



**Community Health Needs Assessment (CHNA)
Implementation Strategy
FY 2017-2019
North Carolina Baptist Hospital
Davie Medical Center
Lexington Medical Center**

Recommended Wake Forest Baptist Health Community Health Needs Assessment Implementation Plan

Introduction

Wake Forest Baptist Health (WFBH) serves patients across a 24 county region in North Carolina and Virginia and encompasses a total of 1,060 acute care and rehabilitation beds across its three acute care hospitals: North Carolina Baptist Hospital in Forsyth County, NC (885 beds), Lexington Medical Center in neighboring Davidson County (94 beds) and Davie County Emergency Health Corporation, dba -Davie Medical Center, in neighboring Davie County (81 beds). WFBH conducted a community health needs assessment (a “CHNA”) of the three counties that comprise the majority of acute care admissions and the geographic location of each of the three hospitals pursuant to the requirements of Section 501(r) of the Internal Revenue Code (“Section 501(r)”). The CHNA findings were approved by the Board in June of 2016 and were made available on WFBH’s public website. This implementation strategy (“Strategy”), also required by Section 501(r), documents the efforts of WFBH to address and prioritize the community health needs identified in the 2016 CHNA.

The Strategy identifies the means through which WFBH as a system, as well as Davie Medical Center, Lexington Medical Center, and North Carolina Baptist Hospital, plan to address needs that are consistent with WFBH’s charitable mission as part of its community benefit programs from FY 2017 through 2019 (see Section 6). Beyond the programs discussed in the Strategy, WFBH is addressing many of these needs simply by providing care to all, regardless of ability to pay. WFBH anticipates health needs and resources may change, and thus a flexible approach was adopted in the development of its Strategy to address needs identified in the 2016 CHNA.

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1. Community Served by WFBH

As an academic medical center and regional referral center, NCBH serves a 24 county service area that encompasses two states, North Carolina and Virginia. NCBH’s principal primary service area is illustrated in the map below and encompasses seven contiguous counties representing an approximate 40-mile radius. However, the majority of inpatient admissions and

emergency visits are provided to Davie, Davidson and Forsyth County residents, representing greater than 50% of the total patient volume for calendar year 2015.



In order to allocate resources and maximize the effectiveness of community initiatives, for the purpose of conducting the Community Health Needs Assessment, WFBH chose to narrow the focus to Davie, Davidson and Forsyth counties as well as neighborhoods that:

- Are geographically proximate to the main hospital campuses
- Have a poverty rate >20%
- High percentage of charity care
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities)
- Have individuals and organizations with developed and historical relationships with WFBH such as FaithHealth and United Way, or have the potential for partnering to address specific health and social issues

2. WFBH's Mission Statement and Community Benefit Charge

WFBH has a long history of engaging our community in identifying health issues and implementing strategies to address needs. Our mission and vision states that Wake Forest Baptist Medical Center's mission is to improve the health of our region, state and nation by:

- 1) Generating and translating knowledge to prevent, diagnose and treat disease
- 2) Training leaders in health care and biomedical science

- 3) Serving as the premier health system in our region, with specific centers of excellence recognized as national and international care destinations

In order to fulfill our mission, WFBH conducts a Community Health Needs Assessment every three years and implements strategies to address priority needs. To undertake this initiative, WFBH formed an internal Community Benefit Steering Committee (CBSC) led by FaithHealth and Population Health with representation from various departments and disciplines. Specifically, the Committee was charged to:

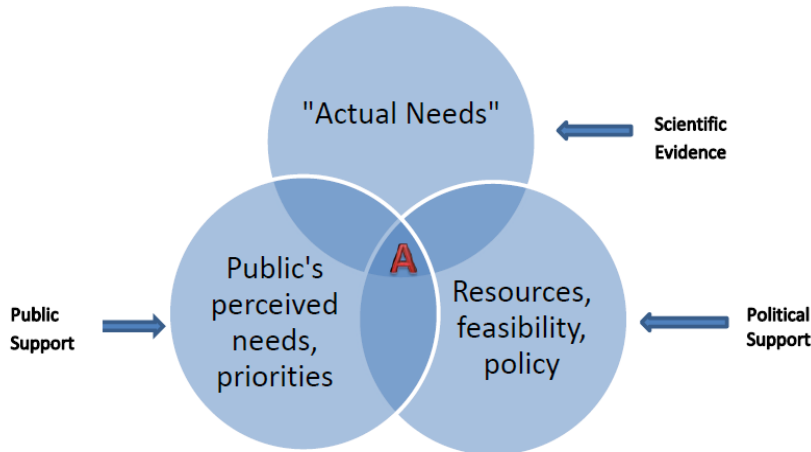
- Develop a strategic community benefit plan based on a comprehensive needs assessment and aligned with WFBH's Strategic Plan;
- Monitor plan implementation and institute corrective measures if needed;
- Conduct ongoing evaluation of community benefit structure & processes;
- Evaluate the effectiveness of individual projects and the impact of community benefit initiatives as a whole; and
- Communicate the plan to external and internal audiences.

