Module 1
Introduction to Community Oriented Primary Care

Note: The underlined text has been personalized by the author of the module. Feel free to delete or modify the text if you would like to insert your own stories.

Slide 1: Title Slide

Thank you for joining us for Module 1: Introduction to Community-Oriented Primary Care (COPC). My name is Winston Liaw, and I am an Assistant Professor in Family Medicine at Virginia Commonwealth University and teach at the Fairfax Family Medicine Residency Program.

Slide 2: Disclosures for Continuing Medical Education (CME)

(No accompanying text)

Slide 3: Agenda

In this module, we will be reviewing the definitions that pertain to COPC, COPC's history, the benefits of engaging in COPC, the steps involved in COPC, the barriers in implementing COPC, and the reasons why you should involve learners in this process.

Slide 4: Objectives

By the end of the module, I hope that you will be able to define COPC, list 3 seminal figures in the history of COPC, state the steps involved in COPC, list the potential members of a COPC team, state the barriers to initiating COPC activities, and provide an example of a COPC activity.

Slide 5: Maezie

This is my daughter Maezie. We have loved getting to know her. But with my wife and I working full time jobs and not having family in the area, we have had to rely on relatives in our extended families, friends, neighbors, and the occasional stranger and have been constantly reminded that it really takes a village to raise a child.

Slide 6: Marriage of Public Health and Primary Care

One thing I want you to take away from this talk is that in order to tackle something that is both difficult and meaningful – whether it is raising a child or improving education – you have to involve a lot of people. Simply put, community oriented primary care, or COPC, is the marriage of public health and primary care. It provides a framework that demonstrates how to engage your community so that you can create your village

I know what you're thinking. This is a daunting, almost impossible task, but it is also an imperative. For years primary care and public health have operated in silos with each working on the same problems but not communicating with one another. In order to improve population health and reduce costs, this will need to change.

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Slide 7: Che Guevara

My path to health care went through an orphanage in Haiti, a sweat lodge on the Navajo Reservation, and a Habitat for Humanity project in Honduras. I was and in many ways still am the idealistic kid that you see in coming of age movies about health professionals – like a young Che Guevara in the Motorcycle Diaries…without the facial hair. In college, I participated in a project to help clean the shores of a lake in Guatemala.

We spent a week building a dumpster so that the community could place trash in a central location rather than along the road. That week was both satisfying and demanding. Several months later, I asked the organizers of the project how many people were using the dumpster.

The answer? No one.

Slide 8: Introduction to Pinares

Fast forward several years to residency…

I started working with a non-governmental organization that was steeped in COPC. We worked in a rural community in Honduras named Pinares. With the community, we started a project to bring ceramic water filters to households in 2006. Today, those water filters are still being used. In Guatemala, our trash dumpster project failed miserably. In Honduras, our water filter project was an amazing success. The reason why the Honduras project succeeded and the Guatemala project failed can be summed in two words: community involvement.

Slide 9: Iris

COPC is a framework that allows you to systematically recruit your village. Since talking about your village and big problems can be difficult to grasp, let's start with something that is instantly relatable to you – a sick kid. You are working in the clinic in Pinares and meet Iris, a 9 year old girl. She has had two days of non bloody diarrhea, is tachycardic, and has dry mucous membranes. You give her oral rehydration therapy and tell her to come back tomorrow. The next day, she looks much better.

At lunch, you talk to your colleagues about your day and realize that there was a 5 year old boy and a 7 year old girl with the same symptoms. Periodically, we'll come back to Iris and the other kids in Pinares to see how COPC can help them.

Slide 10: COPC Defined

COPC is defined as a continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs by the planned integration of public health with primary care. Within this definition, I want to direct your attention to "health" and "defined community". First, since we are talking about health, we are not talking about just drugs, tests, and procedures. And second, the target of COPC is a defined community; therefore, this does not just refer to the patient in front of you or even just the patients coming to your office.

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Slide 11: COPC Steps

There are four steps in the COPC process. The first step is defining the community of interest. The next step is identifying health problems. The third step is developing and implementing interventions. The final step is conducting an ongoing evaluation. Hopefully, by the end of the module, you will come to appreciate that community involvement is critical to each step.

Slide 12: Five COPC Principles

When you are going through the COPC steps, it is important to keep in mind these five guiding principles.

1) Responsibility for the health and health care of a defined population: Those practicing COPC should focus on all patients within a defined community rather than just those who are actively coming to the clinic or those who are acutely ill.

