MetroHealth

# Center for Health Care Research and Policy (CHRP)

# Speed Rounds

PHRI Seminar: October 31, 2025

# Objectives

- Meet the CHRP researchers
- Share key CHRP Highlights
- Discuss CHRP research
- Have Fun!!!

# Halloween Meme





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# Halloween Pun

What's a skeleton's favorite instrument?

# PHRI Organizational Diagram

**PHRI Advisory Council**
(CWRU, VA, UH, CCF, BHP, Community Partner, MHS)

**PHRI - 2020**
Director: Dr. Bolen
Asst. Director: Ms. Dolata
Admin: Ms. Muscatello

**MHS Operations** (PHII/I4Hope; Institutes/Centers, Academic Departments)

**Co-Directors of Education**:
Drs. Thornton and Caron

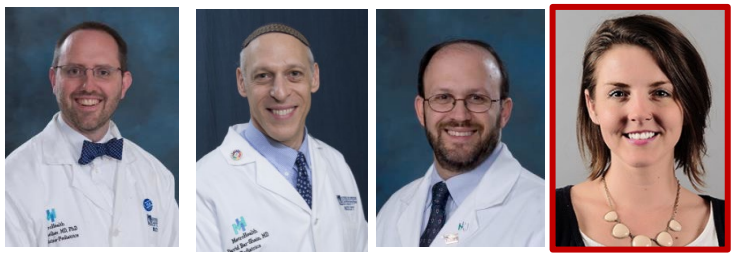
**Division of Biostatistics and Data Sciences**
Director: Dr. Love

**Collaborating Faculty**

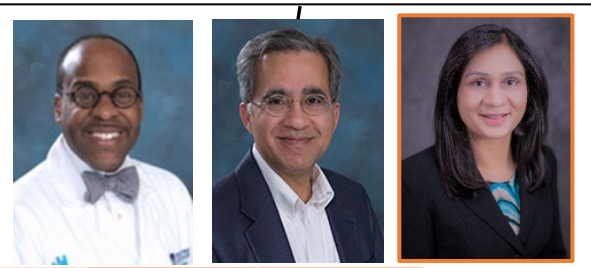
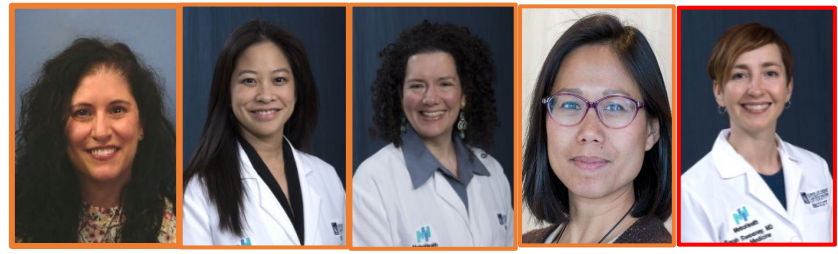
**Center for Clinical Informatics, Research and Education (CCIRE) - 2011**
Director: Dr. Kaelber

**Center for Health Care Research and Policy (CHRP) - 1994**
Director: Dr. Bolen

**Center for Health Equity, Engagement, Education, and Research (CHEEER) - 2004**
Director: Dr. Thornton





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# CHRP TEAM

Jordan Fiegl

Julie Fisher

Hannah Hill

Stephanie Kanuch

Janeen Leon

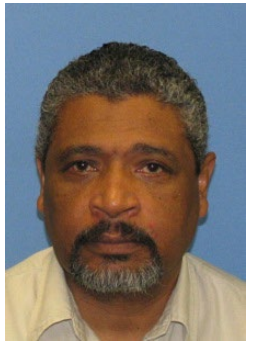
Steven Lewis

Noelle Muscatello

Maria Pry

Anna Rybińska-Campbell

Cathy Sullivan



Charles Thomas

# CHRP Mission

Improve the health of the public by conducting research that improves access to health care, increases the quality and value of health care services, and informs health policy and practice; and

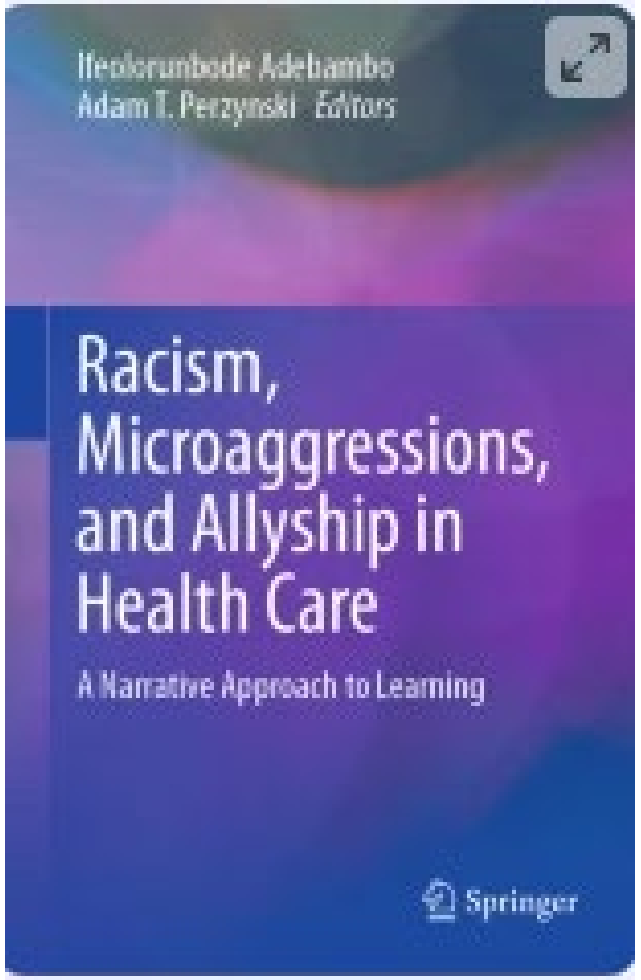
Lead education and training programs that promote these goals.