3. Community Benefit in the Context of Population Health Policy

This document presents the plan for Community Benefit through the lens of population health. As with the rest of Population Health, Community Benefit is not about silver bullets as it is about the slow, patient, systematic attention to the factors that shape the health of people, families, neighborhoods—populations—over time, with appropriate metrics to that kind of impact. This view of Community Benefit is consistent with the broad outlines of federal, state and local governmental health policy as well as the clear priorities of our patients and families and the payers who carry the financial burdens of care. In this sense, community benefit becomes a window into the core strategies guiding many aspects of our partnerships, not just a particular set of programs.

4. Prioritizing Community Health Needs

The focus of the Community Benefit Implementation Strategy is the intersection of the scientific evidence, public support and political support.



A - The greatest potential for mobilization of resources and action -Green and Kreuter, Health Program Planning, 4th ed., NY; McGraw Hill, 2005, fig 2-3, p.40

Poor health status is due to a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care. Addressing the root causes of poor community health can improve quality of life and reduce mortality and morbidity. Table 1 (below) describes the community health needs identified through the 2016 CHNA as priorities. In order to maximize the resources available to WFBH, the Strategy will focus first on the priority health needs listed below, and will continue to evaluate opportunities to fund or partner for other related needs:

Table 1. List of Priority Community Health Needs

Domain	Priority Health Areas to Address
Access to Care	Decrease ED Utilization for uninsured/charity care patients
Access to Care	Increase WFBH patients with health insurance /usual source of care
Access to Care	Increase WFBH patients with access to transportation to clinic appointments
Access to Care	Increase primary care access points in east Winston
Chronic Disease Management	Healthy Lifestyle Behaviors and Community Environment -Screening and linking patients to food pantries

Chronic Disease Management	Increase self-management education opportunities for patients and residents with diabetes
Chronic Disease Management	Increase primary care group visits for diabetic and obesity patients
Chronic Disease Management	Increase patients and WFBH employees enrolled in chronic care management programs
Chronic Disease Management	Health Screening and Early Detection: Provide Mammography/Women's Cancer community screenings
Behavioral/Mental Health Distress	Decrease ED Utilization for behavioral health related conditions
Behavioral/Mental Health Distress	Increase education of basic mental health issues and resiliency strategies for community agency and laypersons support

5. Principles Guiding the Community Benefit Implementation Strategy

WFBH's three priority areas (chronic conditions, mental health and access to care) focus our attention on the long term drivers of health of the whole community. This strategy follows three basic guiding principles: **Focus on the places** (neighborhoods) where need is concentrated. In Winston-Salem, Lexington and Davie that means the handful of census tracts. Second, **focus on partnerships** with community organizations who share the mission. Third, **build the capacity** of people (families and partners) through generous and sustained education (matched always with careful listening). Those priorities and principles will be implemented over the three-year IRS cycle.

Three priority areas, three guiding principles, three unified strategies monitored by common metrics.

- 1) Clinical strategy. The most fundamental strategy of the plan is to do the clinical work for every patient with careful attention to the needs of the most vulnerable. This work falls primarily under the leadership of the VP for Population Health. WFBH will continue to invest in the Downtown Health Plaza, a key node in the proactive work of actively managing the conditions over time. WFBH is also making new investments in core infrastructure needed to care for those with mental and substance use conditions such as the clinic being built as a joint venture partnership with our competitor, Novant, near the Innovation Quarter. Other strategic initiatives include investments in strengthening key community clinical assets, especially the Southside Community Health Center, strengthening the network of free clinics, especially in easing their referral pathways and increasing support for technological, financial, pharmacological, laboratory, human, and other resources. Also, WFBH will explore neighborhood-level primary care and screening through the development of innovative mobile health strategies involving experts from various medical center departments and service lines. The mental health challenges of the community reflect decades of stigma, neglect, underinvestment and under-reimbursement. There is *especially* no silver bullet here and no simplicity to be found at all. Mental health is part of integrated health which is part of population health.

