# WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

## Routine HIV Testing, Session #3, Community of Practice

14 April 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Routine HIV Testing Community of Practice Session Number Three webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC. The Partnership for Care Project is a three year multi-agency project, funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center, or HIV TAC.

We have two speakers today. Our first speaker is Suzanne Robinson Davis. Ms. Davis works at the Bedford Stuyvesant Family Health Center on the Partnerships for Care grant as the program lead. She's very passionate about increasing access to HIV care for underserved people, and has fervently worked with her team to increase the visibility of HIV care services in Brooklyn, New York.

She has worked on HIV-related issues for seven years, and has worked on social and developmental issues at the community levels, national levels and international level, spanning a number of countries over two continents. She's currently reading for her doctorate in health education at Teachers College Columbia University in New York. Please join me in welcoming Ms. Davis.

SUZANNE ROBINSON DAVIS: Hi everyone. My name is Suzanne. Thank you Steven. And I am very excited to be here, and to share our journey at Bed-Stuy, what we have been doing for routine testing at our center.

So the polling question is, do you offer routine HIV testing in your facility, yes or no? This is a good time to just let us know what is going on at you're in a health center. Oh, wonderful. So we all are on the same page, and we know what we're talking about.

So for our presentation today at Bed-Stuy, we're really just going to be looking at three main areas. We're going to be looking at a small excerpt from our policy, and that guides our work

and frames some of what we are doing. And then, we're going to be looking at three iterations of routine testing, what our journey has been so far. And for each of those, we'll be looking at the processes that we have been following, some of the challenges that we have encountered and the results.

And then, we're going to look at some of the recommendations. Things that have worked for us, and that we're proposing maybe you could try out at your health center or things maybe that you're doing already. And then we will be closing out and handing over to the next presenter.

So when we look at the Bedford Stuyvesant testing integration policy, it says that we offer integrated HIV testing to all established patients from ages 13 to 75. HIV testing may be conducted through rapid or conventional methodology. And that we adhere to the HIV testing policies and procedures as defined by the Departments of Health.

And I think it's very important for us, as we look at this policy direction, that routine testing and rapid testing is very important for us in our assessing. Especially in Brooklyn, where we have one of the highest HIV infection rates in the city. And so providing multiple avenues of testing actually increase access for persons who are underserved or racially marginalized. So rapid testing is definitely a key ingredient in our testing methodology.

And then, my attempt here is to show our diagram before integration, what was happening at the center. And I feel like it's very one dimensional perspective to HIV testing. But it was what was being offered before integration, which is really testing at points of care, at your providers, so we're relying on blood draw at medical visits.

And also, persons were really limited to medical staff. You weren't really exposed to non-medical point of care persons. And then the focus really was on persons who tested positive, and this was what existed before integration.

And then as we look at our flow after integration, we see that it's much more robust. We see the integration of rapid testing in our EMR systems, so we're able to capture and reflect data for patients who are walking into the center requesting HIV testing. And not seeing a provider, but just coming in and asking for a rapid test. This can be also captured in their medical records.

Also, we have increased our resource persons who have been a part of our testing teams, so we are able to provide point-of-care testing. And also, we're able to provide biomedical prevention interventions for those persons who are high-risk negatives. So our PEP and our PrEP [INAUDIBLE] have taken place.

Since towards the end of 2015, we have been offering preventive services. And so that also speaks to the continuum of care for high-risk negatives and also providing quantity care for persons who have tested positive. So I feel like this is a good wraparound care for persons who are high-risk and for persons who are positive. And just to highlight for rapid HIV testing, which

we have been doing oral swabs, we are moving or transitioning into our finger prick fourth generation rapid tests. And that was recently approved by ORCMO.

So as we move into the next slide, which speaks to the first iteration of routine testing. So before September 2014, before we actually looked at integration of routine testing at our center. It was really provider-led, patients were asked whether they wanted an HIV test. The focus was more around screening unless our own offer rates.

So when I go back in our system, I could only find screening rates, so the focus was on the screening. And if you look at the screening rate at 50%, it is fairly low, and for a high-risk community such as ours, is it does not do justice for our patients. And so this iteration was very problematic. And it resulted in our next slide, which shows a number of changes that were made when the P4C Program was launched at the center.

So we expanded our EMR capabilities to capture rapid tests. We were averaging 50 to 60 tests per month for patients who were just walking in, asking for a HIV test. So we realized that there was indeed a need in the community for rapid testing.