2) Health care based on identified health needs at the population level: Clinic records may not convey the magnitude of health problems within the community since many have barriers to seeking care. Therefore, the identified health problems should be informed by population level (rather than only clinic level) metrics and should take into account the perspective of community members.

3) Prioritization: The priority health concerns should be determined jointly by health care professionals and community members. This process should be objective, transparent, and should follow predetermined criteria.

4) Intervention covering all stages of the health-illness continuum: In providing care to populations, those practicing COPC will need to consider the needs of both ill and healthy people. When tackling a health concern, the team will need to consider disease prevention, health promotion, treatment, and rehabilitation.

5) Community participation: COPC practitioners need to work with the community and not just in the community. Engaging in dialogue, mutual respect, and collaboration with community organizations increases the likelihood that interventions will be sustainable and effective.

Slide 13: The COPC Team

When you are trying to figure out who to recruit, it's helpful to remember two things:

First, the COPC process is explicit about getting the community involved and engaged from the beginning. As previously mentioned, our project in Guatemala failed because we neglected to uncover the community perspective. Who cares about trash when you wake up worried that you will not be able to find food to eat that day? Community involvement decreases the likelihood that a group of health professionals who may not even live near the clinic dictate to the community which problems are most important and how they should be addressed.

Second, COPC celebrates diversity in teams. To truly address root causes of illness, you need to enlist the help of others. Important ideas will come from the billing department and the phone center, precisely because they have different training, biases, and experiences. Truly powerful interventions should be easily understood by everyone in your community, regardless of their background or level of education. In that regard, non medical people can serve as sounding boards to ensure that the team's ideas make sense and would be successful in the real world. In Honduras, we've used sociologists, agricultural scientists, lawyers, and venture capitalists to refine our ideas and generate new ones.

Slide 14: History- The Data Consumer

COPC is not even a new concept. In fact, this was the framework our predecessors used to practice primary care.

In the 1920s, William Pickles served as the only physician for 7 rural, English towns. He maintained meticulous records on births, deaths, and illnesses. He even recruited school teachers to record school absences so that he could correlate them with illnesses within the villages. Using these data, he was able to demonstrate how an epidemic of jaundice originated from a girl he had seen earlier in the week. He was able to show that a primary care practice could serve as a rich source of epidemiologic data and that data could vastly improve patient care.

Slide 15: History- The Pioneers

The Karks took the data that Pickles collected and added action. In the 1940s, Sidney and Emily Kark were charged with delivering both curative and preventive services at the Pholela Health Center in South Africa. To care for the population, the Karks emphasized research methods, tried to understand local concepts of disease, focused on community diagnosis, and relied on team approaches.

In their assessments and interventions, they used epidemiology, social psychology, basic sciences, geography, and primary care. They trained community health workers to complete needs assessments, survey each individual within their defined community, and implement interventions. Their first project report focused on social determinants such as the need for basic sanitation, the prevention of soil erosion, and improvements in nutrition. During the 1950s, the infant mortality rate of their community decreased from 275 deaths per 1000 live births to 100. Similar declines did not occur outside of their service area.

Slide 16: History- The Birth of Health Centers

Eventually, COPC spread to the United States. In the 1960s, Congress established Medicare, Medicaid, and the Office of Economic Opportunity (OEO) and mandated that each eliminate poverty. The grant to start the first health centers was awarded by the OEO to Tufts where H. Jack Geiger was faculty. Geiger had been active in civil rights since college. In medical school, he struggled with integrating his interest in social justice and medicine. Ultimately, he realized that he could combine his interests by studying the social causes of ill health. He spent time in South Africa with the Karks and was instantly drawn to their approach. Following this formative experience, Geiger employed COPC techniques and concepts when

he became the Director of the Mound Bayou Health Center in the Mississippi delta – one of the two first health centers in the US.

Slide 17: History- The Birth of Health Centers (2)

In her book about the history of community health centers, Bonnie Lefkowitz recounts an encounter that one of Robert Kennedy's colleagues had during an inter-agency meeting on combating poverty. He noted that there was uninspiring conversation, but then an Indian chief asked to be recognized. He said, "I appreciate being here, but I want to deliver a message. People who say they want to help have been deciding what's good for us for a long time. Please, if something new is to be started, plan with us and not for us." That was an unusual moment of learning for government officials and also helped shape the health center movement.