| PHERI Faculty Lead(s) | Funding Source | Abbreviated Grant / Project Title | Total MH $'s All Years (DC + IC) | Start/End Dates | Collaborating Organizations and MH Departments |
|---|---|---|---|---|---|
| **CENTER FOR HEALTH CARE RESEARCH & POLICY (CHRP)** | | | | | |
| Ardelt | Ohio Dept. of Health | P-COVERDELL REGISTRY YR5 Heart Disease and Stroke Prevention (Ardelt – PI) | $244,546 | 6/30/2021 – 1/31/2025 | Collaboration of Stroke Centers Across Ohio |
| Berg, Perzynski | HHS, Office of the Secretary | Restoring Health Equity and Resilience to Cleveland Through Vacant Land Improvements (Berg and Perzynski– Site Co-PIs) | $558,420 | 9/1/2024 – 8/31/2028 | Western Reserve Land Conservancy |
| Berg | NIH R01 HD098127-01A1 | Identifying and Assessing Multi-Level Barriers to Equitable Postpartum Sterilization (Arora-PI, Berg – Site PI) | $216,902 | 9/1/2021-1/31/2024 | University of North Carolina Chapel-Hill |
| Bolen | Ohio Dept. of Medicaid ODM202216 | Ohio Cardiovascular and Diabetes Health Collaborative—Cardi-OH (Konstan, Bolen – PI's) | $1,980,114 | 7/3/2019 – 6/30/2025 | 7 Ohio Medical Schools, Better Health Partnership, Cleveland Clinic, Veterans Affairs, University Hospitals, MHS Primary Care Providers |
| Bolen | Ohio Dept. of Medicaid | Northeast Ohio Quality Improvement Hub (Konstan, Bolen – PIs) | $1,401,797 | 10/6/2022 – 6/30/2025 | Northeast Ohio Medical University, Case Western Reserve University, Better Health Partnership, MHS and Regional Primary Care Practices, Greater Cleveland Food Bank, FARE Program, Medicaid Managed Care Plans |
| Bolen | CDC | Heart Health Equity in Cuyahoga County Communities (Bolen/Caron –PI's) | $3,750,000 | 9/30/2023 – 9/29/2028 | BHP, CWRU, UH, Cleveland Clinic, YMCA, Cleveland Food Bank, Cleveland Housing Network, Barbers, AccessHealth, The Centers, MHS PII |
| Bolen, Caron | Agency for Healthcare Research & Quality U18HS027944 | Heart Healthy Ohio (Bolen, Caron – MPI's) | $4,139,237 | 1/1/2021 – 12/31/2024 | University of Cincinnati, Ohio State University, Case Western Reserve University, 3 regional health collaboratives and community organizations, MHS and statewide Primary Care Practices |
| Caron | HRSA T13HP31899 | Primary Care Training and Enhancement: Training Primary Care Champions (Caron – PI) | $780,289 | 9/1/2018 – 8/31/2024 | Neighborhood Family Practice, Care Alliance, Johns Hopkins, Grace Health, Shindo Medical, University Hospitals, MH primary care (Internal Medicine, Family Medicine, Med/Peds, Geriatrics) |
| Davis, Caron | HRSA T29HP46696 | Community Health Worker Training Program (Caron, Davis – PI's) | $2,996,917 | 9/15/2022 – 9/14/2025 | Cleveland State University, Kent State University, CCC, Better Health Partnership, I4HOPE |
| Caron | PCORI HSII | Health System Implementation Initiative (Caron – Site PI) | $80,010 | 8/1/2023-12/31/2024 | University Hospitals |
| Gaglioti | NORC | Building Capacity for Small Organizations Engagement Award Learning Network (Dullabh – PI; Gaglioti -- Site PI) | $8,000 | 9/1/2023 – 12/31/2025 | NORC at the University of Chicago |
| Perzynski | University Hospitals/ Rosenberg Foundation | Northeast Ohio Renal Research Innovation Award (Perzynski – PI) | $62,500 | 12/1/2021 – 2/28/2024 | Tritonx Inc. |
| Perzynski | NIH 1R01AG080486 | Digital Twin Neighborhoods for Research on Place-Based Health Inequalities in Mid-Life (Dalton, Perzynski – MPI's) | $1,570,148 | 1/1/2023 – 12/31/2027 | Cleveland Clinic |
| Perzynski | Social Security Administration | Racial Disparities in Older Adults Employment (site PI) | $32,197 | 9/29/2023-9/28/2024 | The Ohio State University, University of Wisconsin |
| Roach | TRITONX INC. (NIH/NIA; prime sponsor) 1R42AG080886 | Clinical Effectiveness of a Wearable Hydration Device (Johnson – PI; Roach, Piktel – Site Co-PI's) | $1,046,628 | 9/1/2022 - 8/31/2025 | Tritonx Inc. |
| Seeholzer | American Cancer Society RSG-18-137-01 | CHOOSE2QUIT: Improving Equity in Smoking Cessation for Low-Income Adults (Flocke – PI; Seeholzer – Site PI) | $1,505,451 | 8/1/2021 – 7/31/2025 | Case Western Reserve University, Oregon Health Sciences University |
| | | **TOTAL CHRP:** | **$20,373,156** | | |

**~$20 million in active grants in 2024**

# 2024 Dissemination Highlights

- 57 publications in 2024 and 1 book!