And we also included our point of care testers as resources in our EMR, and that was helpful in capturing that data. And so we do see a slight increase in our numbers, but we were still not satisfied with this. And so when we look at some of the challenges that we've grappled with, we really wanted to understand those factors that were impacting the low offer and uptake rates. We had anecdotal information in terms of what was driving that, and of course, in our community of color, we do have higher rates of stigma. But we also struggled with the asking of the question. Down.

And we also struggled with providers addressing and including HIV. So we had providers who routinely asked and you have providers who had issues with asking. And so these were some of the challenges that we faced. I've been in the P4C sessions, which we have discussed all of these issues before, so this was definitely one of ours. And we also had issues with our EMR, especially with the tickler alert, which providers found to be ineffective.

One of the things that was mentioned is when the patient was tested for or offer an HIV test, the tickler didn't go away. So when you look back into the system the next day, the tickler alert is there, whether you did or didn't offer the HIV test. So it was not a helpful indicator of whether the test was actually offered or done.

And so these challenges led us to make further changes. And so in June 2015 till present, we had another iteration of our routine testing. And in this scenario, we actually shifted the burden from the provider asking the question, and we included the MA, the medical assistants, in this process.

And so the providers still ordered the test, and the MA's doing the blood work. Then taken the sexual history, they would have asked whether that person wanted an HIV test. And also, during that process or that period of time, PrEP was also ruled out at the center.

So we now had an intervention for high-risk negative persons. And so when you look at our results, you see that we did actually increase in our offer rates. And we were very happy with this, and when we looked at our screening rates, it remained about the same.

So there was something underlying as definitely a challenge right here. And this has led to a number of meetings and discussions in our QI meetings, discussion with our medical team. Just trying to unpack why we were still averaging around the 50%, 51% mark for our screening rates.

And as we grappled with that situation, our challenges really was just that persistent offering of the test. We had inability to meet our QI targets, which was definitely one of those drivers to making different change, and seeing what was going on and what we could do better to improve our situation.

So the QI meetings were definitely a sounding board in which we tested a number of strategies. And this has led us to where we're launching right now. So as of last week, we launched our opt out testing.

So we are going away from the asking of the HIV question-- do you want to have an HIV test-- and including HIV in the battery of tests being offered to that person. So we have already posted the seven points to know about your HIV test poster that we received from the Department of Health and Mental Hygiene. And these are at appropriate locations within the center and at both sites.

We are also updating our HIV testing policy to capture this new phase in our routine testing. And with that, we are looking at changing our EMR to be updated and be able to relay some of this information. So the current HIV screen template will be inactive in a few days. And what we're doing is replacing that with a new HIV Opt Out template. And this really is capturing reasons for persons opting out.

So previously, we had anecdotal data of why person's weren't taking the test. With this system, we'll be able to include the test, and also where persons decline to have the test, we try to obtain the reasons for opting out. So we are very excited about this.

I feel like the center is ready and willing to move to another phase of our routine testing, trying to unpack and to have a more robust way of offering our HIV test to our community, who are at higher risk of HIV. And ensuring that everyone has access to an HIV test is definitely the next step for us, and we're definitely excited about where we're heading. And so as we look at our recommendations, we realize that we definitely have been supported by our policy in facilitating the changes that we have been making.

So as you look to expand your routine testing-- which everybody indicated that you already have routine testing at your site-- if there are changes that you want to make, make sure that your policy is definitely robust and able to support you as you do that. And then, ensure that at your QI meetings, your HIV offer rate screening indicators are included because that was part of that momentum, what fueled our changes. Because we were able to see where we were, and we're not meeting our targets.

And it's always good to have a champion. Someone who is present at all those important meeting, who can advocate for changes or can raise concerns as it relates to HIV testing or HIV-related issues. And one of the things that has consistently be in a staple throughout our experience is training up staff, coaching up staff, providing technical support. It's very important, especially in settings where you have staff turnover. You're trying to maintain consistency and continuity in your programs.

And I'm not sure if Steven is on the call, but Steven is one of those advocates for the PDSA, and I really appreciate the role that he has played in our iteration of routine testing at the center. I feel like we have to find something that works for us, and the Plan-DO-Study-Act cycle is one way of ensuring that we obtain or optimize the resources that we have on hand and to achieve our targets.

I think that is it. Yeah. So basically, yeah, that is it. We hope that information that we have shared, you're able to reflect on, to do better. And if you're doing great, tap yourself on the shoulder, and say good job and so forth.

