizations. Furthermore, health equity was considered by the hospital partner to be central to their work. Due to a previous

project through the health council, "there's been a major focus on health equity and resources and training, and it's something that a lot of our partners did very well already. And so it's been a principle of the health council for many years and some of the other coalitions and organizations we work with. We continue to think of that as a core component of our work."

The CBO partner also described their efforts to address health equity, which was at the core of the initiative:

> *"The whole project is based on health inequity. That's what we're trying to do is get at the racial and ethnic divide in health. And that's why we're focused on the two areas of the city that have the largest areas of health inequality. So that's the basis of the grant, the way we're implementing it is that we're trying to address those inequalities."*

Health equity was not explicitly discussed in AHBASS meetings, but it was often discussed in local health council meetings. One healthcare partner provided a definition of health equity based on their work in the health council:

> *"I think that the broader coalition defines it as investing in those communities that have disproportionate outcomes or disproportionate burden … so the broader coalition is really cognizant of its need to invest … in places where the [incidence] of disease is really high and where all the other indicators — income, education — are low. So we're not investing everywhere, we're investing in targeted areas where we can make the greatest impact on equity."*

The CBO partner felt that although health equity was going to "have a different view" under each of the partner organizations, the central goal of the initiative was to "be collaborative and … promote equity across the county. And that includes not just disparities for race, gender, [socioeconomic] status, but we here at Adelante work with … people with disabilities, which is our strength."

The FQHC commented on the lack of an organization-specific definition of health equity but believed health equity was inherent in the work that it does, stating:

> *"I would say that my organization doesn't have a real sophisticated definition of equity, but because of [being a] federally qualified health center, it is designed to serve the lowest-income population. So … by design it has had to invest in those communities that have the highest need."*

Both healthcare partners agreed that health equity was not traditionally discussed in the healthcare sector. A 2017 American Hospital Association mandate requiring hospitals to complete a health equity survey tool triggered conversations about health equity within the hospital. In the prior year, the hospital also signed the Equity of Care Pledge, an American Hospital Association initiative that has been "driving some of our work in health equity and conversations around social determinants of health and population health." The pledge "is a tool to have the conversations and to move the work forward and to support people who are already doing the work."

While the scope of work within AHBASS was not explicitly created to achieve health equity, partners were asked whether they used or applied a health equity model or methodology. One healthcare partner explained that while there was no specific health equity model, health equity was incorporated into their working logic model: "it's kind of core in it but not explicit." Another healthcare partner related how the initiative's theory of change focused on "the policies, system, and environment in communities that experience disparity." The partner felt AHBASS implicitly worked to achieve health equity in the community and that "by changing the built environment and making these kinds of opportunities available, more people in these low-income communities will have the opportunity to take advantage of them." The CBO focused discussion primarily on ways the initiative addressed upstream factors in the community rather than any health equity methodology (i.e., the "Provide" domain in the R4P framework, described later in this report).

The healthcare partners had experience instituting health equity–related models/methodology outside of AHBASS. In addition to health equity being a core component of the health council's Healthy Here initiative, the hospital focused on health equity through its community health work: "we continue to focus on health equity in our work because we've really worked hard to align with the Culture of Health framework,[5] which has equity as a core component, and then again in Healthy Here it's a core component."

The primary challenge related to the process of creating a shared vision of health equity has been how to have conversations about the issues surrounding equity, which are often difficult subjects like power, privilege, oppression, and race. "And how do you have that in a fair way where you're not asking the oppressed to lead that conversation …

5 Robert Wood Johnson Foundation. (2017) Building a Culture of Health. https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html.

they're people who traditionally face oppression." The hospital partner felt this challenge was addressed through thought and conversation as well as overcoming feelings of being uncomfortable personally: "For my position as a white woman, I feel … [I have to] get over my feeling of being uncomfortable and have the conversations anyway and put them on the agenda and try to be true to my values and the values I see in our coalition."

R4P FRAMEWORK

The following describes each of the R4P domains, as outlined earlier, and the ways in which AHBASS addresses each domain.

Repair

We asked partners to describe the historical forms of marginalization and oppression experienced by the local community and how AHBASS attempts to repair or address these forms of marginalization.

One healthcare partner related how the priority area had historically been a low-income community where agriculture was the main source of employment. Because per capita income was around $15,000, people are known as "land rich and cash poor." The other healthcare partner shared how healthcare has also played a role in marginalizing low-income communities through its focus on being a business model rather than providing healthcare services:

> *"Historically … in healthcare, in general … you don't try to get the people with low incomes and who are really sick, you know. You want people who are healthy. And I just think, traditionally, healthcare has made money off of sick people and that has contributed a lot to inequities. And they invest in places where they make money so they can stay afloat. I mean it's a business model, which I think contributes to inequity and trauma for communities."*

When asked whether their individual organizations contributed to historical marginalization, one healthcare partner was critical of bill collection practices in nonprofit healthcare: *"And so, historically, bill collection practices have been pretty harmful and so we've done a lot of work, some of it because we want to and some because we're forced to, on making better bill collection policies, [on] improving our financial assistance policy."* The partners also noted that citizenship requirements and lack of appropriate language interpretation and translation services were additional barriers to healthcare. These barriers were specific to their community, which was home to a high proportion of immigrants.

To address these specific barriers to healthcare, Presbyterian has made its focus to ensure that all resources are free to the public and do not require any form of documentation, or insurance.

While the CBO partner did not discuss any history of marginalization related to their own organization, they shared how a historical lack of trust had initially made it difficult for the BUILD initiative to connect with the Native American community. A clinic that served the Native American population initially didn't participate:

> ***"There's, I think, historically a lot of distrust between the Native American community and most of the white community and certainly the medical profession ... But through continued contact over time the Native American clinics became significant referral sources, referring over 20% of the total."***

In terms of specific strategies for repairing any damage, the CBO and healthcare partners discussed ongoing strategies that fit within the realm of providing services to communities that had been historically denied access to services, which is one approach to indirectly addressing the issues of mistrust or marginalization. The healthcare partners discussed the mobile farmers market program, which provides healthy food in communities that have historically lacked access. As an organiza. on, outside of its work for AHBASS, the health system has also worked to make the environment supportive of a healthy lifestyle. Inability to travel, whether due to lack of transportati on, not being well enough to travel, or not having time or money to afford it, impacts a person's ability to lead a healthy lifestyle. The health system partner circumvents transportation and wellness barriers to healthcare by contracting with a community health worker (CHW) organization to conduct

in-home visits and record various pieces of informa. on through a program that existed prior to AHBASS. The CBO partner did not provide any AHBASS -specific strategies to repair historical marginalization but discussed, instead, their organization's history of supporting people with disabilities through employment, vocational and life skills training, residential services, and volunteer opportunities.

Remediate

Partners were asked to discuss current or existing local policies or practices that may have a negative impact on the local community and the ways in which AHBASS may help remediate or reduce the impact of these detrimental policies or practices.