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# CHRP Research

# Doug Einstadter

## Speed Rounds

## October 31, 2025

# What are my Roles?

- General Internist
- Member of CHRP since 1995 and PHRI since 2020
  - Primary activity – data management and manipulation.
- Primary instructor in Clinical Research Scholars Program (CRSP).
- Teaching
  - CRSP 401 – Introduction to Clinical Research
  - CWRU SOM: Epidemiology and Biostatistics section for Block One
  - CWRU PA Program: Evidence Based Medicine
- Reviewer for NBME Improving Assessment of EBM Skills
- Keeper of the puns

# Current and Recent Project Collaborations

- CARDI-OH – statewide QI project
- Northeast Ohio Quality Improvement Hub
- CDC- Innovative Cardiovascular Health Program
- Digital Twin Neighborhoods for Research on Geographic Patterns in Mid-Life Health Trajectories
- Racial Disparities in Older Adults' Economic Security when Experiencing Chronic Health Conditions: Insights from Electronic Health Records, Wage Earnings, and Credit Data (OSU).
- Family Financial Connections in the Transition to Adulthood and Implications for Stress, Health and Wellbeing (OSU)

# Aleece Caron

## Speed Rounds

## October 31, 2025


Community Health
Worker Capacity
Building Collaborative

# Community Health Worker Capacity Building Collaborative Grant Update

**Aleece Caron, PhD**

**Katie Davis Bellamy, MSN, RN**

# Project Overview

Addressing community health needs with a regional effort between Northeast Ohio Health Systems and CHW training programs, County Pathway HUBs, and other county and community partners. The overall goal of this **collaborative effort** is to recruit, train, and employee CHWs in urban and rural underserved communities, and increase diversity in the public health workforce.

- Goal 1: **Expand the public health workforce** by training new and existing CHWs and health support workers with specialized training and financial support. We will recruit and train a minimum of 240 trainees over three years.

- Goal 2 : **Enhance, expand and adapt existing training programs** and courses to promote health equity and increase the skills of existing CHWs/HSWs and trainees to respond to public health needs and emergencies with an emphasis on the 10 roles of a CHW from the CHW Core Consensus Project.

- Goal 3: **Increase employment readiness** by partnering with the CHWCBC to provide field placements and apprenticeship programs that will allow CHWS to support the needs of the populations they represent and provide them with employment opportunities that offer competitive salaries and benefits.

# Project Updates

- Held regular collaborative leadership working group meetings
- Held a series of continuing education webinars for CHWs across the state
- Needs assessment developed and deployed to CHWs throughout the state to assess skill importance and confidence – 234 completed surveys
- Recorded several important topic podcasts
- Worked with marketing and web team to create website and project logo
- Held 6 Advisory Board meetings with this group
- Alumni survey deployed for evaluation metrics and reporting

# Project Updates

- 215 of our 240 goal have completed the program, 128 others in process
  - 113 self identified from a disadvantaged background
  - 24 self identified from a rural residential background
- Created statewide apprenticeship program in partnership with Greater Cleveland Partnership(GCP)
  - 10 apprentices tracking hours of our 60 goal

CHWCBC Community Health Worker Capacity Building Collaborative

# Outcomes

- **% of students who reported being highly satisfied or satisfied (combined):**
  - Your teachers: 90%
  - Support for feeling ready for a job: 87%
  - Your internship: 84%
  - Support for applying for certification: 79%
  - Support for finding a job: 69%
- **% of students who reported being highly ready or ready (combined):**
  - Service coordination: 99%
  - Health equity: 97%
  - Interprofessional: 96%
  - Public health: 96%
  - Organization: 96%
- **% of students who reported being neither ready/unready or not ready (combined):**
  - Implementation: 21%
  - Vaccine: 17%
  - Teaching: 14%
  - Health insurance: 13%
  - Emergency response: 10%
- **Currently in a NCE and focused on providing more training on topics prioritized by CHWs**

# Heart Health Equity Cuyahoga:

# MetroHealth

Devoted to Hope, Health, and Humanity

## In Partnership With…

THE CENTERS
Health. Family. Work. Hope.

Cleveland Clinic

University Hospitals

American Heart Association.

BENJAMIN ROSE
Let's rethink aging.

Better Health Partnership
*Collaborating for a healthy community*

BURTEN, BELL, CARR DEVELOPMENT, INC.

CASE WESTERN RESERVE UNIVERSITY

CITY OF CLEVELAND
Mayor Justin M. Bibb
PUBLIC HEALTH

Cleveland State University 1964
School of Nursing
COLLEGE OF HEALTH

Cuyahoga Community College

CUYAHOGA COUNTY BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

famicos FOUNDATION

Greater Cleveland Food Bank

Health Impact Ohio
Equity. Access. Quality.