But we just wanted to share some of the things that has been happening at our center, and things that have worked and haven't worked at where we are. And so we're just excited for the new journey that we're about to take for opt out training, opt out testing. And we hope that we'll be having some really marvelous feedback and responses from that from our patients. So thank you very much.

STEVE LUCKABAUGH: OK, thank you. We have a moment here. We can take a few questions. If anyone happens to have a question, please type it into the questions pane in the GoToWebinar toolbar.

We did have one that come in that said, do you know the percent of your patients that screen negative for HIV but were prescribed PrEP or even picked up a Truvada prescription?

SUZANNE ROBINSON DAVIS: That's a very good question. I don't know off hand the percentage of patients who have been screened for PrEP or picked up a Truvada prescription. But since towards the end of 2015, we started rolling out PrEP. And the take up in our community has been quite slow. We are encouraging everyone who we screen for our rapid test and at their medical visits if they meet the criteria as defined by CDC, we encourage them to consider PrEP.

So far, we have about 12 persons who have taken up PrEP, and that has increased as we have rolled out. I hope I've touched your question.

STEVE LUCKABAUGH: OK, thank you. If anyone else has any questions, please enter them now. We have another one that says very nice work moving towards what sounds like a very robust screening program. Have you provided your clinicians with specific examples of how to communicate with patients that they will be screened unless they decline?

SUZANNE ROBINSON DAVIS: Yes. So we had the city Department of Health come in, and we had a very robust training for providers. And providers were very empowered after that training in terms of some other things that they need to do. Of course, we do recognize that providers, especially when they needed to asked the question, persons are coming from different cultural beliefs, and sometimes that also impacts how one asks questions.

But as we have been trained in this way we are going to be doing our opt out training, we find that the individual perspective is less. And so the point of including HIV testing becomes a bit more neutral.

STEVE LUCKABAUGH: OK. Before opt out screening, do you know the biggest reasons cited by patients for not accepting an HIV test?

SUZANNE ROBINSON DAVIS: Yeah. So main reason given was that they're not engaging in risky behavior, they don't need to have one, or they have had one in the last 12 months. Those were 12 of the biggest ones.

STEVE LUCKABAUGH: OK. If we don't have any more questions, I think we will move on. Our second speaker today is Danielle Osowski. Ms. Osowski is a training specialists for the Denver PTC, Capacity Building Assistance Program. She earned her Bachelor's of Arts in psychology and sociology from the University of Colorado. She is currently one class away from her master's, a public health certificate at the University of Colorado, Anschutz Medical Campus.

Danielle comes to Denver Prevention and Training Center after working at the University of Colorado Infectious Disease Group practice, where she was the early intervention services coordinator. There she focused on high-impact prevention, retention and care and substance use services. In her current role at the center, Danielle is helping to build the capacity of health professionals through innovative training and consultation. Please join me in welcoming Ms. Osowski.

DANIELLE OSOWSKI: Thanks Stephen. Hi everyone, thanks for joining us today. I'm going to switch gears a little bit and talk about building strong community partnerships.

When we started this community, a practice, we send out a survey. And some things people wanted to know about were once you do your routine testing and you've integrated into your system, a lot of things tend to come up, and you don't have places to refer people. And so

today, I'm going to talk about referrals, how to build those community referrals, and how we look at it through the lens of collective impact.

So our learning objectives for today, we're going to define the collective impact area is, discussed it's five components and how does collective impact translate into building our strong community partnerships. Many of us may have never heard of this term, it's a new and up and coming term, collective impact. So I wanted to explain a little bit about what it was.

Basically, it's just a framework that you can tackle social problems with. It's an innovative and structured approach to making a collaboration work across government, business, philanthropy, nonprofit organizations, and citizens to achieve significant and lasting social change. So here are the five components, and in the subsequent slides will go into each one with more detail. So the five are common agenda, common progress measures, mutually reinforcing activity, communications, and backbone organization.

Common agenda. All peoples have a shared vision for change, including a common understanding of the problem and a joint approach to solving it through agreed upon actions. So what does this mean in a real world practice?

Clarifying joint goals, and community impact pursued by the partnership and really acknowledging what circumstances prompted this collaboration. What goal are you working towards? What did you identify as missing in your community?

Shared measurement. Collecting data and measuring results consistently across all participants insured efforts remain the aligns, participants hold each other accountable. How do we do this? We do it by building accountability structures into the partnership plan in the first place in order to measure intended outcomes and identify areas in need of improvement. These structures should include regularly scheduled reviews, and should clarify each partner's role in monitoring performance.