There was a stated concern that the WRC was underutilized. Medical staff, such as patient care facilitators or CHWs, were not providing referrals as frequently as the partners had expected. In addition to the challenges with addressing prevention in medical and clinical environments, the partners described other critical issues that contributed to lower referrals from providers. Frequent staff turnover as well as the different pressures doctors generally face (e.g., patient quotas, limited time per patient) were cited as some of the reasons for the lower than expected number of referrals: *"They all have a million, many, many pulls on their time that control the purse strings. The people that control the purse strings set the criteria for success. And if the criteria for success don't have referring for wellness very near the top, it just doesn't happen."*

The CBO partner was working with clinics and providers to remediate this issue by raising awareness about the referral program and making some structural changes:

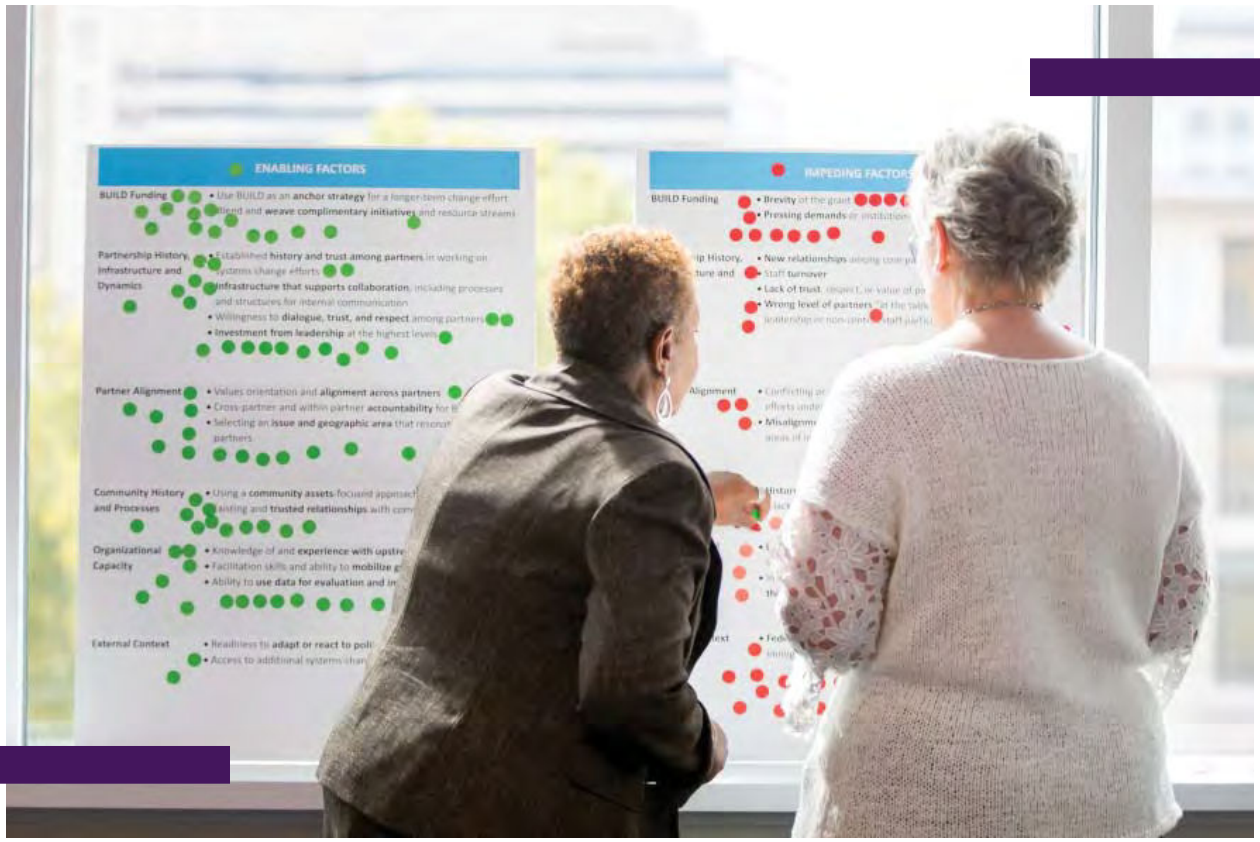
> *"Our main effort right now is going to be focused much more on getting the providers on board with [the referral program], making them see the value of this … and I think they probably see the value, but … they're all a bit overwhelmed at the moment. There's a shortage of physicians. I think trying to shift it much more to a community health worker model who can handle a lot of this. A lot of this is not a medical issue. The doctors know that. They can make a simple referral to someone and … we can work with them [community health workers]. We don't need necessarily to work with a doctor."*

Another key policy issue that had an impact on the community was a relatively new requirement from the United States Department of Agriculture (USDA) and the state that would require Supplemental Nutrition Assistance Program (SNAP) beneficiaries to receive training and education to maintain their benefits. SNAP beneficiaries were already required

to seek job counseling through state providers; but once the new law was put into effect, beneficiaries would lose their benefits if they did not receive job training. This law would make it difficult for people to receive SNAP benefits because, as the hospital partner stated, *"there is nothing meaningful [taught in the program] that would help people get gainfully employed."* The law would be detrimental for families already struggling:

> ***"We're talking about a huge sector of the community. These are parents basically. So the kids can stay on SNAP, but the parents will lose their benefits if they don't get training. Well there is no training available … there is nothing meaningful that would help people get gainfully employed. So we have an opportunity to try to help fill that gap to help provide meaningful training that would meet their requirements. So that they can stay on SNAP until they get the job that they need. And that's going to directly impact our mobile market, it's going to impact the stability of our families and clients because if you've got to figure out whether you're going to buy the medicine or buy the food, you know, usually the food comes first."***

AHBASS partners planned to remediate the impact of this new law through their "capital aspect" program, which related to an existing workforce training center that would expand to include not just hospital employees but also community members. The training received at the newly expanded center should enable SNAP beneficiaries to maintain their status while receiving substantive job training for entry-level jobs in the healthcare sector.



Restructure

In addition to discussing ways in which historical and current practices may have a negative impact on the health and well-being of their local communities, AHBASS partners also discussed ways in which they attempted to actually change or restructure institutional, organizational, or administrative policies and procedures that systematically exclude or have a negative influence on the community.

One healthcare partner stated how the three central projects of AHBASS — the WRC, mobile farmers market, and capital aspect program — "are really about creating community infrastructure that didn't exist." For example, the partners described how the mobile farmers market specifically goes into communities that have less access to fresh foods. The initiative worked to restructure the mobile market program to provide food access to historically excluded communities. The mobile market was intentionally designed to accept multiple methods of payment such as *"SNAP benefits, for farmers market check, the WIC farmers market checks, the senior farmers market checks"* in order to make the food less expensive and more accessible to the community.

When asked how AHBASS restructured policies or procedures, the CBO partner's response focused on listing specific programs offered by their initiative. However, within its organization, the CBO was *"constantly changing with the times … we're always restructuring our approaches based on the current environment so that we're able to meet the needs of people …."* The CBO also recently expanded its organization's mission statement to reflect the broader population it

presently serves, which included not only people with disabilities but also seniors and low-income populations.

