Audio Transcript for "Harnessing the Power of Outreach and Enabling Services to Address Social Drivers of Health" Webinar from November 8, 2023

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https://drive.google.com/file/d/1EKY-8dTrDWdS6NJjth6fsc_ewp8a_jbN/view?usp=sharing

Flor Robertson (00:00:00):

Again, welcome. Thank you for joining us. And I'll go ahead and just give you all a brief overview on what this webinar is going to entail. We will be focusing on providing you information on how to screen special and vulnerable populations, and how to use that data to make change. By the end of this webinar, we hope that you'll be able to identify three new strategies for screening special and vulnerable populations, to also understand the value of [00:00:30] enabling services staff and their impact on clinical patient services as they collect SDOH data, as well as understanding the importance of using SDOH data collection in making sustainable changes among your communities.

(00:00:48):

So on the bottom of your screen, you will see the chat option as well as a Q&A option. Throughout the webinar, if at any point you have any questions or comments, feel free to either add them on the Q&A or on the chat. [00:01:00] We will have an opportunity for open discussion towards the end of the webinar. So if you want to go ahead and just write things down, do them along the way, whatever you prefer, we'll definitely have opportunity for both.

(00:01:18):

So on today's agenda, we're going to go ahead and get started with some introductions, a little bit of time to get to know each other, as well as providing you with an overview of SDOH data collection and the enabling services [00:01:30] staff role. Also, an overview of strategies for addressing SDOH at every level of the SOCIOECOLOGICAL model, as well as enabling services staff experiences through our panelists, our Q&A, and our closing activity and evaluation. With that being said, again, my name is Flor Robertson. I'm a Health Strategy Specialist with MHP Salud and I'll let my colleagues introduce themselves. I'll go ahead and get started with Deanna.

Deanna Canales (00:02:00):

Yes, hello everyone. My name is Deanna Canales, I use she, her pronouns. I'm a Project Manager here at Health Outreach Partners. And then I'm going to popcorn it to Gabrielle.

Gabrielle Peñaranda (00:02:11):

Thanks Deanna, and thank you Flor. My name is Gabrielle Peñaranda, I use she, her pronouns. I am Program Manager of Training and Technical Assistance at the Association of Asian Pacific Community Health Organizations. And I'll pass it over to Lauryn.

Lauryn Berner-Davis (00:02:26):

Hi everyone. I'm Lauryn Berner-Davis, she, her. I am the Director of Implementation [00:02:30] Research at the National Healthcare for the Homeless Council. I'll hand it back to Flor.

Flor Robertson (00:02:34):

Awesome. Thank you so much everyone. Again, you'll be seeing our faces periodically pop up as we do our different sections. But again, if at any point you have any comments or questions, feel free to add them on. So we decided to start with a little bit of an introduction to our organizations. As I mentioned before, I'm with MHP Salud. We are a HRSA-funded NTTAP, which is a National Training and Technical Assistance Partner, and [00:03:00] we've been able to provide training and technical assistance to federally-qualified health centers and other organizations looking to build or enhance Community Health Worker or CHW programs for over 35 years. Actually, we're celebrating our 40th anniversary this year, so we're very excited about that.

(00:03:20):

We are a national nonprofit organization that actually has CHW programs. These programs focus on providing peer health [00:03:30] education, increasing access to health resources, and bringing community members closer. Our mission is that we serve communities by embracing the strengths and experiences of individuals and families, engaging them to achieve health and wellbeing. Our vision is that we believe everyone deserves to live healthy and resilient lives within their communities. In fact, since 2017, we've connected with over [00:04:00] 200,000 individuals through outreach, and served more than 25,000 through our health outcome programs. With that said, I'll pass it on to Deanna.

Deanna Canales (00:04:12):

Yes, hello again. So for folks who may not be familiar with Health Outreach Partners, we are a national nonprofit organization based in Oakland, California, and we like to refer ourselves as Advocates of Outreach because we believe in the importance of serving our special and vulnerable populations and building relationships with them, as well as facilitating access to care. And we do this by providing training, consultation, and timely resources. And we serve community health centers, primary care organizations, and safety-net health organizations. Next slide, please. And if you'd like to learn more about us, you can visit us at outreach-partners.org and then I believe it is AAPCHO or Gabbie.

Gabrielle Peñaranda (00:05:02):

Thanks, Deanna. Hi everyone, it's wonderful to see so many beautiful faces and names, and names I recognize, here today. I'll tell you a little bit about AAPCHO or the Association of Asian Pacific Community Health Organizations. AAPCHO was formed in 1987 to create a national voice to advocate for the unique and diverse health needs of the AA and NHPI communities, and the community health providers that serve their needs. Next page.

(00:05:34):

AAPCHO is dedicated to promoting advocacy and collaboration and leadership that improves the health status and access of Asian Americans, or AAs, Native Hawaiians, NH, and Pacific Islanders, PIs within the United States, US territories, as well as the Freely Associated States. AAPCHO's focus areas are health equity and access, training and capacity building, as well as healthcare quality and innovation. Please visit our website to learn more about our members, our partners, and our work. And I will pass it to Lauryn.

Lauryn Berner-Davis (00:06:09):

Great, thank you so much. The National Healthcare for the Homeless Council is also an NTTAP, National Training and Technical Assistance Partner. But first and foremost, we are a membership organization founded by and for the healthcare for the homeless field. We are grounded in human rights and social justice with a mission to build an equitable high quality healthcare system through training, [00:06:30] research and advocacy in the movement to end homelessness. Next slide, please.

Deanna Canales (00:06:37):

And now we're going to provide a high level overview of what is SDOH data collection, and what role does the enabling services staff play in this data collection. Next slide, please. And so before we get exactly into what is SDOH data, we're going to start with a definition that has been provided to us by the Health and Human Services. So Social Determinants [00:07:00] of Health, also known as SDOH, are the conditions in the environment where people work, play and live that significantly impact their quality of life, health outcomes, and their risk of getting sick. And so with that in mind, there are five categories in this social determinants of health. Some folks already put it, and listed it, in their Mentimeters, but what are some other social determinants of health that we don't talk about as often? [00:07:30] So go ahead and put that in the chat, and I'll take about a minute to do this.

(00:07:40):

So I know folks were really saying, "Not having affordable housing." Another one was transportation. What are some other ones? I want to hear from you all. "Mental health and substance use," yes. "Education and employment." "Health literacy." "Access [00:08:00] to health insurance." "Mental health education," yes, and language. Ooh, that's an important one, "Mistrust in health systems as well." Okay, well keep it coming everyone, we like to hear from you all. And then Flor, if you can just click one more time. So all of those [00:08:30] Social Determinants of Health fall into those categories. For this data, we want to track those conditions to track those SDOH, because we want to see what's going on in the community.