WFBH will continue to build upon its CareNet and integrated health strategies and will also develop a community based plan by June 2018. WFBH will expect this to include commitments for financial resources beyond what we are already expanding.

- 2) Financial Strategy. WFBH will continue to meet and exceed the governmental requirements for providing financial assistance to the most economically vulnerable, those who qualify for charity care. WFBH will go beyond the requirements as we develop financial management of the nearly \$100 million of charity care to create a continuum of care for the very poor so they benefit from the science and techniques of modern care management that are so fundamental to population health. This Plan will be piloted and carefully monitored with community involvement. WFBH believes it will extend meaningful access with enhanced quality of outcomes, as well as allowing for investment in funds for prevention and wellness activities versus treating conditions that could have been prevented.
- 3) Community Engagement. WFBH will continue to invest in the small but innovative initiatives of FaithHealth and the many Medical Center partners working in the most vulnerable communities. Part of the plan is protecting the capacity to invest in continued innovation undergirded by the commitment of the internal foundation, but with a significant shift. While continuing major support for FaithHealth's "ground game," in the next phase the foundation will be able to support such innovation by other parts of the medical center faculty and departments.

6. CHNA Implementation Strategy

WFBH has a strong tradition of meeting community health needs through its ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic health priorities set forth below that focus primarily on three (3) high-priority health need domains as identified in the 2016 CHNA. It is important to note that not all programs provided by WFBH that benefit the health of patients in WFBH's primary service area are discussed in the Strategy. Further, given evolving changes in health care, WFBH maintains the right to change its strategies, and new programs may be added or eliminated. The Strategy laid out in this document has two major parts: implementing programs to address the priority needs from the CHNA, then evaluating the impact of those activities.

A. Identifying Areas of Impact and Planning to Evaluate Proposed New Community Benefit Programs

The 2014-2016 focus of WFBH's community benefit and in-kind resources was identified based on the CHNA Report findings, the prioritized health needs and recommended initiatives to impact the health of the community.

The Strategy is organized according to the following domains:

- 1) Access to Care
- 2) Chronic Disease Management- Cancer, Diabetes, Heart Disease, Obesity
- 3) Behavioral/Mental Health Distress

Through implementing evidenced-based strategies to address these three domains of community health need, WFBH anticipates the following positive impact and improvements in community health:

- Positive impact on disease management and disease prevalence, including rates of obesity and obesity-related diseases (including stroke, cardiovascular disease, and diabetes)
- Improvement in community health status, including reduction in health disparities, increased physical activity, reduced rates of smoking, improved food security, improved health and nutrition status, improved community engagement, and improved maternal and child outcomes
- More appropriate use of health resources, including a reduction in unnecessary hospital admissions and use of some hospital services, including emergency department visits, and an increase in use of culturally appropriate primary care and health screenings

These improvements will be evaluated through review and monitoring of existing data sources, which may include but are not limited to:

- Internal Hospital data, including EMR, referral data, inpatient and outpatient service data, and WFBH HRA employee data;
- Public Health Management Household Health survey data;
- Surveys and key informant interviews with providers and clients;
- Reports from government, state and city agencies, which may include: NC DHHS Healthy People 2020, County Health Rankings, Medicare claims data analysis and County SOTCH reports

B. Address Priority Health Needs through WFBH's Existing and New Community Benefit Programs

WFBH plans to provide community benefit programs responsive to the health needs identified in the 2016 CHNA. The recommended actions may be modified based on on-going input and recommendations from internal and external partners, identification of new partnership opportunities, changes in healthcare and community environment, and availability of resources. Throughout the implementation period, the Community Benefit Steering Committee will identify grants and internal and external funding sources as appropriate to support the strategies and activities. Resources to implement programs are provided in-kind unless otherwise noted.

WFBH - NORTH CAROLINA BAPTIST HOSPITAL

DOMAIN: ACCESS TO CARE

The anticipated impact of the following actions may include: reduction in emergency department visits, increase in the number of insured adults, improvement in access to and utilization of culturally appropriate primary care, reduction of health disparities, and reduction in transportation barriers to receiving medication and care.