Mutually reinforcing activities. Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action. So here is really where you highlight a shared vision, which includes objectives important to all those involved.

And acknowledge and affirm autonomy and distinct roles for each partner. People don't always like to come into a partnership where they feel like they have to be forced into doing something. And they don't want to feel like they're being absorbed into your one organization and being micromanaged. And so this is a really important step in building your community partnership.

Continuous communication. Consistent and open communication is needed across the many players to build trust, assure mutual objectives and create common motivation. Selective decision makers should be respected and empowered by their organization and trusted by their partner organizations to make those important decisions.

Making this is really important, to come up with leaders who will be skilled in conflict management, communication and building consensus. You really need to come up with the best way to communicate with each other, and ensure that the roles are defined so that you can actually be making decisions when you're in your meetings. Make sure to discuss your availabilities for those leaders for regular and scheduled meetings, as well emergencies. So if something comes up and you need a quick answer, how will you contact that main contact person?

The last thing we'll talk about backbone supports. Creating and managing collective impact requires a separate organization with staff in specific set of skills to serve as the backbone for the entire initiative, and coordinate participating organizations and agencies. So these rules and responsibilities should be clearly delineated and distinguished between individual and joint responsibilities to ensure that things don't slip through the cracks and things are getting done.

Organized with an appropriate balance of power so one organization isn't taking on the brunt of the work, or one person doesn't feel like they're doing too many things or one person doesn't feel left out. And accountability structures should be established with a focus on process and outcomes, not structure and input. So not tit for tat kind of stuff, no keeping score. Sometimes an organization may have more to do in a different level or project than the others during your community partnership, and so to know that it will come full circle, and if they need help that they can ask you.

So we all know that when trying to come up with community partnerships, there are some barriers. I just wanted to list out a few that we know ahead of time that have been issues in the past. And throughout the process of initiating and establishing, developing a nonprofit partnership, it's best to anticipate and mitigate these problem areas. These are common barriers, and when organizing your community partnership, you should be proactive in your efforts to avoid some of these pitfalls. Anything at the end here, we can discuss any of the barriers that you might have had when trying to set up some community partnerships.

So what does this look like in real life? So collective impact in practice. I have a case study here of my most recent community partnership before I came to the Denver Prevention and Training Center. I'm going to go through each of these steps and how they align with the different outcomes of collective impact.

So first, recognize the need for faster mental health and substance use referrals, so common agenda. In the last couple of years, Medicaid expansion with the ACA, more Coloradoans here who never were insured had access to mental health and substance use after the expansion, and there weren't enough providers. Wait time for these intakes and referrals were over two months just for an intake. And we saw that we needed to find a way to improve services for our clients.

So next backbone support meet with existing provider network to discuss barriers to providing care. So we set up a meeting to meet the new network providers and discuss barriers to

providing the care. This was a time to introduce ourselves to new people who have never met before and to make that personal connection.

I feel like it's a little bit harder to deny, help or hang up on someone once you've met them in person and made a face-to-face contact. And I really look at this is a bank account, so making a deposit into your-- what do you need to get to them so they know that you are going to help them first? You can't just take money out before you put any money in, so putting a little effort in. You have to give something to get something in the beginning, to build their trust.

Third, mutually reinforcing activities. How can we help the situation? So just because we identified a need or a gap in coverage doesn't mean that there aren't things that we could do on our organization's end to help. And so we needed to show that we were willing to figure out ways to help on our end. How could we help facilitate this problem, and what were our biggest hangups that came from our end that could be fixed?

So we came up with a few ideas. One was to make sure we were sending the most appropriate people to the appropriate referrals. We needed to be a little bit more discerning in who we refer to and to what services they wanted to access. Not every person was appropriate for every kind of service available.

Two, we wanted to ensure that all paperwork was filled out properly, which can be a big time suck for people when they're trying to have their new intake processing clients. So we wanted to make sure that we can help clients fill out all of the necessary paperwork, and have it with them when they went to their first appointment.

Thirdly, having patients bring all of that paperwork with them into the intake, but also any other supporting documents. People need IDs, and they need proof of insurance, and they need all these other things. And sometimes, they don't even know what they don't know. So make sure that we have been prepared for their first meeting.

Assist patients, getting them to appointments. Here in Colorado, we do have some funds to help assist patients in getting to medical appointments. And so no shows for intakes were taking up a lot of time. Patients cited that transportation was their biggest obstacle in getting these. And so that was something we could do that would take a little bit of time on our end, but really show a huge improvement on the intake process.