Changed by his experience in South Africa, Geiger pitched the idea of teams of health care professionals that were assigned to follow specific families, deliver comprehensive, continuous care, and address community level and environmental factors. The authors of the original proposal ensured that the community perspective was pervasive throughout the clinic by mandating a community presence on the boards of clinics. The proposal noted that "the need is not for the distribution of services to passive recipients, but for the active involvement of local populations in ways which will change their knowledge, attitudes, and motivation."

Using COPC and by connecting with health associations, universities, a medical school, and numerous foundations, the health center in Mississippi developed a childhood enrichment program, a nutritional program for elderly isolated residents, a banking program that made it easier for African American residents to get loans, a bus transportation system, an agricultural co-op, and a college preparation program. Geiger sought to create a place that was more than just a dispenser of medications, but rather a center that improved the health of the community.

Slide 18: Why COPC?

COPC is a time consuming process, so initiating COPC activities requires that you believe that the process is valuable. Luckily, there are many reasons to engage in COPC.

First, COPC can help make what you are already doing better. As Health Center Program Grantees, you already have to define your community, assess the needs of your community, create quality improvement plans, and report quality measures through the Uniform Data System. On top of that, many of you are applying for money through meaningful use and are completing applications for primary care medical home recognition.

You are already collecting an enormous amount of data. How then can you act on that data to improve outcomes? COPC can enrich each of these steps so that they are not just another completed task on the checklist but rather processes that will invigorate your community.

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Slide 19: Why COPC? (2)

Second, COPC helps your practice get at the social determinants of health, or the root causes of illness. As primary care providers, we are naturally interested in root causes. We would much rather discourage someone from smoking in the first place than refer a patient to hospice for lung cancer. Health centers are using COPC concepts to address priority health concerns. In response to a high teen pregnancy rate, Mary's Center – a Health Center Program Grantee in DC – started an adolescent after school program, in which they promote primary health care, support abstinence choices, offer family planning services, do HIV/STD testing, and provide counseling, academic support, and college preparation.

Third, COPC can help you write more compelling grants. Consider the power of a gap analysis for a grant that has been informed by COPC. These are problems that have been validated by the community, that your community focus groups are imploring you to address, and whose solutions they helped you tailor to maximize success - all within a framework and process that officials from the Health Resources and Services Administration (HRSA) and other funders will instantly recognize and have actively been promoting.

Slide 20: Why COPC? (3)

Fourth, COPC can help you learn more about and reach those that are not coming to your clinic. Health centers already care for the disenfranchised and the impoverished. Consider the last complicated patient you saw in the office - the patient who has not accessed the health care system in 5 years and has new onset diabetes and is not up to date with any preventive services. Now think about the patients that you have not seen yet because they are less well off than that complicated patient and have even more financial, cultural, educational, and transportation barriers. By undergoing COPC, you could possibly reach that patient and save her from a prolonged, avoidable hospitalization. COPC helps you uncover what you don't know about your community.

Fifth, COPC can help you discover new markets and help you advertise your existing services. COPC is designed to reveal unmet needs in the community. During the process of understanding your community, you may discover that the nearest cardiologist who accepts Medicaid is 2 hours away. In response to that need, your office may choose to offer stress tests, adding a revenue stream for your practice while addressing a critical access issue.

Slide 21: Why COPC? (4)

Sixth, COPC is an ideal response to possible changes in the funding environment. Numerous payers including state Medicaid programs and private insurers are starting to provide incentives for meeting quality measures. I have found that those patients who have uncontrolled hypertension or are not up to date with preventive services are not the ones that I see regularly but rather the ones who only come for sporadic care. COPC ensures that the practice is focused on all patients within a community rather than just those who are proactively coming into the clinic.

Models such as accountable care organizations reward practices that excel at population health. The Robert Graham Center studied an accountable care organization in Texas that is run by a primary care group. The practice is not only financially successful but also boasts impressive quality metrics. Their secret is in addressing any and all barriers to care for their patients. For example, to address patients that were not showing up for appointments, they created a program to pick up patients and bring them to the office.

Slide 22: Why COPC? (5)

Finally, improving population health is the focus of many national initiatives. The Affordable Care Act requires that tax exempt hospitals complete community health needs assessments to ensure they know who they are serving. The vast majority of the Centers for Medicare and Medicaid Services Health Care Innovation Awardees are proposals to get nurses, educators, case managers, and providers into the community rather than get more patients to come to the clinic. The Institute of Medicine released a report in 2012 making the case for better integration between primary care and public health.