Action: Encourage appropriate Emergency Department utilization through care coordination across community, hospital and primary care

- Assess non-emergent and ambulatory care use and develop strategies to reduce the use of emergency services for this population through community and hospital initiatives. Explore models, such as care coordination programs for the charity care population, to address high utilizers/non-emergent care use and seek funding to support recommended model/intervention
- Continue to support the CarePlus care coordination model to reduce ED and IP admissions for Medicaid and Self Pay/Uninsured patients at DHP

Action: Improve access to Community Centered Social and Health Education Services and regular source of health care

- Continue partnership discussions with Novant to create a primary care clinic in East Winston for the self-pay/uninsured and Medicaid population
- Continue to explore the use of a mobile medical clinic in low access WFBH service areas
- Develop pilot for WFBH charity care patients with chronic conditions for care management services including linkages with primary care
- Continue to provide community engagement support through 5 Supporters of Health, 311 congregational partners, 25 Connectors across the service area (including Forsyth, Davie and Davidson counties) and 7 FaithHealth fellows

Action: Improve access to health insurance

- Partner with Healthcare Access leaders to assist with enrolling community members into insurance programs

Action: Improve Access to Transportation to Health Care Services

- Raise awareness about transportation services for Medicaid patients among providers and the community
- Explore providing transportation for patients through UberCentral or another similar model

DOMAIN: CHRONIC DISEASE MANAGEMENT

The anticipated impact of the following actions may include: improved health behaviors, disease management and health status through greater continuity of care with health care providers (including improved adherence to treatment recommendations and improved communication with health care providers).

- **Action: Improve the capacity of community based organizations and health care providers to support efforts related to chronic disease prevention and management**
- Continue to support FaithHealth community health workers to address chronic disease management and community health programming.
- Increase community and healthcare provider referrals to existing WFBH chronic disease management programs and resources by centralizing and disseminating information
- Provide and expand Chronic Disease Self-Management programs offered by WFBH through Emmi.

- **Action: Provide education and support programs to reduce diabetes prevalence and/or improve diabetes management**
- Refer pre-diabetic and early onset diabetic patients at Downtown Health Plaza to the YWCA Diabetes Integrated programs and related educational programs offered by WFBH and other community-based organizations.
- Continue to provide diabetic education at Downtown Health Plaza and the Endocrine clinic
- Continue to provide BestHealth diabetes prevention and nutrition education to the community.
- Explore partnership with United Way to focus diabetes prevention and management programs in identified, high need census tracts/neighborhoods

- **Action: Provide education and support programs to reduce obesity prevalence and/or improve obesity management**
- Continue to support BrennerFIT to increase education and awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families
- Promote healthy eating and weight management through the WFBH Employee Wellness program(s)
- Continue to support community education through BestHealth
- Provide more awareness to WFBH patients and employees regarding the opportunity for weight management program offerings.

DOMAIN: BEHAVIORAL/ MENTAL HEALTH DISTRESS

The anticipated impact of the following actions may include: decrease in ED visits related to behavioral health, increase in the number of individuals utilizing CareNet services and increases in the number of patients at primary care practices and Downtown Health Plaza providing integrated behavioral health screening and treatment.

- Continue to expand integrated care model currently operating at Downtown Health Plaza and Family Medicine Piedmont Plaza
- Increase the current 30+ full and/or part-time staff at WFBMC who work in areas defined as integrated behavioral health (which includes providers co-located in primary care settings or the CCC, behaviorists, etc.)

- Build capacity among lay persons in the community in the areas of mental health first aid, community resiliency model and suicide prevention programs (e.g., Soul Shop for faith communities)
- Continue work of Dr. Liz Arnold with fragile homeless persons
- Develop plan to create more integrated behavioral health graduate medical education offerings for our medical students, residents, faculty and staff

WFBH - DAVIE MEDICAL CENTER

DOMAIN: ACCESS TO CARE

The anticipated impact of the following actions may include: reduction in emergency department visits, increase in the number of insured adults, improvement in access to and utilization of culturally appropriate primary care, reduction of health disparities, and reduction in transportation barriers to receiving medication and care.

- **Action: Reduce transportation barriers for individuals in rural areas of the county**
- Assess need for transportation assistance through various community agencies to determine how to ease access through public transportation or onsite clinics specific to high need areas
- Work with local agencies (Senior Services, Davie Foundation, etc.) to determine resources available to bring care to areas impacted by transportation issues

- **Action: Improve access to Community Centered Social and Health Education Services and regular source of health care**
- Provide health education events and screenings at various locations throughout the county
- Via the Healthy Davie initiative, create opportunities to involve families in regular programming
- Work with local churches to provide programs and enlist lay leader support to assist parishioners needing access
- Continue to explore the use of a mobile medical clinic in low access WFBH service areas
- Continue to provide community engagement support through 5 Supporters of Health, 311 congregational partners, 25 Connectors across the service area (including Forsyth, Davie and Davidson counties) and 7 FaithHealth fellows

DOMAIN: CHRONIC DISEASE MANAGEMENT

The anticipated impact of the following actions may include: improved health behaviors, disease management and health status through greater continuity of care with health care providers (including improved adherence to treatment recommendations and improved communication with health care providers).