And then lastly, informing patients of the process to facilitate realistic expectations. Let them know what they're getting into beforehand, making sure that's what they want, and letting them know that everything isn't going to happen in one day. And I think setting up realistic expectations was one of the biggest things we can do to help the intake process.

Then designating champions for-- that would be continuous communication. We designated clinic champions who were empowered by their organization to actually make decisions that could help facilitate change. It wasn't just about getting the most people in on our partnership.

It really was about getting the right people on the bus, and then getting them all in the right seats.

Everyone has their own niche. And some people are really good motivators, so they could get people really excited about our collaboration. But then you also needed the doers on the front line to execute our vision. So it's really vital that you fill your team out with a diverse panel to cover all of these bases.

And then lastly, met monthly to monitor progress. This is our shared measurement. We met monthly to discuss our progress. We had ample time to go over what was going right, and then to identify areas of improvement.

I always started and ended up on a positive note. Though it's important to fine our areas for improvement, I really wanted this collaboration to focus on the positive. I've been on enough committees where all we did was talk about how unsuccessful something was, and I wanted more action, and less talk.

So the results after six months, we saw reduction from a two month wait list for an intake to a two week wait for mental health and substance use referrals. We had a team of three designated working on the project. It was no one's just full-time job, but we divided and conquered, and it turned out to be manageable.

It was a lot of uptake in the beginning and a ton of work in the first few months. But after the plan was implemented, all duties were more than manageable. And it's now just maintaining and re-evaluating the partnership on a routine basis.

And I think this is important because substance use and mental health issues are a leading contributor of non-adherence in people living with HIV and high-risk negative. And so I think it's of uber importance for us to focus on this gap in the care continuum. I think that's why I feel these community partnerships are such an integral part of the overall health of our community. And collective impact is a great way to frame the approach to community partnerships.

Any questions? I'd be more than happy to talk about any questions you might have.

STEVE LUCKABAUGH: OK. So we have some time here to take some questions. If you have any questions, please enter them into the Questions pane in the GoToWebinar toolbar. And I will unmute Suzanne as well right now, in case she would like to chime in anything. So please enter your questions now.

DANIELLE OSOWSKI: If we don't have any questions, can we maybe poll the audience and see how it's been going with them with community partnerships? What kind of barriers or successes that they might have had that they can share with us?

STEVE LUCKABAUGH: Sure. If folks would like to share that, please enter that into the Questions pane, and I can read them out. OK. Someone said can you repeat the question.

DANIELLE OSOWSKI: Just if they had any successes or any barriers that they've come into when they've been trying to build community partnerships for referral systems in their areas.

STEVE LUCKABAUGH: OK. We have one, barriers. Getting consult reports, clinical summaries back in a timely manner.

DANIELLE OSOWSKI: So is that with their partnering agencies?

ANDREA: Hey, this is Andrea from Broward Community Family Health Center in Florida. So we've been having a challenge. So we have maybe not as successfully as presented set up responsibility or identify the point person in some of the organizations where we partnered with. We've expanded our services. And so just trying to get feedback from us.

So when we refer our clients to them, trying to get feedback on how things are going. If there any particular care, coordination or aspects of care that we just need to be aware of or make sure that our providers are aware of in our organization. Just trying to get that informational feedback in a timely manner has been a challenge.

And so even when we're doing-- well, we call them interdisciplinary team meetings, where we're looking at our different groups of patients. HIV is one of the population of patients that we do ITeams with-- is trying to truly do care coordination without the input from a specialist or someone else we may have sent them for is a challenge. So we're trying to figure out how do we get that information back kindly. And I think definitely identifying who the point person is at the other organization. And it doesn't always have to be the doctors themselves.

DANIELLE OSOWSKI: Right. Now I've found that the doctors are so busy that they don't really respond at all. They're mostly not the person that is our main contact. We look at social services team, and so in our clinic, what we do is we meet monthly basis-- but besides this big meeting-- but we do these care coordination with ASOs, our AIDS Service Organizations.

And we identify, OK, these are the clients we want to talk about this week, so no more than five. We have a quick 30 minute meeting, and we discussed all of their things from their labs, all the way to their last appointment. How they looked, all their social-type barriers.

And then we meet, and we have a one point person. So it would be like their case worker, or their actual substance use clinician or whomever, and then we talk. And so we have this set up a month in advance, so people have time to pull the labs and write notes. And then we just bang it out real quick so it doesn't take a bunch of time.