So why COPC?

 - Because it's the future of medicine

Slide 23: Grotto

Let's go back to Iris. When we last left her, she was feeling much better after receiving oral rehydration therapy. You pat yourself on the back for a job well done. But then you think, "What about the other kids in the house?" "What about the other kids in the community?" The minute that you start thinking about the kids you haven't seen in the clinic, you are starting to see things through a COPC lens. You decide to do some research and come to find that diarrhea is one of the leading causes of death in children less than 5 years of age in Honduras.

You visit Iris's house. They get their water from this grotto. Unfortunately, their cows use this grotto as their toilet. So you gather your COPC team – which consists of a nurse educator, a nurse practitioner, a medical assistant, a public health nurse, a primary care physician, and three representatives from nearby villages - to brainstorm about what to do next. At the first meeting, your team comes up with dynamite ideas but realizes that it is unsure who the target population really is which leads us to the first step of COPC – defining your community.

Slide 24: Defining the Community

Module 2 will cover this in more detail. Briefly, when defining your community, it is helpful to think in terms of numerators and denominators. In the vernacular of COPC, the denominator refers to your defined population. The Karks actually completed their own census in Pholela to determine their denominator. Having a denominator, or defined community, allows COPC providers to measure the success of the program.

Within your defined community or denominator, there are myriad possible numerators. One possible numerator is your active patients, or the people that actually come to your clinic. This is the easiest numerator to address since you know these patients. But the challenge and goal of COPC is to address the unseen, or those in the denominator that are not in your most obvious numerator.

Slide 25: Fairfax Map

Using my suburban clinic as an example, there are numerous ways to define the community for which my practice has accepted responsibility. My clinic is right next to Fair Oaks Hospital. First, you can use existing geographic boundaries to define your community. This makes more sense in rural areas where there are important geographic landmarks. In a mountainous area, your service area could be everyone living in a particular valley. In Fairfax, I picked four streams that could be used as borders, but since these streams have little meaning to our patients, this method does not make sense in our community.

Slide 26: School Districts in Fairfax

Using school districts, we could choose three of the nearby high school pyramids to be our clinic's community.

Slide 27: Census Tract Map of Fairfax

Finally, you could use pre-defined geographies like census tracts. Here, I have picked the nine census tracts where 80% of the clinic's patients live.

As previously mentioned, the community will help you determine which method is most appropriate for your clinic.

Slide 28: Pinares Community Definition

Let's go back to Honduras where we were last struggling with determining our service area. Iris lives in Llano de Balas which is south of the clinic. The clinic is located in Pinares. After talking with community leaders and examining records from the clinic, we realized that the vast majority of our patients were from six villages surrounding our clinic. In Honduras, we decided to define our community as those living in Pinares and the six surrounding villages.

Slide 29: DC Ward Map

The next step is to identify health problems. In order to identify those problems, you will need to gather quantitative and qualitative data to characterize the community. You are looking at a map of Washington DC – which is divided into 8 wards for political reasons. The next couple of slides will describe the community characterization process of World's Greatest Clinic, or WGC for short, located in Ward 8. As you can see, Ward 8 is on the far south-east portion of DC and is geographically separated from the rest of the city by the Anacostia River.

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Slide 30: DC Ward 8 Community Comparison

Looking at the patients that come to the clinic, it identified 16 census tracts that represent its community. 14 of those census tracts are in Ward 8. Because statistics regarding the wards in DC are available, for this comparison, the clinic decided to use Ward 8 as its defined community. Here, the COPC team has compiled quantitative statistics about its community from the US Census and from the DC Department of Health. Ward 3 is in the northwest portion of the city and is relatively affluent. As you can see, the service area of the clinic is relatively younger than the rest of DC and draws from a high percentage of African Americans.

Slide 31: DC Ward 8 Community Comparison (2)

Here, you can see that WGC's COPC team has identified that Ward 8 has an infant mortality rate that is four times that of the nation-wide rate and nearly twice that of the DC rate. Obtaining data from secondary data sets is useful for hypothesis generation and is less time consuming than trying to gather these data on your own through primary data collection. Unfortunately, it is difficult to obtain data that capture your clinic's unique service area. Therefore, COPC teams often have to extrapolate from the data that are available.

Slide 32: SOAP comparison

Up until now, we have only discussed quantitative data, but gathering qualitative data is equally as important.