- **Action: Improve the capacity of community based organizations and health care providers to support efforts related to chronic disease prevention and management**
- Continue to support FaithHealth community health workers to address chronic disease management and community health programming
- Increase community and healthcare provider referrals to existing WFBH chronic disease management programs and resources by centralizing and disseminating information
- Provide and expand Chronic Disease Self-Management programs offered by WFBH through Emmi.

- **Action: Provide education and support programs to reduce diabetes prevalence and/or improve diabetes management**
- Work with Davie County Health Department to refer pre-diabetic and early onset diabetic patients to the Diabetes Self-Management program or to a YMCA or WFBH resource.
- Continue to provide BestHealth diabetes prevention and nutrition education and cooking classes at convenient locations in Davie County.
- Explore partnership with Davie County agencies to focus diabetes prevention and management programs in identified, high need census tracts/neighborhoods

- **Action: Provide education and support programs to reduce obesity prevalence and/or improve obesity management**
- Expand programming in Davie County to increase education and awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families
- Promote healthy eating and weight management through the WFBH Employee Wellness program
- Continue to support community education through BestHealth
- Provide more awareness to Wake patients and employees regarding the opportunity for weight management program offerings
- Work with industry and the school system in Davie County to identify at risk individuals and provide support and programming through the Healthy Davie Initiative

DOMAIN: BEHAVIORAL/ MENTAL HEALTH DISTRESS

The anticipated impact of the following actions may include: decrease in ED visits related to behavioral health, increase in the number of individuals utilizing CareNet services and increases in the number of patients at primary care practices and Downtown Health Plaza providing integrated behavioral health screening and treatment

- Work with CenterPoint to identify key resources for referrals and programming for patients needing mental health services
- Increase the current 30+ full and/or part-time staff at WFBMC who work in areas defined as integrated behavioral health (which includes providers co-located in primary care settings or the CCC, behaviorists, etc.)
- Build capacity among lay persons in the community in the areas of mental health first aid, community resiliency model and suicide prevention programs (e.g., Soul Shop for faith communities)
- Develop plan to create more integrated behavioral health graduate medical education offerings for our medical students, residents, faculty and staff

WFBH - LEXINGTON MEDICAL CENTER

DOMAIN: ACCESS TO CARE

The anticipated impact of the following actions may include: reduction in emergency department visits, increase in the number of insured adults, improvement in access to and utilization of culturally appropriate primary care, reduction of health disparities, and reduction in transportation barriers to receiving medication and care.

- **Action: Reduce transportation barriers for individuals in rural areas of the county**
- Assess need for transportation assistance through various community agencies; determine how to ease access through public transportation or onsite clinics in high need areas.
- Work with local agencies (Senior Services, Medical Ministries, area churches, FaithHealth, etc.) to determine resources available to bring care to areas impacted by transportation issues or provide transportation to health care resources for those in need.
- **Action: Improve access to community centered social and health education services and regular source of health care**
- Provide health education events and screenings at various locations in Davidson county
- Continue to hold and widely promote annual Lexington Medical Center Community Health Day with free screenings and WFBH resources to educate and inform the community on a wide array of health care topics
- Work with local churches to provide programs and enlist lay leader support to assist parishioners needing access
- Expand BestHealth programming at community events/venues in Davidson county
- Continue to participate in Davidson county schools annual flu vaccine program

DOMAIN: CHRONIC DISEASE MANAGEMENT

The anticipated impact of the following actions may include: improved health behaviors, disease management and health status through greater continuity of care with health care providers (including improved adherence to treatment recommendations and improved communication with health care providers).