And we only discuss high importance matters. So we don't just talk about, oh, so-and-so made his last appointment, which is nice to here, but we talk about mostly the people that we're most concerned about.

ANDREA: Cool. That sounds like the thing we do our ITMs. I think our total patients being covered is a little bit larger, so I think I'm going to take that recommendation of us reducing it.

Yeah, it's been a struggle of we have patient care navigators, and their major responsibility is to reach out for those patients where we referrals but we haven't gotten consul reports back. So then we reach out, and that's just been their biggest challenge. Even by the time we get to our ITM, they're just up having a big challenge. Their biggest challenge is that they still weren't able to get the consul reports. So yeah.

DANIELLE OSOWSKI: Having them do the accountability part, I think, is really big. Everyone has to pull their weight in these community partnerships.

ANDREA: The other thing I was trying to convince our providers. Because the doctors are like, oh yeah, well. I think sometimes because they have personal connections or know them in a larger provider environment, they're thinking that they should be more collaborative and forthcoming.

And so it just giving the reminder, hey, this is the doctor you've identified as the one who referred them to. Is it good? I've asked the doctor to reach out now, but now I think it's definitely important for us to establish a more structured accountability arrangement.

DANIELLE OSOWSKI: Absolutely. And it'll make things more smoothly. It might be a little bit more work in the beginning, but in the end, it is very helpful.

ANDREA: It'll be worth it.

DANIELLE OSOWSKI: Yeah.

ANDREA: So thank you.

STEVE LUCKABAUGH: OK. If anyone else would like to chime in with any successes or barriers, let me know. You can raise your hand. If you have audio enabled, I can unmute your phone. Otherwise, you can type questions or comments into the Questions pane.

OK, Victor, did you want to step in here?

VICTOR: Well, I just want to thank everybody for participating in the COP today. And we ended in a little bit early today. I think that the information that was presented, both by Denver Prevention and by our speaker today, Ms. Robinson. And it's really, really useful and really applicable to a lot of the health centers.

And then one thing I do want to point out. Again, if you have any questions or any comments after the webinar, feel free to email us. We'll be putting the email in a couple minutes. Because we do want to hear from the health centers, from everybody. See what they're doing regarding implementing routine HIV testing at their facility.

And a reminder, we do have the fourth session of our Community of Practice scheduled for Thursday, May 5. Usually, we have it during the second Thursday of each month, but for May, it's going to be in the first Thursday of the month due to the all partners meeting that we have schedule for the 12th and 13th, I think, here in DC.

So that's the reason why we moved it to May 5. So the registration information is up on your screen. And of course, we will be emailing information to everybody at the lecture. But you can email me if you have any questions, any comments regarding this webinar, or regarding the content this webinar or for any of the other COPs that we've done so far, please feel free to email me.

And again, just to call out for all the health centers that we do want you to participate as a presenter both in [INAUDIBLE], and also in future of COPs and future webinars. Like I said, I think there's a lot of vital information, a lot of items that health centers can learn from each other. So we'll be reaching out to you, and have been reaching out.

And of course, today Ms. Robinson, thank you very much. To you personally, and also to the Bedford Stuyvesant Health Center and also to Denver Prevention Training Center for being our moderators for this series.

DANIELLE OSOWSKI: Thank you, Victor.

SUZANNE ROBINSON DAVIS: Thank you.

STEVE LUCKABAUGH: Thank you. And I don't know if our speakers had any final thoughts or anything before I wrap it up here.

SUZANNE ROBINSON DAVIS: This is Suzanne from Bed-Stuy. I want to, again, thank everybody for giving me this opportunity to share some of the work that we're doing at Bed-Stuy. And I want to also encourage all the health centers to participate in these COP sessions. I feel like it's really good to review some of your work, and also share some of the things that you're doing. Particularly an opportunity for us, which is what the P4C Program is all about, learning and building partnerships.

So we want to hear from you too. So consider future COP sessions to be a panelist. We would love to hear some of the stories and some of the journeys that you have been on. So that's my plug.

STEVE LUCKABAUGH: OK. I want to thank you for participating in today's webinar. And we hope you're able to find the information provided useful as you continue your P4C project, and ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Thank you again for participating in today's webinar, and thank you to our presenters for that excellent presentation. If you have additional questions for the P4C project or for our presenters, please email us at p4chivtac@mayatech.com. Take care everybody, and we'll see you next time.