Remove

This particular domain was focused on the ways in which BUILD sites identified and removed institutional forms of racism, classism, sexism, heterosexism, and other direct forms of exclusion. The healthcare partners spoke of efforts to address racism by inviting anti-racism speakers to health council meetings and allocating time on meeting agendas to discuss equity. The hospital partner discussed enabling open dialogue at these health council meetings:

> *"The coalition [health council] … put on this agenda for several meetings in a row — different speakers to talk about anti-racism, to talk … actually very, very explicitly. It was a very intentional thing to do and it's not a one-time thing. It has now made it something that people can bring up at any time without worrying that you know they're going to … because [the hospital partner] is also a funder so it's … hard to tell your funder something critical, but [the hospital partner has] invited that kind of dialogue by setting the agenda and saying, OK, today, for the next three months we're going to talk about equity. And so it's just created this opening where now community people can say we can approach this coalition and talk about this openly without fear of being cut out of any projects or … fear of being shut down in a meeting. So that was very intentional and it's not usual … with hospitals."*

However, both healthcare partners agreed that AHBASS does not explicitly remove institutional forms of bias. One healthcare partner explained:

> *"What [AHBASS] has done is enable those of us on the ground to work on these issues in a way that, because we're conscious of … racism, classism, and sexism, that we're trying to mediate those on the ground, but to be honest, the conversation is not happening at the leadership level that explicitly."*

Both healthcare partners also felt that AHBASS funding supported the conditions/opportunities for people to access healthcare, nutritious food, and job training where before they did not have access. Additionally, requiring the health system partner to provide a one-to-one match for funding helped to *"create important conversations about why we should be at the table supporting this work"* at a higher level of hospital management.

When asked about the ways in which AHBASS removes institutional forms of exclusion, the CBO partner discussed an AHBASS program that focuses on access

to healthcare. The program, run by several other AHBASS partners, contracts CHWs as care coordinators that connect at-risk patients to health resources, one of which is the WRC. The CHWs conduct in-home visits and monitor patients' progress toward improved health outcomes. This enables people who may not be able to travel, due to finances or physical well-being or ability, to still connect to programs that will impact health outcomes.

Provide

Finally, AHBASS partners discussed the ways in which they assess the unique needs of the community and take that into account when developing programs or services for their initiative. Community needs are evaluated through recurrent community health needs assessments that pre-date AHBASS; program development is informed using multiple sources of data. Here, the hospital partner explains:

> *"... all of this work has been driven by community health needs assessments for years ... And so we have invested and brought partners to the table and developed plans based upon health outcome data, demographics, focus groups, surveys ... many different points of data that have guided where ... the work goes."*

As discussed throughout this report, there are several ways AHBASS took into account the unique needs of the community when providing services. Addressing a lack of food access in this community, the mobile farmers market traveled to provide access to fresh foods in places that did not have

them. The capital aspect program will expand to provide job training to community residents, which addresses a new need of SNAP beneficiaries who want to maintain their benefits. The WRC is, as the CBO partner said:

> *"... locally, culturally appropriate ... and time sensitive ... The whole idea was to really try to set up an effective mechanism working with the providers, clinics, and the people that offer different wellness resources in the community ... to get people from those target areas into healthy outcomes, whether it was through eating classes, whether it was through fitness classes."*

There are several examples of how programs were oriented around providing optimum access to participants. Based on feedback from participants who could not attend weekday classes due to work schedules, extensive weekend offerings were created. A bilingual class that teaches food storage, preparation, and preservation includes childcare and groceries participants can take home. In

Characteristic Equity Approaches	Description
Institutionalized-Equity Approach	Builds organizational structure from outset to consider equity in all policies, practices, procedures.
Equity-Add-On Approach	Engages in post hoc actions to graft equity considerations and approaches onto existing (usually non-equity-supporting) institutional frameworks.
Cultural-Matching Approach	Focuses on developing, implementing, and disseminating approaches, usually limited to education and care, that match historical, cultural, and social needs and desires of populations of color.
Diversity Approach	Focuses on including a more diverse workforce. While organization hires more people of color, it usually does not give them power or resources.
Missionary Approach	Provides evidence-based practice in traditional ways, targeted specifically to people of color, usually delivered by people of different ethnicity than population served.
"Raise-All-Boats" Approach	Focuses on improving systems of care for outcomes, with the expectation that improved systems will automatically impact all population groups and achieve equity.
Selective Approach	Chooses a population or inequity to address as sole programmatic focus, (e.g., income inequality but not racial inequities; Latinas but not African Americans).
Concerned, Non-Action Approach	Knows that inequities exist, but does not know how to incorporate equity into programmatic actions.
Low-Awareness Approach	Conducts professional work in absence of recognition or consideration of need to address inequities.

Table 3: Characteristics of Equity Approaches

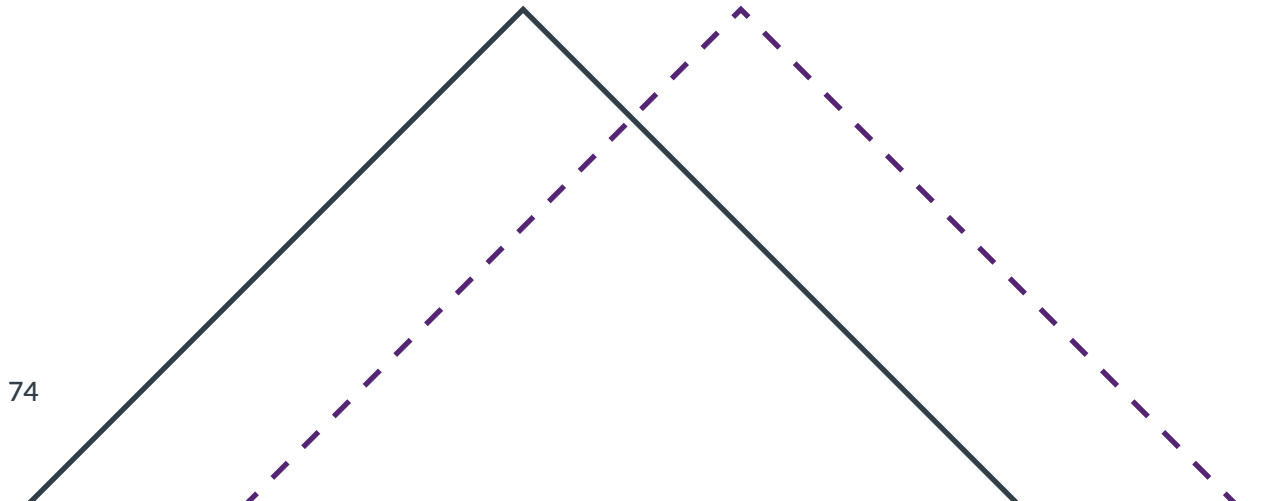
addition, the program incentivizes positive health behavior change through both a rewards system (see the Referral Tracking System and Wellness Rewards Program Flowchart on page 14) and frequent personal contact (calling, texting, emailing).

Assessing Equity Capacity

Based on an analysis of interviews with the CBO partner and two healthcare partners, the Characteristic Equity Approaches developed by Hogan et al.[6] (see Table 3 on page 73) were applied to determine the ways in which this initiative approached equity. Although they may have had characteristics that fit within more than one type, presented here are the typologies that were most prevalent. The Characteristic Equity Approaches are a qualitative way to describe the current practices and are not based on a linear progression of better or more intensive to less.