(00:08:42):

And for folks who might be already familiar with it, but there are SDOH data tools to help collect that data. So we have PRAPARE, which is the protocol for responding to and assessing patient's assets, risk and experiences. We also have ICD-10 Z Code and Documentation of SDOH, [00:09:00] and the CMS Accountable Health Communities and Health-Related Social Needs Screening Tools. And those are all resources there, and we'll drop them in the chat or in the follow-up feedback. Next slide, please.

(00:09:13):

And so big question that folks might be asking, why is it so important to collect SDOH data? In order for us to achieve health equity, we do this by having data and data collection, because that data is going to provide a foundation on how to move forward. Also in [00:09:30] the Uniform Data System, the UDS data that was collected, in 2022, US Health Centers serve over 30 million patients. So that's a lot of people. And also not every patient is going to be the same. So we're not going to treat them the same way as well. So that's why it is crucial that we all recognize how important SDOH is on patient health. And when we start with proactive measures such as screening and having a very robust [00:10:00] data collection system, we're able to identify barriers to care and then we're going to be able to create change.

(00:10:06):

And now, in the next slide, we're going to talk about who might be the best person to collect this data. Go ahead, Flor. And that is enabling services staff. And so enabling services staff might include community health workers, case managers, outreach workers, and a lot more. And the reason why they're the perfect people for this job is because they work closely [00:10:30] with the patients, and they also assist patients with complex needs. So again, with what folks typed in the chat was homelessness, public housing sites, working with agricultural workers and their families. So those very complex needs. There was a study that was published in 2023 by NACHC, they saw that when enabling services staff were involved with patients, patients had the likelihood of [00:11:00] setting up for health insurance, having a routine checkup, and also having an overall satisfaction with care.

(00:11:08):

And so when we recognize the impact of enabling staff and outreach and community health, it's going to be very important for us to achieve lasting change. And then when we pair that with data collection, then we have the blueprint on moving the needle towards health equity. And now I'm going to pass it back to Flor.

Flor Robertson (00:11:27):

Awesome. Thank you so much Deanna, appreciate it. [00:11:30] There's also, of course, challenges to collecting this data among enabling services staff. And there's a lot of different factors that can go ahead and be taken in, whether it be things like language barriers or the distrust that I've seen mentioned a couple of times here in the comments. But some of the other challenges that we have that you can see maybe is the staff buy-in. Sometimes in order for you to collect accurate information, you need to explain to your staff why that information [00:12:00] is even needed. They need to understand the importance of capturing the SDOH

data. Saying, "Well, I forgot to fill in the form, but it's fine, I'll fill it in next time." Now we have a missed opportunity to gather that information. So the probability of completing something as simple as a PRAPARE questionnaire increases when everyone is on the same page.

(00:12:24):

If everyone understands the importance of collecting that data, then [00:12:30] you're going to see those numbers go up and you're going to see those completed questionnaires be a little bit more complete, more well-rounded. Obviously, you want to create that consistency and you want to have that understanding be at every level of your organization. Another thing that I've seen mentioned here in the comments is staffing. Having the appropriate staff, not just the numbers, but also the people that are selected to evaluate [00:13:00] the SDOH data is really important. Hiring the correct staff for the job is really important because it ensures that the individuals that are collecting this data have the appropriate skills and qualifications in place to help address these Social Determinants of Health. If you have someone from your community come in and say, "I'm having issues with getting enough food," or, "Transportation," or, "Housing," whichever it is, if the person who's filling out the questionnaire says, "Tough [00:13:30] luck, next." That's definitely going to create an issue. So you want to make sure that everyone that is collecting SDOH data understands its importance and what to do with that information in the first place.

(00:13:45):

Another thing to consider is the cultural appropriateness. Think about the language that your organization may be using or what is the questions within your SDOH surveys and how to make this culturally appropriate fitting [00:14:00] for your community. Of course, we have things like reimbursement issues. How can SDOH data even help address those reimbursement issues? How can we help address maybe if there's a gap in the resources available? And navigating and analyzing Social Determinant of Health data. When you have 100, 200, 300 SDOH questionnaires, it can be a little overwhelming and [00:14:30] intimidating to even start sorting through all of that data. But once you get there, this information is going to help you shed light on your community struggles. How are you going to address any gaps in resources or information if you haven't even gotten started in asking those questions? So for example, if food insecurity is a significant Social Determinant of Health for low-income communities. Whereas, access to transportation [00:15:00] may be more important for rural populations. So understanding the differences in those needs for your communities is very important.

(00:15:13):

Some of the other challenges can include things like the capacity to respond. Like we mentioned, there's some gaps in resources where you say, "Well, I have a huge need for housing and transportation resources, but there's just nowhere to go. I don't [00:15:30] have anywhere to refer people to." That's definitely a challenge and it can be discouraging and overwhelming, but even though building that capacity can be a little difficult, especially when you're limited in things like funding, it's always important to have the data to back you up when you do go ask for that funding, when you want to go ahead and pull community resources to help address these issues. And you can do these things by building partnerships, [00:16:00] whether it be with other organizations in your community, things like government funding, stuff of that nature.

And we can definitely do a whole webinar into that topic, but by discovering these mutual community partnerships, it can definitely help address any gaps that might be existing in your community.

Gabrielle Peñaranda (00:16:22):

We're going to continue talking about SDOH and building on this capacity, and it's really interesting to see a lot of the [00:16:30] commonalities with some of the challenges you all are facing within your health centers or your organization. So you've all identified one of these three aspects; people, processes, and technologies. So when it comes to building capacity to act on data and respond, there are some suggestions that come from the PRAPARE toolkit to help guide you in that direction. Essentially, you want to ask yourself [00:17:00] what happens after you screen and identify social needs? What can you do within your organization or what capacity do you have within your organization to address those needs? And a lot of you're asking those questions and we can tell because you're able to respond with your comments about the challenges, you know where you're at. So it's really great to see that you're all at this assessment stage or beyond.

(00:17:24):

But it does begin with an assessment of your organization's current capacity. So you could ask yourself, [00:17:30] what resources does your organization have available to focus on addressing the identified needs? And in what context do these resources exist? Are these needs internal to your organization or do they exist outside your organization, within your community, your city or your state? And if you consider the following resource categories, of people, processes and technologies, or consider the following categories when you assess your resources [00:18:00] within your organization. You all have already talked about staff time. Do you have the staff time, the people power, that can be dedicated to SDOH initiatives at your organization?