HUNGER NETWORK

Humana
Healthy Horizons™ in Ohio

Major League Barbershop

Ohio Association of Health Plans

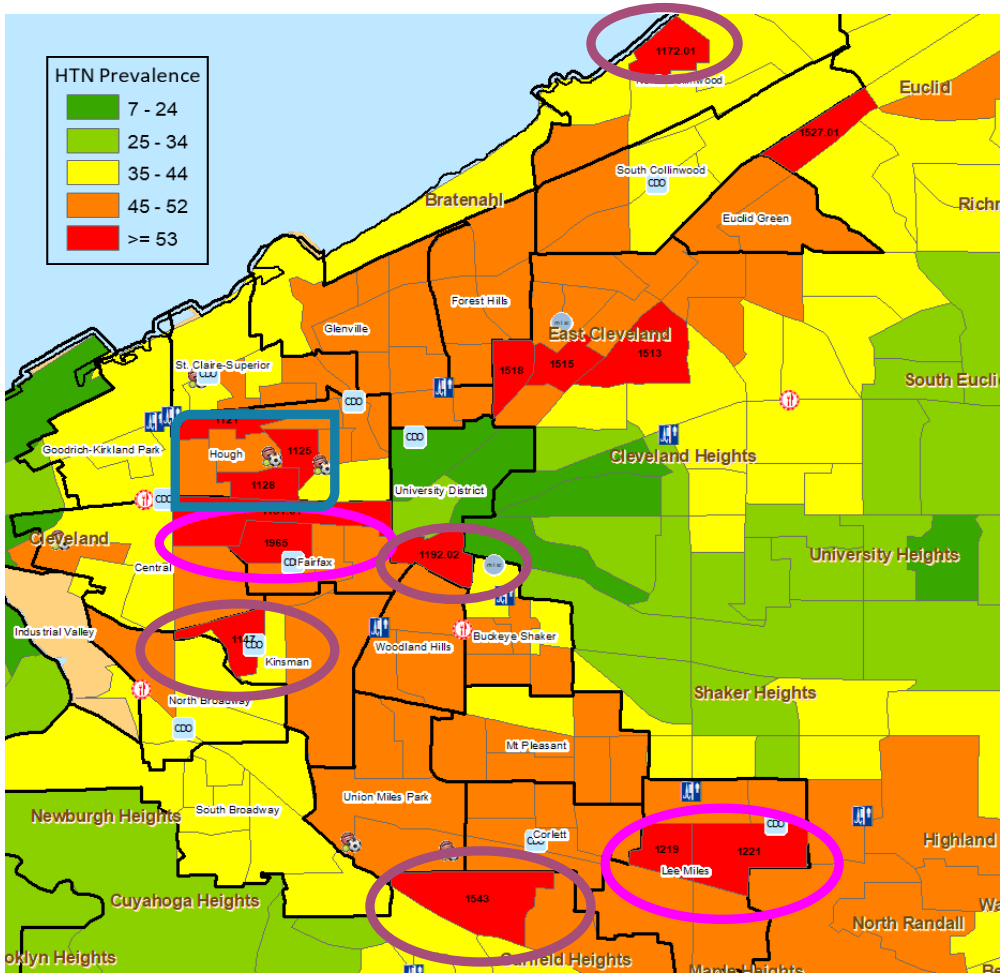
The Urban Barber Association
TUBA

the YMCA

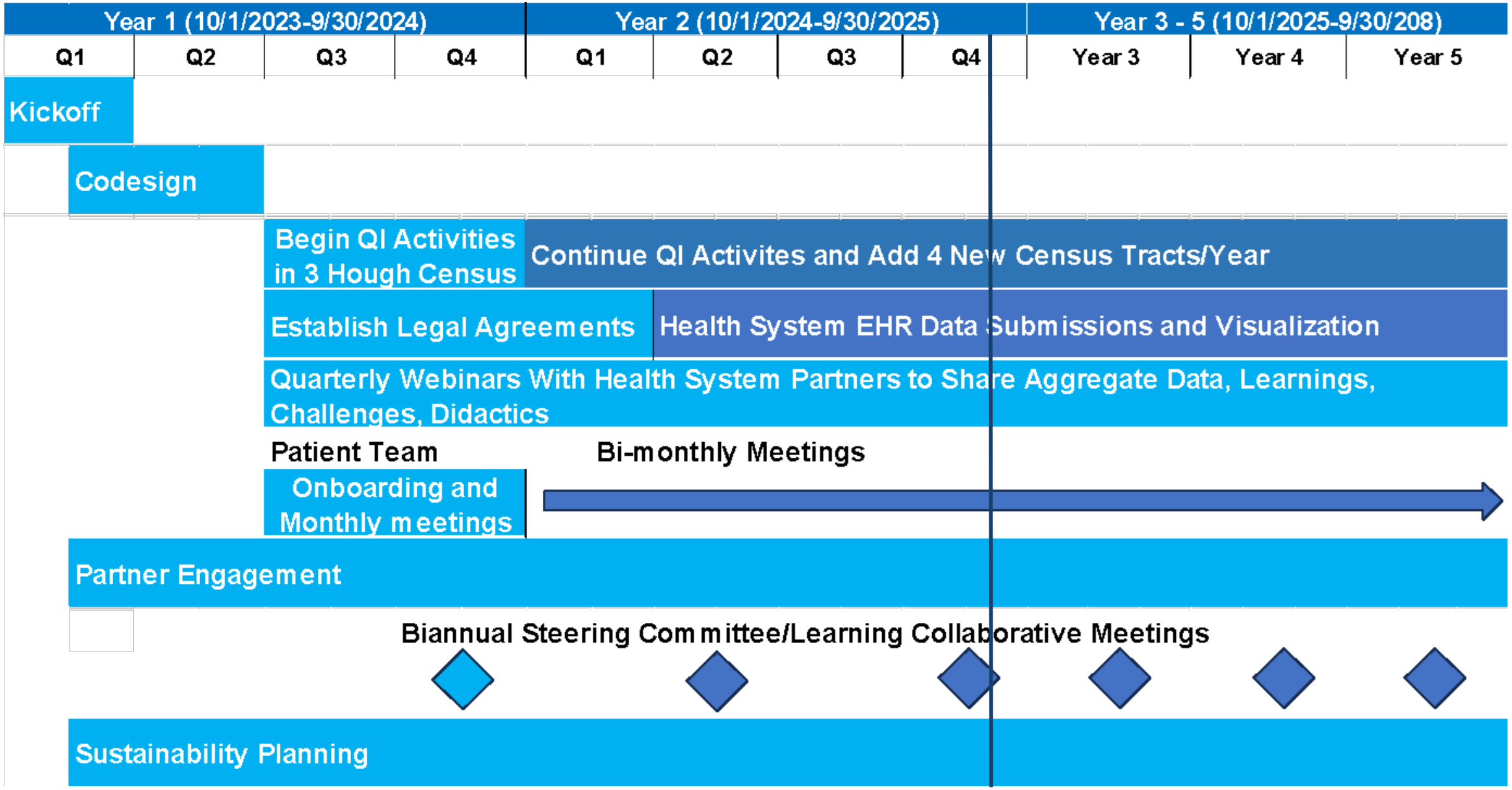
# Heart Health Equity in Cuyahoga County Communities

<u>Purpose</u>: improve high blood pressure and cholesterol within identified neighborhoods at highest cardiovascular risk through:

1. Tracking and Monitoring Clinical and Social Needs Measures
2. Implementing Team-Based Care
3. Linking Community and Clinical Services



# Project Timeline



# Health System Partner Activities Update (CCF, UH, MHS, Centers)

- Health system partners are meeting monthly with the quality improvement coach and quarterly on webinars to share learnings
- Quality improvement activities of health systems thus far include:
    - Team-based care to improve blood pressure (BP) control
    - Home BP monitoring
    - Accurate office-based BP measurement
    - Timely follow up (at least monthly follow up until BP controlled)
    - Referrals to community organizations to address health-related social needs such as food insecurity, transportation, utilities, etc.
    - Outreach to patients with elevated BP in census tracts of interest