AHBASS leveraged two different, yet complementary approaches. The first was a Cultural-Matching Approach, a category that "focuses on developing, implementing, and disseminating approaches, usually limited to education and care that match historical, cultural, and social needs and desires of populations of color." As discussed in the previous section "Provide," the initiative had multiple approaches to match the historical, cultural, and social needs and desires of its focus population. Although equity was not explicitly stated as a goal, AHBASS focused on the "system and environment in communities that experience disparity." As a result, the partners' work also fit within the "Raise-All-Boats" approach. Through a three-pronged effort consisting of improving access to nutritious foods (mobile farmers market), establishing a system where healthcare providers could "prescribe" chronic disease self-management resources (WRC), and creating a hub for health and economic improvement resources (the SVCC), they sought to create a wellness environment. By creating the infrastructure for better health outcomes, AHBASS worked to create the opportunity for all people in its low-income community to live a healthier lifestyle.

6 Hogan V., Rowley D.L., White S.B., & Faustin Y. (2018). Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations. MCHJ, 22, 147–153.



KEY TAKEAWAYS & LESSONS LEARNED // HEALTH EQUITY

Partners were asked whether health equity came to mind when thinking of AHBASS — in essence, whether they thought health equity was a foundational element to the AHBASS initiative's design.

Because all three core organizations had worked on health equity concerns prior to AHBASS, the AHBASS initiative was seen as a continuation of their work in health equity issues. The FQHC partner shared that health equity "definitely comes to mind" when thinking of BUILD:

> *"Because the B in BUILD for bold is like an indicator to me that what we've been doing as a country has not been enough. That we're being given permission and resources to do the work that has not been done systematically before. So I think it was very intentional… and it was place-based. It was always about neighborhoods and communities that are adversely impacted … from the lack of investment and lack of … resources. So I think it's been inherent from the beginning. This was never supposed to be about doing more of the same that has gotten us to a place where we have inequities. It was designed to break that mold."*

ADDITIONAL LEARNINGS

The following describes additional areas of importance raised by AHBASS in its eff orts to conduct its community health work.

Sustainability

The initiative's sustainability plan looked to both traditional as well as more sustainable sources of funding. In addition to developing new policies around medical billing (described on pages 24 and 25), the partners pursued traditional sources of funding such as time-limited or restricted funds such as grants. Applying for the BUILD grant was part of a larger sustainability plan for their work for the CDC REACH grant. While they had applied for more traditional funding (and achieved an additional fourth, and final, year of funding from the CDC REACH grant and a four year USDA grant), the partners focused on ways to make their initiative sustainable in the long term. Some of the funding sources and approaches included:

- **Mobile Farmers Market**
  - The mobile farmers market brought in some revenue, "although it's not enough to sustain it, but it does help create dollars for reinvestment."
  - Receipt of a four-year USDA grant with matching funds from the hospital partner.
- **SVCC:** The FQHC was in charge of the SVCC. The hospital partner was unaware of specific funding sources but believed that the FQHC "has a whole range of different funding sources for the [South Valley] Commons development."
- **Wellness Referral Center**
  - The hospital partner plans to continue to provide funding for the WRC and the programs it runs even after the BUILD grant ends.
  - The CBO and other partners plan to meet with other organizations, including payors, to address ways in which medical billing could support the WRC.

See Appendix D for the most recent version of the WRC sustainability plan.

CONCLUSION & NEXT STEPS

Partners shared their ideas on the future directions for the project once the BUILD funding ends.

One partner believed the focus will be to "keep working on upstream rather than downstream kinds of interventions" and that their partnership will "continue to build our capacity and resources that are targeted to communities of highest need where the equity needs are the highest."

The CBO partner hoped that the partnership would grow stronger and discussed how they would like to see the project and the partners' work together "grow and become more and more sustainable as key players." The hospital partner stated that the future of their partnership "goes back to proving the model," being able to show a cost-benefit as well as a "health outcome benefit" to funders and consumers. One partner hoped the NMDOH would play a more central role in the future.

The health systems partner stated there was no foreseen shift in focus of AHBASS. As part of their sustainability plan, however, the partner noted that the mobile farmers market would be "expanding its vision to help to build community leaders over the next several years."

The CBO partner discussed several ways they were considering fostering

sustainability of the WRC. The CBO was contemplati ng ways to bill for services as a sustainable funding path forward (detail on this is provided in the Bold section on page 25). The CBO partner shared that they were considering two possible changes in their approach to the WRC: how to expand the WRC and, at the same ti me, mold it to better fit in with the mission of their organization. The CBO partner shared some of the questions they were discussing: "What is the long term … not just sustainability but how does it long-term integrate with the rest of our mission? How can we either expand it in a way that makes sense or not do it?" One way they think they can integrate the WRC with the CBO partner organization is to shift the focus of the WRC to training people that they already help (developmentally disabled, disadvantaged, and seniors):

> *"We have been sort of working generally to try to see [if] there is a way that we could make it about training. Our part of our mission is to help people with developmental disabilities, disadvantaged, and seniors. So could we train people who are traditionally disadvantaged to work in a wellness referral center or could we train them to technically support the wellness referral center … people come in, they learn how to do this, and then they go out and get a job somewhere else. That's something we thought about. Because we're always trying to figure out … how we can take what we know and somehow do something that the nonprofit organization would be interested in supporting."*

FINAL THOUGHTS

AHBASS developed creative, bold, and upstream solutions to address the high rate of chronic diseases in their community.

AHBASS has innovatively utilized the intersection of technology and data to understand patients' use of non-medical resources and close important gaps in healthcare between providers and patients.

Over the two-year grant period, the member organizations built a cross-sector, interdisciplinary, and integrated partnership that has begun to successfully address coordination of key health, community, and social services for residents to support their ability to make healthy life choices.

As AHBASS looks to implement sustainable options for continuing its initiatives, the partners are attempting to create long-lasting systemic change in their community.

APPENDIX A

ABOUT BUILD

BUILD seeks to contribute to the creation of a new norm in the U.S., one that puts multisector, community-driven partnerships at the center of health in order to reduce health disparities caused by system-based or social inequity.

Awardees include community based organizations, local health departments, and hospitals and health systems that developed partnerships to apply the BUILD principles.

To date, BUILD has supported 37 projects in 21 states and Washington, DC.

BUILD AWARDS

Eighteen community partnerships from across the country focused on a wide variety of upstream factors and became part of the first BUILD cohort of community awardees from 2015 to 2017.

Each community collaborative served as a pilot program to address root causes of disease (also commonly referred to as the social determinants of health) in their local area by leveraging multisector partnerships.

Seven implementation awardees received $250,000, technical assistance, and individual support over two years to strengthen existing partnerships, accelerate more advanced health data and analytics initiatives, and expand their impact. Eleven planning awardees received $75,000 and technical assistance to kick-start still-nascent projects addressing specific health challenges with a committed group of community partners. Ten of the planning awardees went on to receive implementation awards and funding to continue their efforts.

The partnering hospitals and health system(s) in each implementation award have also committed a 1:1 match with financial and in-kind support to advance the partnership's goals.

To learn more about BUILD, please visit buildhealthchallenge.org.