This can seem like a foreign process, but it's actually similar to what you do every day when you are listening to what a patient, documenting what you observe, and then making an assessment and plan for stated problems. For instance, one can document observations and impressions regarding the community. Written and oral histories of the community can be obtained from interviews with citizens. Community issues can be identified in the media. Finally, touring the community's streets, houses, workplaces, parks, schools, restaurants, and stores can help the practice get a sense for the community's hazards and resources.

Slide 33: Identifying Health Problems

Furthermore, key informants and focus groups can generate lists of health problems. Your quantitative data collection may suggest that one issue is a problem, but it's critical to determine whether that issue is actually a concern of the community.

Finally, practices can engage in primary data collection. In many ways, primary data collection is the most complete and automatically tailored to reflect your defined community. The community health workers helping the Karks would gather the same information for each household year after year creating a comprehensive and useful database that could be updated periodically.

Determining which problems will be addressed and in what order is another important step in this process. We will be reviewing one method for prioritizing health problems in the "Identifying Health Problems" Module.

Slide 34: Selecting an Intervention

Let's go back to Iris. When we last left her, she was recovering from diarrhea. The team had just defined the community as the six villages surrounding the clinic in Pinares and was now trying to figure out how best to address diarrhea in the community. Having learned about COPC, you know that community involvement is essential at every step. After defining the community, you have to validate the definition with the community. After identifying the key health problems, you have to ask the community if this is really an issue. After implementing your intervention, you have to verify that this approach is actually acceptable to the community. And when monitoring the effectiveness of the intervention, you have to ask the community if the intervention is actually working and how it can be improved.

Engaging the community is not just a task to be completed, but rather, is key to the survival of your COPC projects. Otherwise, you'll be left with a dumpster in Guatemala that is not used. In this community, we recruited citizens to participate in a health committee, which manages all of the projects, recruits community members to assist with the implementation of projects, and decides which problems should be addressed. The representatives are from each of the villages within our defined community.

Slide 35: Selecting an Intervention (2)

The health committee verified that water security was a priority concern for them. When asking them about approaches, they provided a history of interventions that have already been tried.

This slide has a picture of cisterns designed to collect and store rainwater that were built by another NGO in the 1990s. The cisterns worked well for several years until they started cracking. Unfortunately, the NGO had left the area and repairing the cisterns would cost two hundred US dollars or half of the average family's yearly income. So we know what the problem is, but how are we going to address it? And how are we going to make sure that the intervention is working?

This brings up to the next steps – implementing and evaluating the intervention.

Slide 36: Selecting an Intervention (3)

When choosing an intervention, I think it's helpful to follow Sir Isaac Newton's lead when he said:

"If I have seen further, it is by standing on the shoulders of giants."

Rather than develop interventions from scratch, it's helpful to use interventions that have already been pilot tested and studied. If your COPC activity is focused on dental care, then talk to the providers of dental care in the safety net in your community or the leadership of the local dentistry professional group to see what has already been done. A literature review can elucidate what is being done

nationwide. In later modules, we will examine other tools that can identify innovative solutions. In selecting an appropriate intervention, you will also want to weigh the feasibility, acceptability, and cost of each option.

Slide 37: Evaluation

Next, it is time to monitor the impact of your project. There are many reasons to plan for a thoughtful evaluation:

First, the evaluation provides feedback. Often, in the process of studying the intervention, you will uncover which aspects of your project are working well and which need fine tuning. Responding to this crucial information will make your intervention even more effective. Second, in studying your program, you may uncover other, upstream health problems that are more pressing or potential interventions that may be more promising. Third, the evaluation may help you obtain future funding. Funders often want to see evidence that your idea has been pilot tested and was successful on a smaller scale before investing in larger projects.

Slide 38: Evaluation (2)

The evaluation can seem like a daunting task, and there are many misconceptions about this step.

The first misconception is that the evaluation must be complex. In the majority of cases, the results of the evaluation will be read by staff, partners, and funders. Therefore, the evaluation is best when the results can be communicated in a way that is instantly understandable to a wide array of professionals, most of whom likely lack PhDs in epidemiology. The second misconception is that the evaluation should include complex statistical methods. While a statistician is helpful in analyzing and interpreting data, employing one is not a necessity. While it is nice to know if your program has an effect even after controlling for race, gender, and age, it's still helpful to know whether the outcomes of interest increased or decreased compared to the baseline. The final misconception is that the evaluation begins after the project has been completed. Ideally, the design of the evaluation occurs concurrently with the intervention. This allows your team to know which measures to track and how much time and resources to allocate to the evaluation.