# Patient and Community Engagement Updates

- We **meet with a team of nine patient advocates bi-monthly** to facilitate bi-directional feedback on grant activities, including health system Plan-Do-Study-Act (PDSA) cycles. Recent topics include:
  - Community-based blood pressure and SDoH screening
  - Project Community Dashboard
  - Food is Medicine and community-based pantries
- Planning for several community-based pilots are underway:
  - **Barbershop Blood Pressure and Linkage to Clinical Care** – Major League Barbershop and American Heart Association
  - **Food pantry nutrition education and medically tailored options** – Greater Cleveland Food Bank and Hunger Network
  - **Pathways HUB CHW care coordination pilot** – Better Health Partnership and The Centers
- Project team members **completed the National YMCA Healthy Heart Ambassador Program**!
  - We will recruit a health system or community partner to pilot the program in year 3

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# Mary Jo Roach

## Speed Rounds

## October 31, 2025

# CLINICAL EFFECTIVENESS OF A WEARABLE HYDRATION DEVICE

NIA STTR-Triton X, Eamon Johnson PI: Site PIs: MJ Roach & J Piktel

Older persons [55+] often have difficulty monitoring their own fluid intake and in maintaining adequate hydration levels. Existing technologies do not present a consistent, actionable mechanism for measuring the risk of dehydration-related complications. Our device (Codenamed D.R.INK.: Device that Recognizes Need to INtaKe water) is the only one available that measures hydration levels in real-time using a single wrist worn device.

Phase I Completed-25 participants [75% had mild or moderate dehydration at admit to the ED]

- 78% stated they would be interested in use the device in their daily life.
- The device was accurate in determining dehydration comparted with the osmolality lab test

Phase II

- Clinical Control Trial To test the effectiveness and understand the user experience of a wearable device to detect hydration levels in older adults admitted to the emergency department and during home use.
- Began Recruitment October 1st [Enrollment Anticipation:75 Intervention; 75 Control]

# THE EFFECTS OF EXTREME WEATHER ON PERSONS WHO USE ELECTRICALLY POWERED DURABLE MEDICAL EQUIPMENT

PHRI & CTSC PIs: MJ Roach & T Aung

PURPOSE: To understand the experience of persons who use electric durable medical equipment in extreme weather conditions.

METHODS: Qualitative Interviews

Recruitment was through Physician, Flyers, the Chapter of United Spinal & Social Media

SAMPLE: 20 interviews; 13 with persons with tSCI and 7 with persons with a chronic health condition

Age ranged from 35-64

7 White; 6 Black

9 Males; 4 Females

# HEALTH CONSEQUENCES

*"[I] did not go to dialysis on Saturday…"*

*"I fell out of my chair and had to scoot on snow and ice to get back in. This caused a pressure ulcer…"*

*I…when electricity goes out in my bed, my mattress is an air mattress because of the sores and stuff on me, so the mattress goes flat. So now I'm lying on a metal platform, I guess you could say."*

*"..there was a power outage …where my nurse lived and she had…there was no lights anywhere, including in her house, and including on the roads, and she didn't feel comfortable driving. So, she couldn't make it out to my house to do my bowel care."*

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# FINANCIAL CONSEQUENCES

*"I had to throw out a lot of food after the storms. I contacted food stamps, and they said they would add some extra money to my card. Do you know how much they gave me? $4.00, $4.00. What am I supposed to do with $4.00?"*

*"...I actually had to take some time off to heal wounds."*

*"If you don't have power in the winter...means going to a hotel or motel, which is typically my plan..."*

# SOCIAL SUPPORT: Instrumental

*"On Saturday, I went to a neighbor who is on the 1st floor apartment to wash up. They were able to help me wash up and I have wounds, one on my side and they helped change my pads for the wound. "*

*"So mostly it's just my friends around here and they'll come right away. And, they love doing that stuff [helping me when I need it]."*

*"We took all our chargeable things to their [NEIGHBOR] garage …"*

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# BURDEN ON FIRE DEPARTMENTS

*"I called the fire department to get me upstairs."*

*"...if they hadn't gone on [ELECTRICITY], I would have had to get the fire department to take me."*

*"...my fallback probably would have just been calling emergency personnel to get them here."*

;

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Ohio Cardiovascular Disease Collaborative: CARDI-OH

- Data & Evaluation of ECHO QI projects

CDC Grant

- Assessing SDOH screening & referral process between health systems & community organizations
- Case Study Assessment of a successful Hypertension Project

NEURO TRAUMA RESEARCH GROUP

2025 projects that have been published or submitted for publication

- Predictors of withdrawal of life-sustaining therapies in older adults with TBI
- Novel association of the Rotterdam computed tomography score with decompressive craniectomy
- Pre- and Post-Clinical Trial Prescription Practices for Neuropathic Agents Among Patients with Acute Spinal Cord Injuries
- Isolated Trauma vs Polytrauma on Rehabilitation Outcomes

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# Shelia Malone

## DrPH, MPPA, BS, CPH

# Research Interests

## Recent Publications

- Jones E, **Malone S**. History of Medical Sociology. Encyclopedia. 2025; 5(3):134. https://doi.org/10.3390/encyclopedia5030134
- Shoman A, **Malone S**, Barnes T, Hynes A, Jones W, Jones E. Trends in Obesity Among Adultsin Mississippi, 2017–2023. Obesities. 2025; 5(2):21. https://doi.org/10.3390/obesities5020021

## Other Work and Training

- Resource mapping (Web Application)
- NIH SCHARE Training - Data Preparation for Creating AI-ready Quality Data

## Recent Presentations

- **Poster Presentation** - ACADEMY HEALTH 2025 Annual Research Meeting (June 7-10, 2025) Minneapolis, MN
  **Title:** “Employing Spatial Analysis to Determine Neighborhood and Structural Inequities Contributing to Hypertension Prevalence”
  **ID:** 73247
- **Oral Presentation** - THE SOCIETY OF BEHAVIORAL MEDICINE 46th Annual Meeting & Scientific Sessions is happening in San Francisco, CA, March 26 - 29, 2025.
  **Title:** "Context Matters: Hypertension Prevalence in Identified Underserved Communities"

# Current Research

## Barriers to Implementation and Use of Online Referral Platforms

### Health Systems

- Intake processes are often loosely structured and highly manual, relying on personal relationships and traditional communication methods such as phone calls and faxes. This lack of standardization leads to inefficiencies and skepticism about transitioning to electronic platforms.
- Workflows are typically person-specific, meaning tasks are tied to individual staff members rather than a shared registry, which complicates collaboration and task transfer within teams.
- Resource and coordination gaps further hinder progress, as some agencies lack the bandwidth or infrastructure to respond promptly to referrals, resulting in delays and unmet needs.
- System design and usability issues also pose challenges, particularly when cases need to be transferred between inpatient and outpatient teams, often requiring manual workarounds due to platform limitations.