(00:18:13):

Maybe it's even just getting SDOH initiatives started up. It's not even about collecting data or responding to that data, it's really about getting staff buy-in, I think as somebody already mentioned, and building the internal organizational knowledge on what SDOH is. [00:18:30] And another people-aspect when it comes to resources and internal capacity is, are there specific roles, community health workers, et cetera, and other roles within your organization that are focused on addressing patients' social needs? If you don't have those, it is exceptionally challenging to want to ask your staff to build in this really important responsibility of thinking about SDOH and working on SDOH when they have all of their other responsibilities [00:19:00] going on. And that's part of the reason why we've focused on CHWs and their role to address SDOH and act on it in this webinar.

(00:19:09):

Another element to consider when it comes to internal capacity and building internal capacity are processes. So you could ask yourself, do you have the referral workflows in place for connecting patients with resources to address their social determinant or social driver needs? That's certainly a tough question. [00:19:30] I know a common challenge that organizations and

health centers are experiencing is, how do they close the loop? You may be advancing in your SDOH data collection, but are actually maybe a little bit stuck on how to refer patients to CBOs. But also how to make sure that they've reached out to the CBOs, and you can confirm that they have made the connection and got the resources and services that they need.

(00:19:59):

Additionally, in terms [00:20:00] of processes, you might ask yourself if you've formed partnerships with external organizations. It seemed like food insecurity was a common challenge that you all are facing. So are there local food banks that are overlapping or also seeing, and hearing from the population that they serve, that there is a need that maybe they can't serve or maybe that they have the resources, and they just need to hear more about what specific [00:20:30] services that they should provide. It would be a great opportunity for health centers to connect with those external organizations.

(00:20:39):

And finally, technology. So I know with the health centers here who are submitting to UDS, I think a big question that AAPCHO is definitely interested in is whether you are ready, whether you're ready to submit UDS+ data and patient-level data, especially disaggregated racial and ethnic language [00:21:00] data, because a lot of organizations, a lot of health centers, their EHR is not ready to support or systematize disaggregated data collection. So you could be absolutely ready for that mission to collect disaggregated data, or disaggregated SDOH data, but if you're not in sync with your EHR, or your EHR has the same [00:21:30] priorities to collect that within their system, then that's incredibly challenging for sure.

(00:21:36):

And finally, if you have this data, if you have the processes, are you able to share data with external organizations? So that connects to what Lauryn is going to talk about in the next section is, how do you share that data that you've collected, that you have the staff to collect, that you have the processes to collect in a way that protects obviously patient safety, but in a way that you can share enough [00:22:00] information with the other community organizations that could meet your patients' needs? Let's go to the next slide.

(00:22:10):

So this is another helpful tool or graphic that comes from the PRAPARE toolkit. It's from chapter eight, and it's just a matrix of both the organizational resources as well as local community resources and how to navigate your organization within that matrix. So after you assess your own resources, [00:22:30] it's important to determine what resources exist in your community. So analyzing your setting in terms of what type and what extent of resources are in your organization and in your community, will give you a sense of how to bolster your internal capacity to address the SDOH needs of your patients. So it's really, building internal capacity, is kind of a two-step process. It's both building the people, the processes and the technology aspects, but it is [00:23:00] also looking out into the community to assess how you can connect to external organizations.

(00:23:09):

So here, the vertical axis represents your organization's internal resources. And the horizontal axis represents the amount of resources that are in your community. So for example, if you identify that your organization has few or fewer resources to respond to your SDOH data and that your community has limited resources to address your patients' [00:23:30] needs, the bottom left quadrant might offer a good starting point for you to build that internal capacity. So in this case where you have a few internal as well as few external resources, you can build capacity by raising awareness, to strengthen staff buy-in, as well as patients' knowledge and partner knowledge as social drivers of health. Each quadrant also offers very specific suggestions on how to build capacity for each of those aspects, people, processes, and technology [00:24:00] categories. So take a look at this tool.

(00:24:03):

But if we move directly up along the organizational resources axis, those who locate themselves in the top left quadrant will have more internal resources, but local resources are still going to be potentially scarce or limited. This puts you in a good position to potentially create in-house services. So if you have staff time, resources for sure, financial resources, or you have highly effective processes or [00:24:30] workflows, you can develop services internally that meet your patients' needs. And if community resources do spring up, then it's great to build on each other's already established programs. But if you have the internal resources, this is a great way to get involved in the SDOH mission.

(00:24:53):

You also might find yourself in the reverse position where your community has an abundance of resources, but your organization's internal [00:25:00] resources are still developing. So if you find yourself in the bottom right quadrant, you'll find that partnering with community-based organizations or community leaders can help you act on SDOH data even though your internal capacity is still growing. This could even, maybe it doesn't mean anything specifically formal in terms of program development, but even just reaching out to community leaders that you've identified or that your patient population [00:25:30] has identified and hearing what they have to say about what the community needs, is a great way to harness the external resources if your internal resources are still limited.

(00:25:44):

And finally, for those organizations who both have many internal resources and many external community resources, you can still do more and strengthen your capacity to act on SDOH data. This is a really great position for organizations or health [00:26:00] centers to engage policy and advocacy using the data that they've already collected, using the data that their partners have collected, as well as the stories that they're hearing from the community in the work that they're doing.

(00:26:16):

So it's important to locate yourself somewhere between these four quadrants. And it doesn't mean that even if you locate yourself maybe in the bottom right, low community resources and low internal resources, that [00:26:30] that's going to be the same for every SDOH that you've identified. It might be the case that your health center has a robust response to food insecurity both internally and externally, but is being challenged in addressing SDOH, like transportation,

and that totally makes sense. In the end, it's important to still look back and assess these three categories for every SDOH that your [00:27:00] health center is aiming to address. So let's go to the next slide. Thank you.

(00:27:09):

So just a few key takeaways when it comes to building internal capacity. So the first one we'll focus on is just start with the data. What social risk factors are you seeing as the most prevalent when you screen your patient populations? If there is a handful, which it seems like it was the case based on the responses from [00:27:30] the several organizations here, identify what resources are already available both internally or externally to address those needs. Additionally, you can identify strategic opportunities. Are there already well-resourced partners, external and in your community, who are looking to serve your patient population but don't have the relationships that your health center has already served, or the point of access to your patients? This is the good opportunity for a partnership.