Slide 39: Reducing Diarrhea…

Let's go back to Iris for the last time. When we last left her, the health committee and the COPC team were trying to figure out an appropriate intervention. Other communities in the region have adopted household based ceramic water filters. The literature indicated that these filters were effective and the health committee thought families would use them. At $16 US dollars, they are much cheaper to produce than the cisterns.

Slide 40: Reducing Diarrhea…(2)

Ultimately, we distributed ceramic water filters covered in colloidal silver to households within our community. We charged $1 US dollar to purchase the filter and tracked in vitro and in vivo outcomes for

the first 24 filters we distributed. We monitored the percentage of filters and usual water sources that grew coliforms, bacteria that indicate fecal contamination, and the number of episodes of diarrhea in the youngest child of each household. Among those with filters, 85% of the youngest children had any episodes of diarrhea in the preceding 6 months while that figure dropped to 16% after the water filters were distributed. More research is needed to determine whether that difference was sustained over time.

Slide 41: Warren Buffett

This is Warren Buffett. My mom would be proud that I was able to incorporate him into a COPC lecture. I bring up Mr. Buffett because investors like him know the power of compounding interest. Let's say you start with $10 and are earning 20% interest each year. At the end of the year, you will have $12 and now earn interest on $12 rather than $10. Year after year, the amount on which you are earning interest grows and before you know it, you have a billion dollars – or maybe a hundred dollars.

This is similar to involving the community. Initially, you may involve one key informant. Then, your key informant recruits her cousin to help out. Her cousin recruits his family, and his wife recruits her rotary club. When you involve the community, projects grow in size and scope. Instead of just the health committee being engaged, others in the community are engaged as well.

We started with water filters in our community. With the help of an active population, the committee pushed us to start an under 5 nutrition program, a scholarship program, a program that encourages young girls to start micro-businesses, a community garden, a composting project, and a cook stove project to improve indoor air quality that requires recipients of the cook stoves to help their neighbors build cook stoves. None of these projects would have started without buy in from the community. None of the projects would run without sweat equity from the community. There is only so much that we would be able to do on our own.

To do big, meaningful things, it often takes a village.

Slide 42: Barriers

Even after hearing this talk, many of you are probably still skeptical, thinking that:

1) There is not enough time to do this work

2) This is not what you were trained to do

3) You lack contacts in the community

4) You are not paid to do this work

Slide 43: Why is the time right for COPC?

Luckily, several developments start to address the lack of time and expertise. When the Karks were practicing COPC, they had to sift through paper charts, create databases by hand, and aggregate

disparate maps. With the rise of electronic medical records, it is easier to generate a list of diabetics or those who are not up to date with colon cancer screening. With the online tools that we are going to discuss, COPC enthusiasts no longer have to generate their own hand made maps. These efforts to automate health care delivery and to distribute free mapping tools will hopefully start to address the concerns of those who lack time and mapping expertise.

Slide 44: Why Involve Learners?

You may also be wondering why you should involve learners in COPC. There are many benefits to involving trainees in this process:

First learners tend to be more idealistic. Though idealism declines during training, that idealism likely drops even further after trainees enter the workforce. Luckily idealism can be replenished with experiences that remind them why they went into health care in the first place, such as addressing big issues in populations that need help the most. Second, many trainees already have to do quality improvement and scholarly projects. Giving them a piece of a larger COPC project would satisfy these requirements. Need some statistical work done? Approach the doctoral and masters students at your local university and see if they would be interested in helping with an evaluation. Third, teaching them COPC will prepare them for the future of primary care as we previously discussed. Finally, it's important to teach them COPC because Health Centers were built on this concept – it's part of their health center DNA.

Slide 45: Take Home Messages

Ultimately, we hope that you remember these things:

 - COPC is the marriage of public health and primary care

 - The 4 steps of COPC are: 1) define the community, 2) identify the health problem of interest, 3) develop and implement interventions, and 4) conduct ongoing evaluation

 - COPC can improve the health of your community, help you write stronger grants, and improve the things you are already doing.

 - To do big, meaningful things, it often takes a village

 - Team engagement and community involvement are critical to successful programs

Slide 46: Survey Links

(No accompanying text)

Slide 47: To Obtain CME Credit

(No accompanying text)