BUILD HEALTH CHALLENGE SITES

PORTLAND, OR

BUILDing Health and Equity in East Portland

Expanding access to affordable housing, green space, and healthy food

SEATTLE, WA

Seattle Chinatown-International District

Improving economic development, housing, and safety

DES MOINES, IA

Healthy Homes Des Moines

Reducing pediatric asthma through home improvements and education

OAKLAND, CA

San Pablo Area Revitalization Collaborative

Revitalizing local businesses and expanding affordable housing

ONTARIO, CA

The Healthy Ontario Initiative

Developing "health hubs" to foster strong bodies and communities

LOS ANGELES, CA

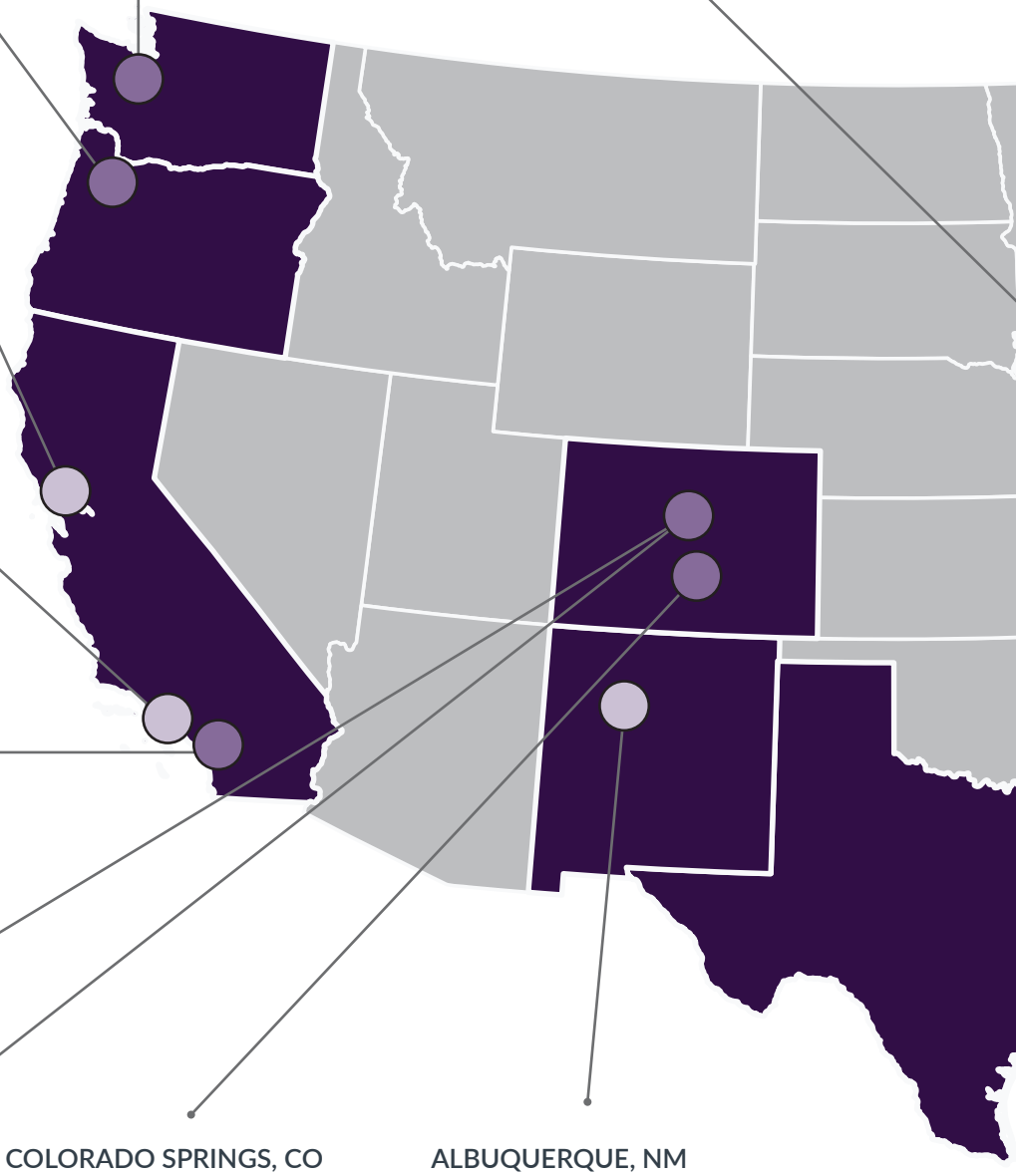
Youth-Driven Healthy South Los Angeles

Mobilizing youth ambassadors to advance community wellness

DENVER, CO

East5ide Unified

Creating safer, healthier communities for children



AURORA, CO

Increasing Access to Behavioral Health Screening and Support in Aurora

Eliminating health disparities by age five

COLORADO SPRINGS, CO

Project ACCESS

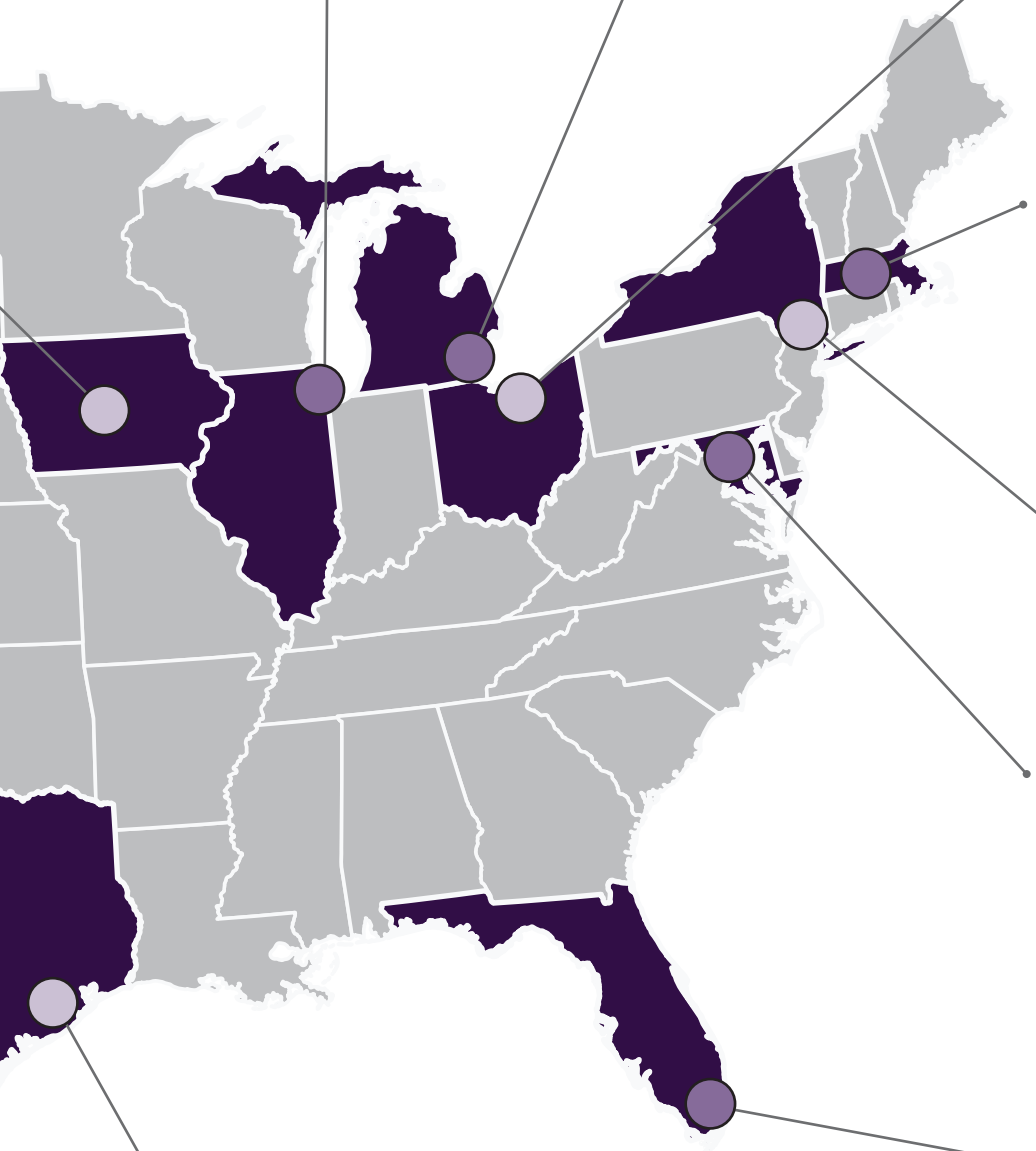
Preventing neighborhood violence by engaging community members