(00:27:59):

Third, [00:28:00] let the needs of your population guide you, of course. It's really important to listen both to the data, but also just listen to your patients as the people in the chat have really and thoroughly expressed, listen to not just the data, but also the stories and the qualitative data that you're getting just from listening to patients and their families regardless of your role in the health center.

(00:28:26):

And finally, go where the resources are. [00:28:30] I remember in the Mentimeter there were some challenges when it came to rural transportation and rural health services in general. So if you're in a rural area or you're in a small town where resources are scarce, consider reaching out a little bit farther to the next closest large city and see if they'd be willing to partner with you and your organization to serve your community's needs. Although, I do recognize that that also poses [00:29:00] a challenge to patients and their capacity to access those if you're already in a rural area, if they would have to go to the next big city to meet their needs. Let's go to the next slide.

(00:29:16):

So it's a very complex problem, no one really thought it was simple. It's certainly very complex. Here are just a couple of resources that we'll share with you in the chat. The first one is the PRAPARE toolkit. [00:29:30] We shared a little bit about PRAPARE. PRAPARE's the protocol for responding to and assessing patients. Assets and risks and experiences, the social risk screening tool. You can also learn about enabling services in AAPCHO's Enabling Services Accountability Project. And it's a standardized codification system to document enabling services provided. The EDS toolkit and past trainings were developed by AAPCHO, HOP, National [00:30:00] Healthcare for the Homeless Council. With that, I'll thank you all and pass it over to Lauryn.

Lauryn Berner-Davis (00:30:07):

Thanks Gabbie. I'm just going to take a couple of minutes to talk a bit more about partnerships and building external capacity. We know that you all are incredible, health center staff are so

creative, but also have so much on your plate, and we don't have to do it all ourselves. So when you're thinking about who to partner with, as Gabbie mentioned, [00:30:30] looking at what the needs are and what that handful of things that you might be able to start addressing look like. And so starting with the screening and identifying needs and gaps. And then again, flex your creative muscle about who may be doing that type of work and what skills might be needed to do that, and who may have those skills or relationships.

(00:30:51):

A lot of folks mentioned housing as a need, and we know that there is not enough affordable housing anywhere in the country. But a starting [00:31:00] place might be looking at finding someone from your team who might be interested in sitting on your local continuum of care, which distributes the housing funds and helps place individuals into housing or connect them with subsidies, and maybe working with housing providers specifically to provide support services for folks in their units and helping think through about how you can maintain stability for folks who may be unstably-housed.

(00:31:30):

[00:31:30] We've also seen a lot of success addressing food insecurity through things like partnerships with farmer's markets. So hosting markets in areas that don't have access to healthy foods or grocery stores, food deserts, and providing extra benefits for those who are using SNAP. So maybe $10 in SNAP benefits purchase $20 in healthy food at the farmer's market, or distributing leftover produce after the market has closed, which helps reduce [00:32:00] food waste and also meeting the needs of the community, or creating community gardens as a way to provide healthy food and have some control over the types of food that are available. We also talked with a nurse who just volunteered with a local shelter and soup kitchen, and one of the recommendations that she had when she was working with them was, can we just rearrange the food and put the salad up front so that all of the healthy food and vegetables were the things that folks filled up their plate with [00:32:30] first? And then moved on to some of the things that were maybe a little bit more carb or salt-heavy.

(00:32:36):

And also just asking specifically for healthy options. So if folks are making donations and you see a lot of cakes or pastas, or you see a lot of pastries, I know is a very popular donation item, but asking specifically for things that are more nutritious to [00:33:00] be provided. Transportation came up in our conversation, and it's always a challenge. We did hear from one health center that was located in a smaller jurisdiction that they were able to work with their city council and work with their county to advocate and add a new bus route. They found that there wasn't a bus stop that connected their clinic and many of the other services that were available [00:33:30] in one neighborhood to the place that most of their folks were living and staying and spending most of their time. So they were able to work with the city to reroute some of those buses or create a new bus line that made things more accessible.

(00:33:44):

Other folks are using rideshare programs, and we know that Medicaid and Medicare may have transportation assistance options, but also look at some of your local organizations around you. Are there others that may have transportation [00:34:00] vouchers or is there, if it's summer,

what are the school buses doing? Can you work with the department of education in your area to get some of that? Or church buses that are sitting in a parking lot right now. So getting creative with some of those solutions is an option. And then when we're thinking about safety, working with community development organizations, this can really help to provide safe options for folks in the community, start to replenish resources. [00:34:30] Working with them to identify areas that might need some additional lighting or improvements to infrastructure. And again, working with the city planning office to improve some of those physical conditions in your neighborhoods.

(00:34:44):

And then partnering with the justice system. One of the things that we see in the area of homelessness is that small interactions really do have a huge impact. So I live in Tennessee, and camping on public property after a certain time is a felony. [00:35:00] Before that time, it's a misdemeanor. So things like that can really make a huge impact for somebody who is trying to access work, trying to access housing, or having tickets for loitering that go unpaid, causing larger issues. So working with your local legal aid, working with the police department and advocating that they help create some diversion programs, or creating some medical legal partnerships in your community, can really make bigger changes down the line. And there are health centers that we know [00:35:30] of in places like Denver and Albuquerque that are doing a lot of really incredible work in these areas. Next slide, please.

(00:35:41):

And I know I've used the word creative a lot, but the work that our folks do every day in trying to meet people where they are and meet their needs is really creative work. And so thinking about how that applies to how your partnerships look. So you're probably [00:36:00] already referring folks and connecting folks to the known resources in your community. But thinking about how you can strengthen those relationships, and talking with them about ways that you can have follow-up, like Gabbie mentioned, how can we find ways to know if people actually made that connection? If folks aren't comfortable, we saw some of your responses about people don't really want to ask for help or they're not comfortable asking for help, coming up with a list of resources or having a brochure [00:36:30] in the library where they can find help that they could maybe, or library, lobby, but also the library, they could grab inconspicuously if you find that people are concerned with that stigma. So you can just grab this paper with all of your other paperwork on the way out the door.

(00:36:47):

And then there's also opportunities to continue that communication and build work out. And so how can you reduce some of that burden by having these conversations with multiple agencies [00:37:00] that are working with the same individual? So if this person is working with an outreach worker or a community health worker in the health center, but they also have a case manager with this organization and a housing navigator with this organization, how can we try to bridge that gap? Maybe you work with their case manager to help document disability, which is required for accessing housing, and they can help provide transportation so that this person can get to their healthcare appointments. Obviously, this type of collaboration does require

[00:37:30] consent from the patient, but really taking integrated care to the next level, and thinking about what it looks like to integrate social services into your practice.