### CBOs

- Usability issues with referral platforms are common, especially the lack of visibility into the status of referrals, which can leave organizations uncertain about next steps.
- Staffing shortages frequently limit the capacity of CBOs to fulfill social needs, sometimes forcing them to refer clients elsewhere.
- Eligibility requirements can also exclude certain clients from receiving services, creating additional challenges.
- Referring organizations sometimes lack adequate screening or knowledge about the services offered by CBOs, leading to confusion and misdirected referrals.

# Current Research

## Facilitators to Implementation and Use of Online Referral Platforms

### Health Systems

- **Improved accountability and tracking**: The system creates a secure, electronic "paper trail" for referrals, eliminating the risk of lost paperwork or human error from manually documenting in a spreadsheet. This ensures every action is tracked from the initial need until it is met.
- **Quantifiable data and insights**: The system automates data collection on referrals, quantifying the qualitative work of social workers and other community support staff. This provides valuable data to business leaders to identify community gaps and make data-driven improvements.
- **Enhanced efficiency and time savings**: Electronic forms pre-populate patient information, standardize templates, and eliminate the need for manual data entry. The real-time visual tracking of referral status also saves time for staff, allowing for quicker and more efficient multitasking.

### CBOs

- **Centralized oversight and reporting:** The system provides management with high-level dashboards for an at-a-glance view of all referrals, allowing them to quickly identify and escalate stalled cases. It also generates monthly reports for referring organizations to track referral volume and outcomes.
- **Enhanced communication and transparency**: The platform serves as a central hub where staff can log detailed notes on a case, which are then visible to other agencies and partners. This promotes direct communication between workers and organizations, improving transparency and understanding of the client's situation.
- **Streamlined partnerships:** The platform facilitates partnerships and relationships with other CBOs, allowing them to work together more effectively. This leads to smoother transitions for individuals and avoids the need for multiple referrals.

# Current Research

## Recommendations

More standardization

Transparency

Well-resourced systems to support effective social needs referrals

# Halloween Trivia

Where is the world's longest haunted house?

**Shari Bolen MD, MPH**

Professor of Medicine

Director, Center for Health Care Research and Policy

Director, Population Health Research Institute

# About Cardi-OH

CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

Founded in 2017, the mission of Cardi-OH is to improve cardiovascular and diabetes health outcomes and eliminate disparities in Ohio's Medicaid population.

**WHO WE ARE:** An initiative of health care professionals across Ohio's seven medical schools.

**WHAT WE DO:** Identify, produce, and disseminate evidence-based cardiovascular and diabetes best practices to primary care teams.

**HOW WE DO IT:** Online library of best practices resources available at Cardi-OH.org and via our web app, including monthly newsletters, podcasts, webinars, and quality improvement using the Project ECHO® virtual training model.