ALBUQUERQUE, NM

Addressing Healthcare's Blindside in Albuquerque's South Side

Pioneering data-driven approaches to wellness

18 community partnerships in 14 states



CHICAGO, IL

Health Forward/ Salud Adelante

Pursuing legal solutions to make communities less vulnerable

DETROIT, MI

Chandler Park Healthy Neighborhood Strategy

Restoring the heart of a community to improve public safety and education

CLEVELAND, OH

Engaging the Community in New Approaches to Healthy Housing

Remediating lead-poisoned housing stock

SPRINGFIELD, MA

Healthy Hill Initiative

Spurring economic development and public safety

BRONX, NY

The Brox Healthy Buildings Program

Retrofitting housing for sustainable health improvements

BALTIMORE, MD

Healing Together: Preventing Youth Violence in Upton/Druid Heights

Empowering youth leaders to stand against violence

PASADENA, TX

The Harris County BUILD Health Partnership

Mitigating food insecurity by redesigning the local food system

PLANNING AWARDEES

IMPLEMENTATION AWARDEES

LIBERTY CITY, FL

Building a Healthy and Resilient Liberty City

Breaking the cycle of violence at all ages

APPENDIX B

PARTNERSHIP AGREEMENTS & MOUS

Consortium for Older Adult Wellness

Clinic/Agency Agreement between the Consortium for Older Adult Wellness (COAW) and **Adelante Development Center, Inc.**
Regarding Referral Handling and Enrollment into the **National Diabetes Prevention Program** and **MyCD Series**, this includes the Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP), Tomando Control de su Salud (Spanish CDSMP), Programa de Manejo Personal de la Diabetes (Spanish DSMP), and others.

We, **Adelante Development Center, Inc.**, agree to the following:

- We understand that we will be coordinating referral and enrollment efforts with the **Consortium for Older Adult Wellness (COAW)**. COAW is a contractor to the State of New Mexico Department of Health for the purposes of the **Evidence Based Program Referral System (EBPRS).**

- We understand our referrals will be enrolled into the NDPP and/or MyCD series programs with suitable space complying with the Americans with Disabilities Act standards including access to restrooms and drinking water.

- We understand that our clinic/agency will refer to COAW for the enrollment of clients in the NDPP and/or the MyCD series throughout the area. We will address other interventions or curriculums in a separate agreement.

- We understand that we will assign a **contact person** to work directly with COAW on establishing all logistics and workflow for the processing of referrals and enrollments. We will provide email, secure email, phone, and fax access.

- We understand we will continue to actively process referrals to attend NDPP and MyCD. COAW staff will be available for technical assistance and support in this effort.

- We understand that all related data forms including attendance tracking, demographic forms and satisfaction surveys completed in the workshops and/or classes are collected by COAW for tracking in the **EBPRS**.

- We understand that we must maintain privacy and confidentiality of all protected health information (PHI) according to **HIPAA guidelines**.
  - We will share/transmit the minimum amount of protected health information to accomplish the referral, enrollment, and feedback loop.
  - COAW and Adelante will only use secure email or fax to communicate protected health information. If a phone conversation is required to clarify information, we will use landlines (vs. cell phones).
  - COAW will not contact Adelante clients without a written referral for the specific individual.

- COAW and Adelante will not leave messages for the referred individual without their prior approval.
- COAW maintains protected health information on a secure cloud-based server. Any necessary hard copies of information are in locked file cabinets. Records are shredded on a regularly scheduled basis.
- Information collected in the workshop or class series are handled appropriately such as transporting the forms inside a folder and a locked file, mailing the forms to a designated staff person in a non-transparent mailer, or faxing forms to a designated staff person.
- Workshop participant data is entered by COAW into the EBPRS as de-identified data. Reports produced will reflect aggregate data.

- ☐ We will transfer information as outlined on the COAW Referral Form via 1) fax, 2) secure email, or through the COAW website **as received**.

- ☐ We understand that the direct exporting of referrals from Adelante to COAW will be made via **csv files** sent via secure email. **No technology or programming costs will be incurred until approved by all parties.**

- ☐ We will send to COAW the patient/clients currently on the wait list for classes via **csv files** sent via secure email.

- ☐ We will inform the client/patient of **goal of the referral**. This is the preferred messaging: "We've shared your name and contact information with our approved partners, COAW. They will be in touch to answer all your questions and get you enrolled in the self-management/diabetes prevention program we discussed/your health provider discussed with you. You can expect their call within the next business day."

- ☐ We will provide the patient/client with COAW provided information **(toll free number 888-900-2629 and COAW contact name)** and the **expected timeframe for contact (end of the next business day)** following receipt of the referral.

- ☐ COAW will provide a single **referral contact person** for Adelante.

- ☐ COAW will provide a single referral contact person for the patient/client.

- ☐ COAW will **confirm receipt** of referral **as received** via HIPAA compliant communication. Confirmations that contain protected health information such as the name of the referred individual, address, phone number, etc. will be sent only via secure email or fax. A confirmation that only acknowledges receipt of the referral may be sent via email.

- ☐ COAW will contact the referred patient/client by the **end of the following business day**.

- ☐ COAW will provide **staff training** and support on making referrals to self-management programs at Adelante's request.

- ☐ COAW will assist Adelante prior to the referral if Adelante is uncertain of patient appropriateness.

- COAW will communicate with patients/clients who **"no-show"** to class after enrolling and advise Adelante.

- Adelante will notify referring providers on patient/clients who **decline** participation. Adelante will advise COAW how to proceed.

- COAW will attempt a minimum of **three phone contacts** for each referred patient/client. COAW will notify Adelante when there is "no contact achieved" and/or "no response". A voice mail message will not be left unless **approval to leave a message** is given as part of the referral.

- COAW will work with the State of New Mexico Department of Health, Program Coordinators, and partnering organizations to provide **options in class availability** according to patient/client needs including geographic location, time of class, curriculum, language, etc. For example, COAW will work toward setting workshops in underserved areas such as the International District and the South Valley, and in English and Spanish.