(00:37:39):

And then some cases, you may even be able to offer your services in the same space. Is there a room in your health center that could be an office for someone at a partner agency once or twice a week? Having someone come in who could do an assessment for housing or someone who could come help assist with benefits. And can your health [00:38:00] center provide mobile clinic or street medicine or popup services at a prominent service site in your community? And really thinking about what it looks like to go out to where people already are. And then there's this kind of high level full service or integration where you're taking that care coordination piece and offering services ideally in the same space, having a care team that is multi-agency, multi-sector.

(00:38:29):

When we were talking about [00:38:30] what this could look like, someone once mentioned that our ideal partnerships and our intentional partnerships often look kind of wheel and spoke where there's a person in the middle and they connect to this person who connects to this person, who connects to this person, and then they are connecting with each other. But ideally, we want that partnership to be so seamless that someone who is moving through these relationships and working within these different organizations, don't necessarily know who is employed by which organization and [00:39:00] where one service starts and another ends. But it is so intertwined that it feels more like a plate of spaghetti. And so I leave you with the image of spaghetti and I hope that you have all had the opportunity to have a lovely lunch today. But at this point, I'm going to hand it back over to Deanna so we can talk more with our panel.

Deanna Canales (00:39:21):

Thank you so much, Lauryn, now I'm hungry. But I want to present our panelists, our lovely panelists. So we have [00:39:30] David Li, who is the Social Impact and Policy Officer at the Chinese American Service League. We also have Monica Calderon, who is a Resource Specialist at MHP Salud. And then we have Melisa Laelan, who is the Chief Executive Officer and Founder of the Arkansas Coalition of Marshallese. Next slide, please.

Gabrielle Peñaranda (00:39:52):

Thank you, Deanna. I'm very excited to introduce David Li, Social and Impact Policy Officer at the Chinese American Service [00:40:00] League, or CASL, a community-based social services organization located in Chicago's Chinatown neighborhood. David is a licensed social worker who serves as, I did already say that, the Social Impact and Policy Officer at CASL. CASL has served immigrant and minority communities for over 40 years by offering high quality programming and childcare, eldercare, housing, financial assistance, benefits acquisition, career coaching, behavioral healthcare, [00:40:30] and legal assistance. David's role is to leverage data to better understand and respond to the unique needs impacting Asian American, Native Hawaiian and Pacific Islander, AA and NHPI communities on a local, state and national scale. This includes implementing and developing more targeted interventions aimed at eliminating

health disparities in these communities. Let's give an emoji round of applause and welcome, David.

David Li (00:40:55):

Hi everyone. I was like, oh, okay. Well after the exercise in silence, [00:41:00] thank you Gabbie for the wonderful introduction. Super happy to be with all of you today. As Gabbie has mentioned, I am the Social Impact and Policy Officer at CASL. We have nearly 30 different programs, serve about 6,000 clients a year. Services range from childcare to eldercare and everything in between. We have a little over 600 employed staff [00:41:30] members. A little bit about my background. I'm not an administrator by trade. Most of my experience is clinical, but I use that to inform a lot of the health equity strategies that we have at CASL. Next slide, please.

(00:41:49):

So in terms of Social Determinants of Health at CASL, we offer a lot of services, but what's the story that brings clients in from the community at large? That [00:42:00] is the question we're trying to get at. So starting with this, why SDOH? Here we have a couple of our deliverables and reports. As data nerds, we love to find different trends, explore gaps, and then find ways to actively bridge those gaps. And then in terms of who cares? Community organizations like us do care, not only because of our program services, [00:42:30] but also because of the impact that it has on the broader community. I heard at a TED Talk from Luvvie Ajayi Jones, I'm probably butchering that, that everyone's wellbeing is community business. And so that is something that we strive to emphasize. The fact that health disparities not only for the AA and NHPI communities are preventable, [00:43:00] they're solvable, and there are root causes of inequities that we can readily address with 30 plus programs.

(00:43:09):

So what matters is that SDOH is not the destination. It's an ends to a mean. Excuse me, a means to an end. And so in terms of the people that we serve, collecting SDOH data is more so about [00:43:30] understanding that individual's story, and then pulling that together in creating active spaces for participation and change. We do use PRAPARE. We're currently in the second year of using it. In terms of tracking data, we use Salesforce, similar to the capacity as many of y'all might use in EHR. And so just in terms [00:44:00] of why now? We have the capacity for data, but administrating it is something a bit tricky. For instance, if we don't serve a lot of clients who identify as migrants, what do we do with that question? Or what is it that we actually want to know within the community if we don't say offer a particular service or program? [00:44:30] Next slide, please.

(00:44:33):

So what we use Social Determinants of Health for is essentially a referral system. So in terms of how referrals went at CASL prior to having or collecting SDOH data, it was basically a free-for-all. So it was essentially, I know Deanna, or I know Lauryn, [00:45:00] or I know Monica or Melisa, Gabbie, and based off of that relationship, word-of-mouth. That led to a lot of inconsistency, because if I didn't know another staff person, the client would not know that there are 30 different programs that could potentially meet one of their needs. So a lot of client and patient needs got missed, [00:45:30] and that represented an area of improvement for us. So staff using

discretion for complex needs, we didn't have anything that was standardized. Now, the client gets to choose how they receive care. It doesn't rely solely on staff discretion.

(00:45:50):

And then, since we do manage our data through Salesforce, we can actually track the referrals, how long it took, [00:46:00] and then increase collaboration between departments. Some clients might not have known we have a welcoming center, or we have legal services. We have about 400 home care aides who often just see that one client, or have a limited client base. So we're still currently in the early phases of collecting social drivers [00:46:30] of health information at CASL, but as we like to say, we're building this plane as we fly it, or flying this plane as we build it, I'm not entirely sure how that saying goes, but essentially all of it is iterative. And so, we're learning as we go. Just as much as we're learning about our clients by collecting SDOH data. Next [00:47:00] slide, please. And if any of you have any questions, please feel free to keep in touch. This is my contact information, otherwise you can also visit caslservice.org.

Flor Robertson (00:47:16):

Awesome. Thank you so much, David. As a reminder, I know some of the participants were asking, this webinar is obviously being recorded, so that will be shared. You'll have access to all this wonderful information [00:47:30] that David has shared, and of course our other two panelists will share. So you will have an opportunity to go ahead and hear that out again, and obviously you have the contact information here available. Thanks again, David. Awesome job, appreciate it.