*Learn more at Cardi-OH.org*

CASE WESTERN RESERVE UNIVERSITY School of Medicine

In partnership with

The Ohio State University College of Medicine

College of Medicine and Life Sciences, The University of Toledo

Ohio University Heritage College of Osteopathic Medicine

Northeast Ohio Medical University

University of Cincinnati College of Medicine

Boonshoft School of Medicine, Wright State University

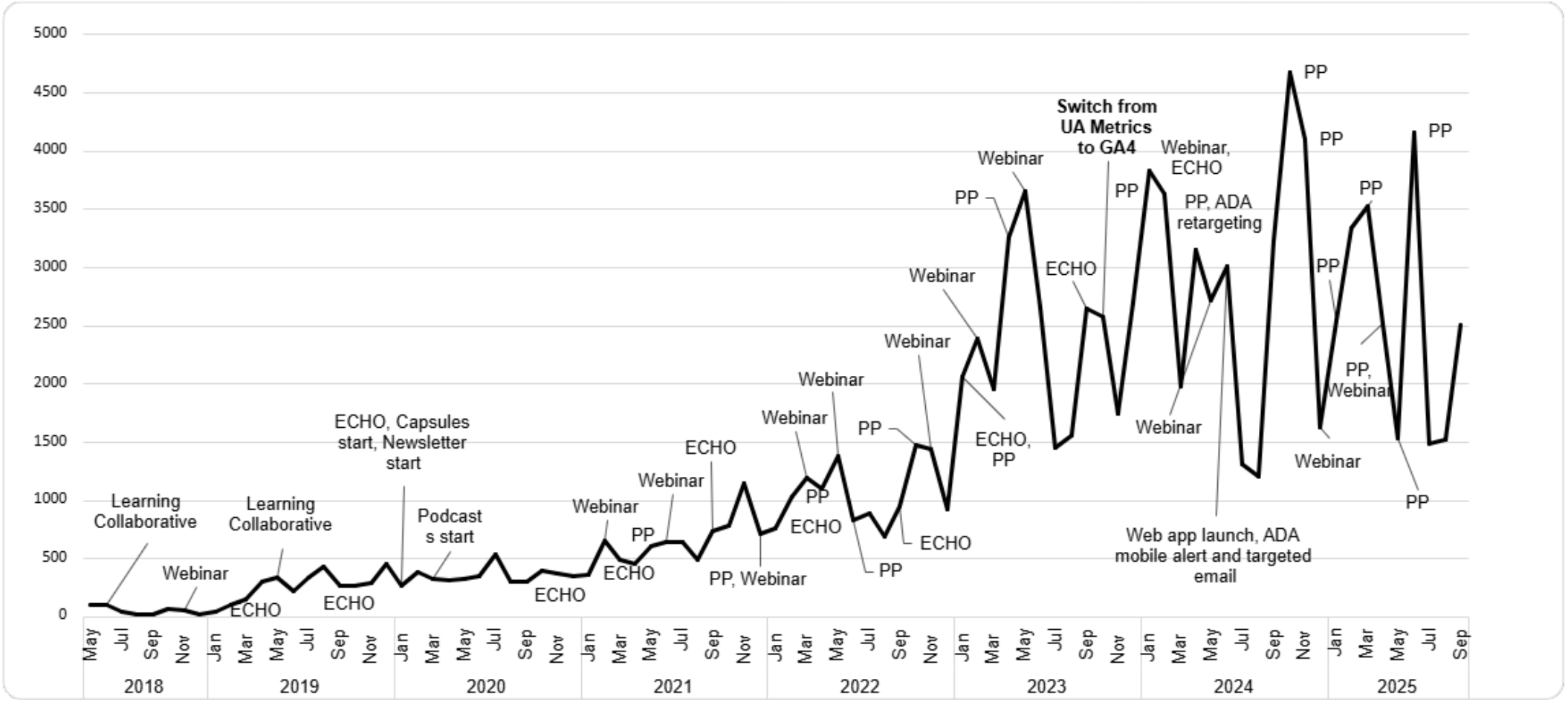
Government Resource Center

medtapp

Ohio Department of Medicaid

# Monthly Number of Website Users

CARDI·OH
Ohio Cardiovascular and Diabetes Health Collaborative



**Statewide Webinar**

# Think Well, Live Well: Brain Health Through a Holistic Lens

**Wednesday, December 3, 2025 | 12-1 p.m. ET**

**KEYNOTE SPEAKER**


**Robert B. Saper, MD, MPH**
Professor, Cleveland Clinic Lerner College of Medicine
Case Western Reserve University
Chair, Department of Wellness and Preventive Medicine
Cleveland Clinic


## OBJECTIVES

- Understand the impact of lifestyle and behaviors on cognitive wellness
- Identify modifiable risk factors for decline in cognitive function
- Counsel on key lifestyle interventions for the prevention of cognitive decline and protection of brain health

**Register at Cardi-OH.org**

**1.0 CME Credit Available**

CARDI·OH

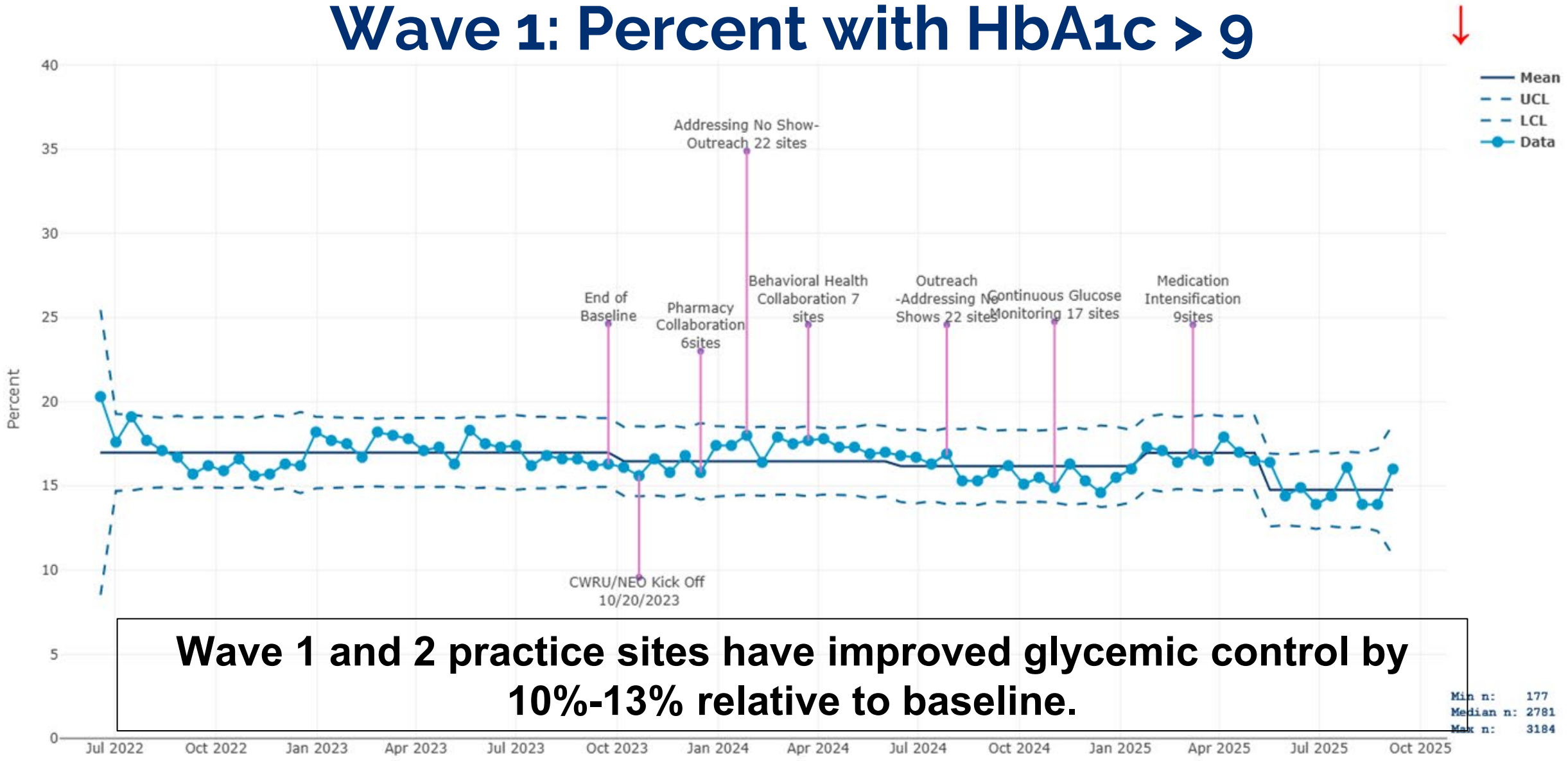
# Regional Quality Improvement Hubs

Reliably translate best-evidenced care into clinical practice, offering structure to collectively support health improvements that can be measured at the levels of Ohio's populations.