- COAW is available to speak with, or meet with, **referring providers**.

- COAW will **mention Adelante** and the referring provider when interacting with the patient/client.

- COAW will send timely reports to Adelante for forwarding to the referring provider to include workshop withdrawl, workshop completion, and results of workshop participation in csv format via secure email. **No technology or programming costs will be incurred until approved by all parties.**

- COAW will notify Adelante, for forwarding to the referring provider, of major interventions, emergency care, or hospitalizations made aware of during the conducting of the workshops.

- COAW will provide Adelante with useful and necessary education/guidelines/protocols, as needed.

- COAW and Adelante will inform patients/clients of **on-going community resources** in support of patient's self–management goals and may provide educational material and resources to patient.

- COAW will provide Adelante and the State of New Mexico Department of Health with **data** regarding referrals, enrollment, completion rate, patient/client feedback, and demographic summary on a quarterly basis or as determined.

- We understand that approved marketing materials will be supplied by the State of New Mexico Department of Health for our use. We agree to have any additional **recruitment and/or media** for our classes pre-approved by the State of New Mexico.

- We understand if we have any questions regarding the implementation of this referral and enrollment program, we are encouraged to contact COAW.

- Either party can terminate this agreement by providing thirty days written notice.

Consortium for Older Adult Wellness (COAW)
3222 S. Vance St., Suite 240
Lakewood, CO 80227
888-900-2629
303-984-1845

Maripat Gallas, Director of Implementation
Maripat@COAW.org Maripat@secure.COAW.org

Signed:

Lynnzy McIntosh, Executive Director _____ Date

Agency Representative _____ Date

APPENDIX C

SALESFORCE PRESENTATION

Adelante
DEVELOPMENT CENTER, Inc.

A diverse, connected non-profit
touching over **60,000** individuals
throughout New Mexico.

We support people with disabilities, the senior community, and individuals with disadvantages in discovering and implementing their personal life goals.

Adelante
DEVELOPMENT CENTER, Inc.

backinuse.com

The STOREHOUSE New Mexico
A Community Resource Fighting Hunger

Benefits Connection Center
Benefits Outreach & Enrollment Center

Adelante employ Ability

Healthy Here Wellness Referral Center

Adelante ENTERPRISES

Adelante Desert HARVEST
FOOD RESCUE PROGRAM

Adelante + Salesforce = *INTEGRATED GROWTH*

Silo-ed information now shared.

Expansion of Benefit Connections Call Center

The Connected Non Profit

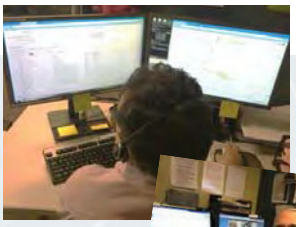
Adelante DEVELOPMENT CENTER, Inc.

salesforce

Related Data Points

- Chronic Diseases are a serious problem.
- 90% of wellness happens outside the doctor's office
- Non-drug approaches are superior to drug-based approaches for diabetes prevention.
- Physicians want to "close the loop".

Healthy Here Wellness Referral Center



REFERRING ENTITIES
Providers
Patient Care Facilitators
Medical Assistants
Community Health Workers

RESOURCES
Activities
Classes
Programs
locally grown

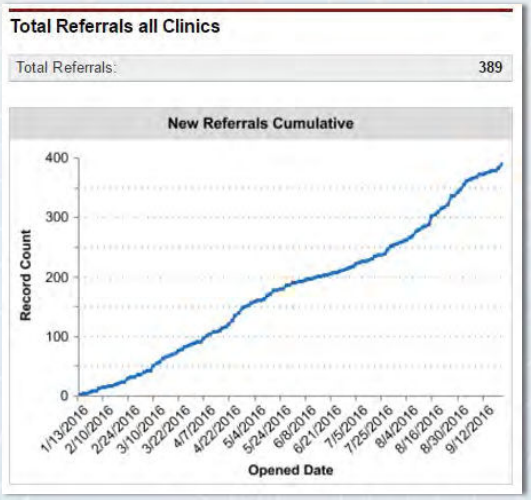
PARTICIPANTS
Chronic Disease
diagnosis: diabetes
hypertension, high
cholesterol, obesity

Healthy Here Mobile Farmers' Market

salesforce

Successful Pilot

- Multiple Clinics Participate, 1 -> 7, & expansion within clinics
- Resources - expanded, more Spanish classes, childcare, weekends
- Referral - over 400 Referrals as of October 1, 2016



salesforce

Running Medicine

"Kids watch mom and dad sweat," he said. **"And mom and dad watch kids sweat."**

"I'm a family doctor. This is the type of medicine I want to prescribe," he said, gesturing to the gathering group of runners and walkers.

Case Management

- Track referral by status
- Registration, rewards, unable to contact letters create
- Bulk SMS texting for class reminders (all communication in both Spanish and English)
- Track all calls with call notes
- Reporting back to "close the loop"

Rewards for Attendance

Gift Cards and Farmers' Market Vouchers for Completing a Program

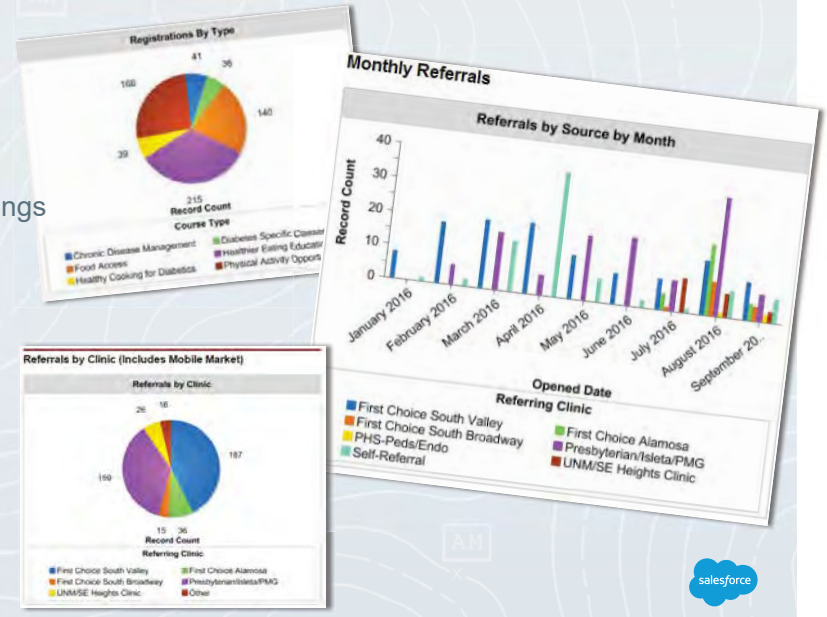
Quarterly drawings for Fitbits and Laptops

First Laptop Winner

First Fitbit Winner

Dashboards

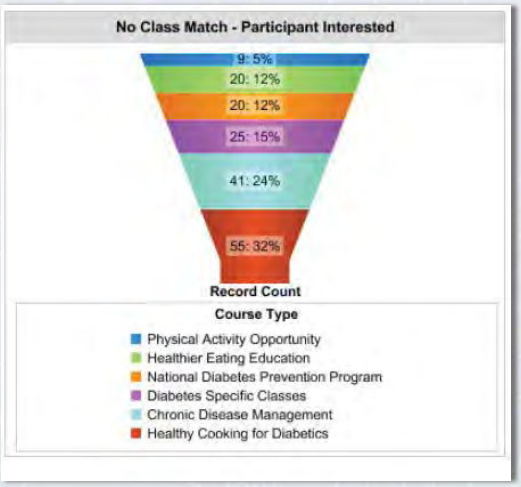
Aggregate Data for Partner Meetings



Outcomes

Systems and Behavior Change

- Clinic staff from diverse in size and design, incorporate new process in their already tight schedules
- Local resources changed locations, languages, times of week and times of day for programs
- Largest Fully Integrated Delivery Healthcare System in the state is now presenting the WRC to clinics outside of target areas



Next Steps

- Community Portals
- Expand outside of initial target areas
- Electronic medical record, the referring entities use different EMRs, EPIC, Cerner, eClinicalWorks

Thank you to Salesforce and DF16

And Hamilton Families for joining us.