(00:47:45):

And with that said, it's my pleasure to introduce my colleague Monica Calderon. She's a Resource Specialist with MHP Salud, and she's also a certified community health worker and a certified community health worker instructor in the state of Texas, with [00:48:00] eight years of CHW experience working with state and nonprofit organizations ranging from early childhood education, prenatal health, aging and disability services and migrant health. Currently, she develops culturally and linguistically-appropriate resources that support the CHW workforce, CHW program development and implementation in areas that relate to public health and minority health. She also develops [00:48:30] and facilitates educational sessions, provides training and consultation to other CHWs as well as to other organizations in the areas of migrant health. She has worked within our strengthening aging services for older Hispanic adults as well as other programs within MHP Salud.

(00:48:55):

And prior to her joining our team here at MHP Salud, she worked [00:49:00] as an Outreach Coordinator and CHW for a global nonprofit health organization in which she engaged in national, state and international projects geared to reduce health disparities along border communities. She has a bachelor's degree at the University of Rio Grande Valley and multidisciplinary studies with minors in psychology, sociology, and rehabilitation. And she's located remotely in Laredo, Texas. So big round of applause. [00:49:30] Welcome, Monica. I will go ahead and pass it on to you.

Monica Calderon (00:49:33):

Hello everyone, and thank you so much for that introduction. I'm always excited to be able to share some of those experiences because I strongly believe that as community health workers applying those CHW-lived experiences, definitely make strong impacts in the communities that we serve. And also, provide us that opportunity to be able to [00:50:00] learn more on the focus that we're doing. So with that being said, in thinking of how community health workers connect and why we are a key aspect of the work that is being done in addressing Social Determinants of Health, we look at applying CHW-lived experiences. When we think of applying CHW-lived experiences, we want to [00:50:30] think of, well, how is it that we can help support community health work, address Social Determinants of Health, health disparities and impact health outcomes? Community health workers are uniquely positioned in their role to help implement culturally competent health promotion and prevention programs. So we're the boots-on-the-ground, we're the grassroots approach of community health work.

(00:50:59):

And [00:51:00] as an individual that has had the opportunity to serve our community, I feel that in expressing how CHW can, the CHW role, excuse me, can be used in the health center and in diverse communities. We can definitely recognize that the intimate knowledge of the community and the shared identities of race, ethnicity, maybe education, socioeconomic status and other [00:51:30] areas definitely help us make those connections with our communities, improving access to care, helping us identify problems, and further contributing to addressing the health disparities that are a part of our communities. So we act as a bridge between the community and the healthcare systems, which is the goal of helping reduce and address Social Determinants of Health. [00:52:00] And as a community health worker, we think of how we can use and position ourselves in a strategic way to help improve those health outcomes. And that's something that we invite health centers to embrace and to explore and to support and think of how you can utilize a CHW role to help increase access to care and address SDOH. [00:52:30] Next slide, please.

(00:52:38):

And so, one of the opportunities that MHP had was providing support through a national virtual platform during the COVID-19 pandemic in helping CHWs connect. And so we offered a support group, a nationwide [00:53:00] support group, with the efforts to one, create a space for CHWs to be able to connect, to learn about what were some of those challenges, what were some of those areas that CHWs needed help in addressing SDOH within their communities, and also other emerging health issues relating to COVID-19. And we found that a lot of those support systems that CHWs were needing [00:53:30] in addressing SDOH were access to sufficient training for CHWs, becoming knowledgeable of what tools they were using out in the community, or they were, as many of you expressed through the chat, having culturally sensitive opportunities or resources that could help them communicate and connect their communities to the needs.

(00:53:57):

So I know it was mentioned, [00:54:00] finding a crucial part within the health system and the community system that could connect and interweave that experience for patients or communities, definitely involves a role of a CHW or an individual that helps support that transition. And so providing them with adequate supervision and proper integration to clinical teams [00:54:30] and helping them support throughout the whole development of being and identifying where they stand with support in being able to address all these needs, can definitely make a difference. So we were able to take away a lot of that information, provide training throughout the time that we had an opportunity to connect with CHWs nationwide, by providing them on community resilience training, mental health per state information, [00:55:00] and also linking them to state and local resources that would help support them in their professional development as well as informing them of any other additional resources that were there for supporting their community work.

(00:55:18):

And so that was a really great opportunity to learn and hear the voices of community health workers, and how we could give back and provide some of that support that they were seeking or connect them to the adequate [00:55:30] organizations that could help them within their cities or their states. And so just in sharing, thinking about how those things can be tied in to our actual organizations, using that reflecting or assessing process of how we can better support the CHWs that are situated within our clinical teams or organizations can definitely make a big difference in those outcomes. Next slide, please.

(00:56:00):

[00:56:00] One of the other things that is very important in addressing Social Determinants of Health or other areas of health education is using tools that are also developed by CHWs, incorporating the voice of a CHW or having them voice what is working well for them. In here, I'm able to share some of the CHW tools [00:56:30] that we've had an opportunity to develop, the service dual learning tools. They help the community health worker be able to explain, for example, chronic disease management, preventive health, in plain language, and in addition, it serves as a resource tool for the clients or the patients that the CHWs are working. So integrating, again, those lived experiences, that cultural expertise [00:57:00] that they bring from their community or the voice that they're able to tune in, in developing resources or assessing what is working for the health systems is a crucial part in helping them connect the content of what they're trying to promote or support the community and engaging in. So those practices are also very beneficial and helpful in supporting [00:57:30] the educational tools that CHWs are given.

(00:57:35):

And so these are resources that we also have available in our website that we'll be sharing at the end, but we invite you, we always are welcoming feedback. Also, anything that you feel that you might need guidance, we have a lot of resources for CHW programs, so you don't have to reinvent the wheel. There is a lot of thought that goes into [00:58:00] assessing those needs that are important to our communities, and then bringing back, the voice of the community health worker, and implementing it in tool development. Next slide, please.

(00:58:15):

Another way that CHWs are supported within the different health systems and experiences in their community work is again, having them have a platform or a way to voice [00:58:30] best strategies and practices and identifying barriers and emerging health needs. So this is another tool or area that MHP gets involved in supporting the CHW voice. In supporting this, we produce CHW voice focused blogs and newsletters. Again, assessing the needs that are actually going on within the diverse communities that we engage [00:59:00] in. And even when we have opportunities like this, we definitely take into account all the feedback that is placed within the chat box where the questions that are voiced, and we utilize them to help implement and plug in the CHW approach or voice. Recognizing that, in doing so, we again support the role of CHWs within their communities.