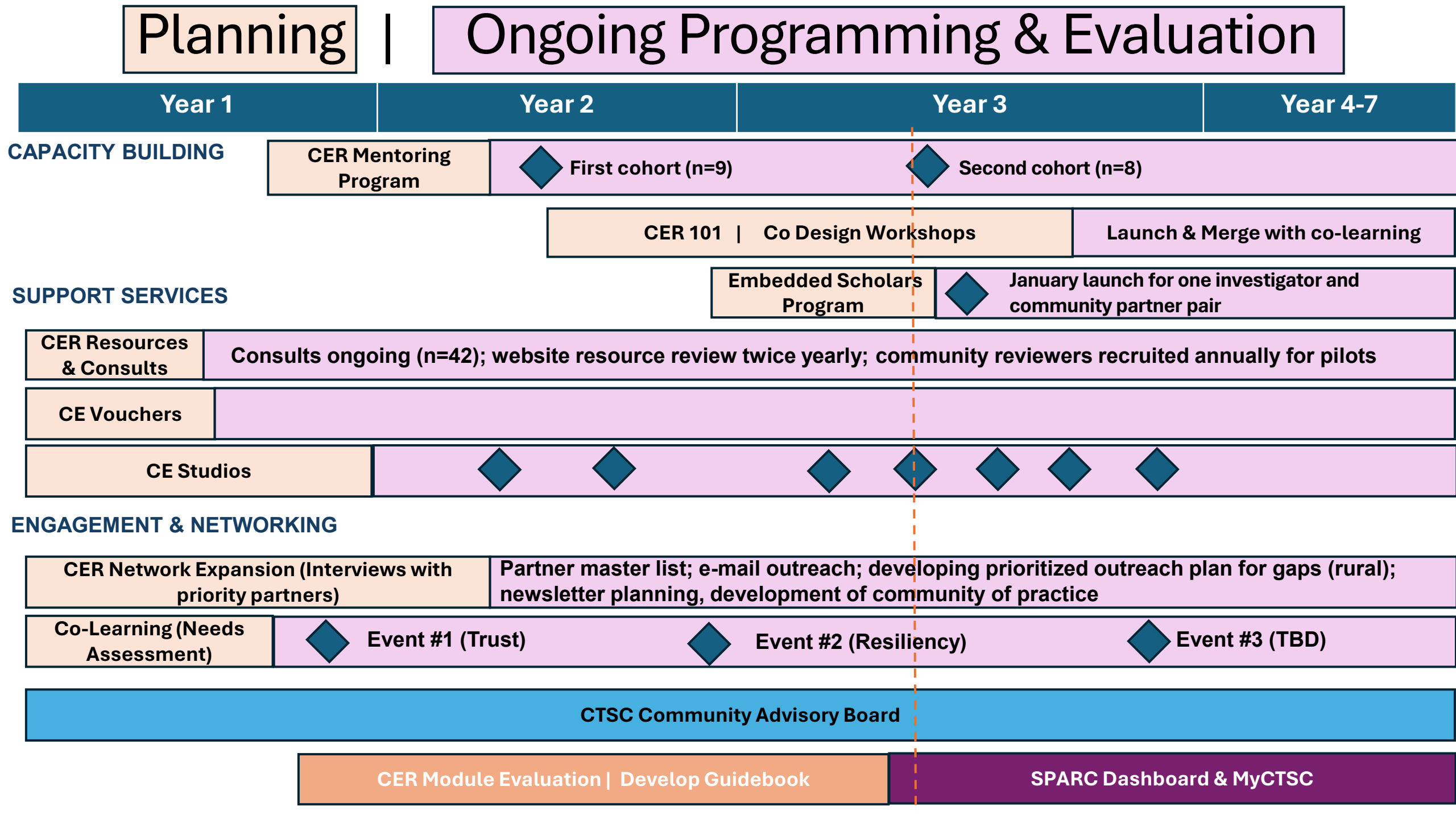
# Project Overview

- The Ohio Department of Medicaid has established Regional QI Hubs across Ohio to advance population health improvement for Medicaid enrollees.
- The NEO QI Hub is led by Case Western Reserve University School of Medicine in partnership with NEOMED, regional healthcare systems, and FQHCs.
- The initial QI project of the NEO QI Hub, AHEAD (Achieving HEAlth Equity in Diabetes), seeks to improve the health of adults living with diabetes in NEO by using QI science to improve glycemic control and eliminate disparities.
- To date, 47 NEO primary care practices across 11 health systems are enrolled: 25 in Wave 1 and 22 in Wave 2.

# Wave 1: Percent with HbA1c > 9




**Wave 1 and 2 practice sites have improved glycemic control by 10%-13% relative to baseline.**


Planning | Ongoing Programming & Evaluation
Year 1
Year 2
Year 3
Year 4-7
CAPACITY BUILDING
CER Mentoring Program
First cohort (n=9)
Second cohort (n=8)
CER 101 | Co Design Workshops
Launch & Merge with co-learning
SUPPORT SERVICES
Embedded Scholars Program
January launch for one investigator and community partner pair
CER Resources & Consults
Consults ongoing (n=42); website resource review twice yearly; community reviewers recruited annually for pilots
CE Vouchers
CE Studios
ENGAGEMENT & NETWORKING
CER Network Expansion (Interviews with priority partners)
Partner master list; e-mail outreach; developing prioritized outreach plan for gaps (rural); newsletter planning, development of community of practice
Co-Learning (Needs Assessment)
Event #1 (Trust)
Event #2 (Resiliency)
Event #3 (TBD)
CTSC Community Advisory Board
CER Module Evaluation | Develop Guidebook
SPARC Dashboard & MyCTSC


Halloween is woke,
and there's nothing
we can do about it.
~ Jason Blum
Happy
Halloween




MetroHealth