Consulting Partners: Include SaasFocus in Idaho, RedPointCRM out of Albuquerque/Denver

Products: Non-Profit Success Pack, Apsona, Drawloop, ActionGrid, Rollup Helper, SMS Magic out of San Francisco and India

Funding Partners:

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APPENDIX D

WRC SUSTAINABILITY PLAN

Sustainability Plan
June 30, 2017

The Wellness Referral Center (WRC), an integrated chronic disease management referral system that links clinics to community resources in order to improve health outcomes, has been in operation since early 2016. There are currently 15 referring entities from four healthcare systems in addition to a group of referring Community Health Workers (CHW) through Presbyterian Healthcare Services. Since inception, as of June 30, 2017, the WRC has processed 1,400 referrals to 20 community resources including chronic disease management classes, healthy cooking classes, physical activity opportunities, and the Mobile Farmer's Market. Participants have earned 150 rewards, gift certificates, for participation. Three laptops and three Fitbits have been awarded as part of a quarterly drawing based on participation.

As the Wellness Referral Center looks toward continuous regeneration as a resource that works in conjunction with clinics and community resources to reduce chronic disease, several opportunities and challenges identified.

Figure 1: Presentation of laptop to Drawing Winner

1. Program Growth and Opportunities

Short and Long-term Goals

a. Expand target audience (e.g., developmental disabilities)

Adelante has been providing services to individuals with developmental disabilities for almost 40 years. Research from the CDC has concluded that individuals with developmental disabilities are more likely to experience chronic disease than people without disabilities, and are more likely to be overweight, smoke, and lead sedentary lifestyles. As a result, Adelante is in the initial phases of expanding Wellness Referral Center services to the developmentally disabled population. The Adelante Albuquerque Independent Living Program clients will be part of the pilot. Physicians for these individuals have been identified and community resources open to integrating their classes have been identified. Outreach to clinics is the next action step.

b. Expand and grow partnerships with other collaborators (e.g. Consortium for Older Adult Wellness or COAW)

In 2017, the Consortium for Older Adult Wellness (COAW) began coordinating referral and enrollment efforts for the MyCD and NDPP series programs. The COAW is a contractor to the State of New Mexico Department of Health for the purposes of the Evidence Based Program Referral System (EBPRS). This partnership was an effort to reduce duplication of services through coordination.

c. Continue inviting community input and engagement

Through monthly virtual huddles and ongoing technical assistance, clinic input and recommendations that result in improved service delivery will be an essential component to the success and sustainability of the program. If clinics and providers do not feel like the program is beneficial to patients, they will not refer them. A true partnership mentality is required to keep the program relevant to clinics.

d. Electronic Medical Record (EMR) expansion

Clinics have indicated interest in incorporating WRC activities into the EMR by having the medical records department attach one page PDFs of the referral status to the patient electronic medical record. To date, the two clinics, FCCH-South Valley and PMG-Isleta, have attached PDF files to patient EMRs. Based on feedback, this has greatly enhanced the experience for the providers as they could easily see the status of participation.

e. Data compilation

Cooking for Health, a healthy cooking class offered by the Agri-Cultura Network as a resource for WRC participants, collects evaluations from each participant. These evaluations have the potential to demonstrate the effectiveness of the program with regards to improved health and wellness. The more the WRC and the associated partners can demonstrate the value of the program, the more appealing the program is to the community, and to funders.

<u>Possible other areas of expansion that have been identified:</u>

a. Adelante Development Center has assumed management of the services provided by New Mexico Aids Services (NMAS) including implementation of the Positive MyCD classes that were coordinated through NMAS specifically for HIV patients. Adelante is negotiating a contract with DOH for the upcoming fiscal year.

b. Retired seniors through New Mexico Retiree Health Care Authority (NMRHCA): a newly hired Community Health Worker (CHW) with Presbyterian was introduced to the Wellness Referral Center with the potential to partner for referrals if funding is available.

c. UNM Medical School's Preventive Medicine Residency Program – meetings with the Associate Program Director, Dr. Olivia Hopkins, have been held to discuss potential partnerships involving residents.

d. Southwest Indian Polytechnic Institute (SIPI) – we are meeting with school leadership to discuss the opportunity for interns to gain experience through working as referral agents. This may also open the door to expanding reach to Native American populations.

Figure 2: referring patients to the WRC

2. Financial Sustainability

Through contributions from CDC REACH, Presbyterian Foundation, and BUILD Health, the WRC has been able to establish the program and expand. However, grant funding fluctuates, so finding alternate sources of revenue are essential to keep the resource operating sustainably. In an ongoing effort to ensure that the Wellness Referral Center has the ability to operate independently of CDC REACH funding, areas of supplemental funding are being explored.

The following funding sources have identified as potential financial sustainability measures:

a. Centers for Medicare and Medicaid Service
    i. January 2018: reimbursement begins for NDPP (National Diabetes Prevention Program) referrals
    ii. Investigate NDPP referral requirements and processes
    iii. Investigate NDPP training of certification of NDPP providers
    iv. Investigate NDPP for the Developmentally Disabled (DD) population
    v. Stay attuned to additional reimbursement for wellness referrals as CMS and others seek to lower costs
b. Non CMS referrals for wellness
    i. CMS often leads the way for private providers for reimbursements.
    ii. Investigate additional support for WRC services to reduce cost and improve outcomes
    iii. Meet with MCO operations and policy leaders to discuss possibilities of WRC referral payments

c. Other grants and sponsorships

d. DD Waiver clients – billable as part of an Individual Service Plan (ISP)
e. Referrers, other than MCOs, pay for WRC Services (for example, NMRHCA)
f. Establish data-driven Return on Investment

In order to navigate the health plan reimbursement system and determine opportunities, several meetings have either taken place or are in the works.

These meetings include:

1) Presbyterian Health Plan
2) CNM Medical Billing program
3) Blue Cross Blue Shield Health Plan
4) Conference – Diabetes Prevention in New Mexico: State Engagement Meeting

Other funding possibilities including grants and sponsorships are being solicited. Potential additional funders include:

1) Blue Cross Blue Shield of New Mexico
2) Con Alma Health Foundation
3) McCune Foundation

Figure 3: Fitbit Drawing Winner

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