(00:59:27):

So other specific areas that CHWs [00:59:30] definitely are always wanting to learn more on and learn about those strategies and turn back and be able to connect their strategies and addressing their local barriers or areas of need within their communities are areas such as substance abuse and addictions, mental health, trauma response, or other chronic emerging health issues or reduction to harm. Those are some areas that [01:00:00] also have been identified. And again, we use some of these areas that have been identified and integrate them into resources that definitely can connect to the CHW, and in turn, be able to be used for community support. Next slide, please.

(01:00:21):

Okay. And so here we have another [01:00:30] one of our tools. And one of the reasons that I am focusing a lot on the CHW preventive tools and viewpoint and integration of the voice of the CHW tool development is, again, to make that connection. And we thinking of ways how we're going to address social development. I'm sorry, HDOH. We want to think about how it could be easily understood. We were talking [01:01:00] about earlier, as I was listening to the presenters, on data collection tools and how that was being used or analyzed to support in determining or analyzing the outcomes of SDOH and how we were working on strategizing to improve it or make a difference. So we want to think about how the tools that we're providing our teams for CHWs, again, are culturally appropriate, [01:01:30] user-friendly, not only for the CHW, but for the communities that we serve.

(01:01:35):

So again, I invite you to explore a lot of these CHW-centered tools that can be used by the communities, and also, again, serve as an educational component for the individuals that we serve. And so thank you so much for allowing me to share this information. I'm also open for questions. I know they're going [01:02:00] to be addressing us at some point, so I thank you very much. I hope that I'm able to support and provide additional information as we go forward in this presentation. So thank you so much.

Flor Robertson (01:02:14):

Thank you so much, Monica. I really appreciate your presentation. Everyone, you're more than welcome to go ahead and pop any comments or questions in our Q&A or in the chat box. Like I

said, we will have time for a discussion at the end, [01:02:30] but without further ado, I'll go ahead and let Gabbie present our next presenter.

Gabrielle Peñaranda (01:02:36):

All right, thank you everyone. Thank you Monica for your presentation. I'm very excited to introduce Melisa Laelan, she is the Chief Executive Officer and Founder of the Arkansas Coalition of Marshallese, a nonprofit organization based in Springdale, Arkansas. That is a Marshallese-operated organization that focuses on health, [01:03:00] leadership, education and culture. Her daily work puts her in the middle of social services and policy advocacy, especially around Marshallese issues. Her leadership has led to recent changes in state laws. In 2018, Governor Hutchinson signed a resolution that allows Marshallese children to have access to the state Medicaid program. Her latest policy work has led to the passing of bill HB 1488 and HB 1789, [01:03:30] both bills that give Marshallese mothers and children protection against human trafficking and adoption schemes. Her advocacy work has also led to victory in a 25-year battle to restore COFA Medicaid, extending the Medicaid program to over 56,000 COFA migrants living in the United States. That's compacted re-association. Melisa is a native of the Marshall Islands, born and raised in the capital city of Maduro. Melisa, the mic is all [01:04:00] yours.

Melisa Laelan (01:04:04):

Thank you, Gabrielle. I'm just going to go right into what our organization does and really just want to share with everyone some best practices and how we're connected to our local providers, particularly the community clinic as well as the Arkansas Department of Health. But over the years, and I think someone had mentioned [01:04:30] the need to prioritize the needs of the community, and I think that's the main driver for the work that we're doing at Arkansas Coalition of Marshallese. We really want to identify those specific needs that are very important, impactful to the lives of the Marshallese that live in Arkansas, and then find solution for them. So our mission is really to empower the community through a culturally sensitive approach to education, leadership policy and holistic services.

(01:04:59):

And [01:05:00] what do we mean by holistic services? Is really not to just give community members the map to do things, but give them the map and also run through the maps and guide them throughout, because there are a lot of things, a lot of components, those social determinant that make things kind of difficult to access resources, particularly around language access. Some of our community members, [01:05:30] second language is English, so they're not fluent in the language. So it's very important for us to address those needs as well. Can we go to the next slide?

(01:05:45):

So let me give a little bit of background of how the Marshallese migrated to Arkansas and why Arkansas? So right after the World War II, leading up to the Cold War, the US military actually had identified [01:06:00] the Marshall Islands as the perfect location for the testing of their nuclear weapons. So from the year of 1946 to 1956, which is about 12 years, the islands were used as the ground for nuclear weapons, including thermonuclear weapons. One was detonated

on the island of Bikini, and that [01:06:30] one had the strength of 1000 times of what was dropped on Hiroshima. So to this day, not a lot of people still they're aware of that particular bomb that was donated there, but what that caused, that caused a lot of displacement as well as this disruption in their social lives and their livings.

(01:06:55):

So when we created, and we really wanted to work on this organization, [01:07:00] and having those conversations with the community and asking, "What do you need?" One of the responses was, "We need y'all to really provide a hub, a resource center, for our people." So that's how this organization came about. And our vision is really to create a thriving community through initiatives that are designed to empower and uplift the community. Nurturing is really a big part of our culture. So I don't remember, and I don't [01:07:30] know if we're ever going to avoid that, because that just in our nature, being a Marshallese person. Marshallese is the largest COFA migrant group living outside of the islands in Arkansas. The population of that community has accounted for 12,172 people living according to this 2020 census. And majority of the workers here, they work for the poultry industry, and they're considered essential workers, very important to the economy.

(01:08:00):

[01:08:00] The community is alive, is alive and very rich. Even there are over 40 churches, and the culture is very much alive and full of life. Traditional leaders and faith-based organization are very important in the way we do our outreach and connecting to the people. So as I had mentioned earlier, those needs are very important. One of the ways for us to address those needs is by running the one-stop shop, [01:08:30] and is really set up to provide a wraparound service provided to me and our community. You cannot address one specific issue if you don't really look at everything that's impacting that person. So we wanted to make sure that everything that we're doing, at least trying to really cover other services as well. The needs of the community are major drivers in the programs that we run. As I had mentioned earlier, we really want [01:09:00] to run our program based on this concept of designed by us, for us.

(01:09:05):

I think we're the people, for frontline people, that understand the needs and I think in order for those program to be effective, you have to live those experiences. And many of our staff and board members have actually been there and done that. By operating based on this concept, we can actually directly address those social determinant that distributed [01:09:30] to health disparity. Just so you know, on a yearly basis, we receive around 4,800 to 7,000 people, or visits, a year. And those visits, they can be one person coming to our office 10 times a month or things like that. So that's a pretty large amount of services that we provide and amount of people that we see. Other services that we provide are [01:10:00] listed there, immigration services is very important.