- **Action: Improve the capacity of community based organizations and health care providers to support efforts related to chronic disease prevention and management**
- Continue to support FaithHealth community health workers to address chronic disease management and community health programming
- Increase community and healthcare provider referral to existing WFBH chronic disease management programs and resources by centralizing and disseminating information
- **Action: Provide education and support programs to reduce diabetes prevalence and/or improve diabetes management**
- Work with Davidson County Health Department to refer pre-diabetic and early onset diabetic patients to area diabetes management programs, inclusive of WFBH programs

- Continue to provide BestHealth diabetes prevention and nutrition education and cooking classes at convenient locations in Davidson county
- Explore partnership with Davidson county agencies to focus diabetes prevention and management programs in identified, high need census tracts/neighborhoods
- Participate in opportunities with area schools to screen for diabetes and/or educate students/parents on diabetes prevention
- **Action: Provide education and support programs to reduce obesity prevalence and/or improve obesity management**
- Expand programming in Davidson county to increase education and awareness of nutrition and healthy lifestyle choices for uninsured and Medicaid patients and families
- Promote healthy diet and weight management through WFBH Wellness programs
- Continue to support community weight management education through BestHealth
- Increase awareness among WFBH patients/employees of weight management programs
- Educate elementary and middle school students/parents on good nutrition and healthy eating options through in-school programs
- Educate adults through community resources or employer partners on healthy eating habits and healthy meal options

DOMAIN: BEHAVIORAL/ MENTAL HEALTH DISTRESS

The anticipated impact of the following actions may include: decrease in ED visits related to behavioral health, increase in the number of individuals utilizing CareNet services and increases in the number of patients at primary care practices and Downtown Health Plaza providing integrated behavioral health screening and treatment.

- Grow awareness of CareNet services available at Lexington Medical Center with greater exposure of CareNet among community based organizations and community events
- Work with mental health resources in Davidson county to identify key resources for referrals and programming for patients needing mental health services
- Increase the current 30+ full and/or part-time staff at WFBMC who work in areas defined as integrated behavioral health (which includes providers co-located in primary care settings or the CCC, behaviorists, etc.)
- Build capacity among lay persons in the community in the areas of mental health first aid, community resiliency model and suicide prevention programs (e.g., Soul Shop for faith communities)
- Develop plan to create more integrated behavioral health graduate medical education offerings for our medical students, residents, faculty and staff that see and serve patients across the WFBH network

7. Expanded metrics

WFBH also regularly tracks quantitative data specific to FaithHealth programming initiatives in the following four areas:

1. Focus on Places
 - a. # of persons afforded expanded clinical access that partner with FH
 - b. # clinical sites that offer expanded clinical access to under-served persons
 - c. # of un-insured persons (no coverage at all) who are afforded access to clinical care
 - d. # of under-insured (cannot afford co-pays or medications) awaiting activation of MCD, etc.,
 - e. # of persons who enroll in the exchange annually, or are navigated to MCD or other coverage, by FH staff
2. Focus on Partnerships
 - a. # of partnering organizations, churches, coalitions and other groups who help us provide care in the community
 - b. # of caregiving encounters conducted by Connectors and Volunteers
 - c. # of unique volunteers
 - d. # of visiting clergy
3. Focus on Building Capacity via Education
 - a. # of community trainings held annually and type
 - b. # of volunteer hours of community training offered and completed annually and type
 - c. # of curricula of tiered education for behavioral health, crisis responding, helping the homeless, chronic disease self-management, transportation, food access, etc.
4. Focus on Costs of Total Care for Vulnerable
 - a. # of persons who are enrolled in the Plan AND live in our focus areas
 - b. Aggregate costs of charity care patients to WFBMC
 - c. Shortfall between reimbursement and cost of patients insured through government programs
 - d. The population within our focus areas will also be more closely evaluated to see differences in utilization after enrollment, including access to primary care and other allied services

8. Partnership extending beyond the WFBH's Mission or Community Benefit Program

Addressing all of the health needs present in a large community/service area will require resources beyond what any single hospital or social service agency can bring to bear. WFBH is committed to fulfilling its mission as well as remaining financially viable so that it can continue its commitment to excellence in quality care and provide a wide range of community benefits. Between FY 2017 and 2019, WFBH will focus its efforts in order to make a true and measurable impact, and thus plans to implement actions that will address those needs identified through the Community Health Needs Assessment. WFBH will continue to evaluate opportunities for funding or resources to commit to addressing the remaining needs and will work with community partners and health systems that are addressing other identified priorities in our communities.

We view Community Benefit as a set of principles that are visible to the community as a set of coordinated programs. It is also a lens on how Wake Forest Baptist Medical Center is a learning organization and how that process of learning is itself a benefit to the community. We work in partnership to achieve a healthier community; thus we learn in partnership and the lessons illuminate the future work of those partnerships.