(01:10:04):

Marshallese are not US citizens, so they still have to go through the hurdles of renewing their paperwork, their documentation, especially the I94 form that comes when they enter the United States. To replace that, if it's missing, it's a hurdle. We have to take them to the border, to the border of Texas and Mexico, about 14 hours away, and bring them back. [01:10:30] And

it's daunting, is a lot of work that are put into that. So the reason why I listed all these services, it just so you can get an idea of the work that we are doing, but also the importance of how we understand, and try to understand, not just addressing one specific need. We have to address so many others that are there. Can we go to the next slide?

(01:11:00):

[01:11:00] The programs and impacts. And these data that we pull out, they are from our own office. So in regards to the direct services, which is pretty much one of the top pillar of service that we have, and that includes coming to the food pantry. We do have a food pantry, and 40% to 60% of our visit are going to the food pantry. [01:11:30] At the height of the pandemic, over 50% of our death cases in one region alone, it was from this community. So one of the big need that the community had identified was food, access to food. So based on that, we really just try to address what they wanted and needed. And so we started the ENRA Food Pantry. ENRA means, it's a dish, it's a weave dish [01:12:00] that the Marshallese use to share food. So we really want to make sure that everything cultural is also incorporated into our program. There are some other data that I put here, but I think I only have few minutes, but I can go to the next slide.

(01:12:21):

This chart right here is called [inaudible 01:12:24], [inaudible 01:12:24] is a stick chart that our ancestors, our navigators, used to use [01:12:30] to navigate the ocean. Micronesian and also Marshallese, that include the Marshallese, are one of really the best navigators long time ago. So we really want to use that tool still and see how we navigate those services and those hurdles that our people are going through. Social media is pretty big, as you can tell, 20,500 people, they would tune into that TV outreach and [01:13:00] education virtual session. But also we know door-to-door works as well. And also our people love incentive. If you go, "We're going to give out gift card or we're going to give out chicken," they will be there. They'll be at the event. So these are three main top avenues that we've used in the past, and it has actually worked. Can we go to the next one? Next slide.

(01:13:27):

Oh, these are some highlights [01:13:30] on some impacts of work that, through our partnership with the AAPCHO folks and the [inaudible 01:13:38], we do have our own Pacific Islander Diabetes Prevention Program. Very, very successful, 62% actually completed participant. Our site, ACOM alone, had actually had a lot of impact and a lot of the outcomes were beyond our imagination. So just [01:14:00] wanted to share that. I love this one, 298 actually lost 5% of their body weight. Can we go to the next one? Yeah, so if you have any questions, here is our address, our phone number, email. It's right there. And it was a pleasure talking to you all today and thank you for having me.

Deanna Canales (01:14:25):

Yes, thank you Melisa, David, and even Monica for coming [01:14:30] here today and letting us know about the great work you're doing on the ground. So the one question that I just want to ask everyone actually is, what is one recommendation that you would have for health centers or

even community-based organizations about how to achieve lasting change in your communities with the SDOH data?

Monica Calderon (01:14:54):

I can go ahead and answer [01:15:00] first. So I feel that based on the experiences that I've had, it is always being in tune with your community needs. So we know that there's always... [inaudible 01:15:10] important data always helps in this. And being able to identify emerging needs or recurring needs within our community. So I think if we are in tune, not only with having the conversations, connecting conversation to [01:15:30] data, and then identifying what has worked or what hasn't worked, and both having that open mind to see how we can engage our community in addressing SDOH can definitely, because this is where those lived experiences can make a big impact, and involving the community to be a part of it, more than anything, can definitely support sustainable change.

Deanna Canales (01:16:00):

[01:16:00] Thank you, Monica. So there is an issue for, there's a question that asks that they're facing a challenge in securing funding for a service such as care coordination. So what should folks do or go to advocate for funding for the specific need? Maybe I'm going to direct this to Melisa.

Melisa Laelan (01:16:28):

Well, I think my experience [01:16:30] and my skills are very grassroots. So I know that it took me a long time to gain, I feel like, a lot of the funders around here, they kind of heard about us, but they just checking us out from the distant, you know what I mean? But I think it takes, for me personally, we really went beyond our comfort zone. It didn't matter whether I was shy or not, I really had to [01:17:00] break that. And in order for me to receive more funding, I just needed to do what I had to do, if that makes sense. Also, building partnership with national organization like AAPCHO folks. I've had few project with them. And I think just building those relationship, and I think your work also tells it all. You put action into the work that you do, and I think people would recognize that and realize that. [01:17:30] I hope that was helpful. It might not fit what you're looking for, but that's just my personal experience.

Gabrielle Peñaranda (01:17:37):

Can I just add real quick, that's a really great and important question, but Melisa, do you want to talk real quick, really briefly, about your relationship with community clinic, or ACOMs relationship with community clinic?

Melisa Laelan (01:17:49):

Yeah, and also the Arkansas Department of Health, because I felt the community clinic here, we always had this relationship, but nothing formal. But then the Arkansas [01:18:00] Department of Health, we all know they hold all the cards, that they have the power, they have the vaccine, they have all the experience and the skills and everything. We didn't. So we really went beyond

our comfort zone and had a meeting with their top guy and say, "Hey, listen, this is what's happening in your state. We think we can help you get to where you need to be." And at that time, people, especially specifically on [01:18:30] TB to work close [inaudible 01:18:31] education, it was a hotspot here in Arkansas, and it was just perfect timing for us to realize that the Arkansas Department of Health was needing our help. And then at the same time, we already know all these things are existing, we just really need to bridge the gap. So we signed a contract and then further on, later on, we also added more project to our partnership. Which [01:19:00] was great. It turned out to be a really great partnership.

Monica Calderon (01:19:05):

I wanted to actually add, from a CHW perspective, and also being able to contribute to some of those feedback on what we have funding and sustainability. I think that taking the approach of return on investment and highlighting how CHWs make those impacts within the communities, and the value [01:19:30] that we have in situating CHWs within programs can definitely help support sustainable funding. It could also bring that added value approach, and adding another layer to the community work because CHWs can be incorporated in diverse positions when they're adequately and properly trained and provided the tools that they need and extracting from again, those lived experiences, and definitely [01:20:00] bring that return on investment, and funders would take interest in that from that perspective.

Gabrielle Peñaranda (01:20:07):

Also, just a reminder, please email us if you have any questions. If there's any lingering question that you have maybe that you didn't get to ask here, or if you go back and want to just watch the recording or if you've shared the recording and a question came out of re-watching it, please message us. Please message us. Feel free to include all of us in your question. [01:20:30] We would be more than happy to make connections for you or just elaborate on anything that was discussed here.