rchn
community health foundation

IMPROVING POPULATION HEALTH, ADVANCING HEALTH EQUITY

CONTENTS

Cover photo by Simon Fitzpatrick

MESSAGE FROM THE PRESIDENT AND CEO

Dear Colleagues,

We are pleased to share with you a summary and update of projects supported by our population health improvement initiative, now in its fourth year.

This is an adaptive, encompassing effort and the successes of our program grantees reflect deep engagement, substantive collaborations and committed leadership at all levels. We are grateful to our health center and PCA partners and are excited to continue this work into the future.

My special thanks are extended to our advisors and colleagues David M. Stevens, M.D., FAAFP, Paul Melinkovich, M.D., and the late Merle Cunningham, M.D., MPH for their invaluable expertise, leadership and collaboration.

Feygele Jacobs, DrPH
President and CEO

The RCHN Community Health Foundation is a not-for-profit foundation established to support the national community health center movement. Launched in 1965 to provide care to medically underserved communities, today's community health centers offer affordable, accessible, and comprehensive primary health care services to urban and rural communities and populations designated as medically underserved because of poverty, elevated health risks, and a shortage of primary health care. Health centers address the needs of all community residents, from infancy through old age, are governed by community boards - a majority of whose members are health center users - and provide access both to high-quality clinical care and additional services to enhance access for all patients, regardless of income or ability to pay. The earliest health centers - established by the Office of Economic Opportunity as a War on Poverty demonstration program - borrowed from a model that was part of pioneering efforts to improve the health of South African homeland residents under apartheid and emphasized not only affordable care but also extensive efforts to improve the underlying social conditions that affect health. This commitment to health, not just health care, remains true today. Across the country, health centers are extensively involved in their communities, not only as providers of culturally competent health care services but as community-anchoring institutions whose staff are active participants in efforts to improve education, social services, employment opportunities, affordable housing, transportation, access to good nutrition, and other services.

These signature characteristics uniquely position health centers to engage in efforts to strengthen and expand their capacity for population health improvement and to reduce health disparities. The capacity for successful population health management is essential if health centers are to flourish in the evolving health reform environment, which emphasizes value-based primary care.

In 2015, the Foundation launched a population health initiative, intended to help health center organizations implement comprehensive and community-centered population-focused health improvement strategies. The aims of the RCHN CHF program are to:

- Support health center-level progress toward improving population health management capacity and outcomes;
- Strengthen capacity to identify, engage and manage health in a defined population, incorporating both patient- and community-level approaches;
- Deepen features of patient- and community- centered health homes;
- Advance efforts to address social determinants of health;
- Encourage local and regional collaborations and broader opportunities for sharing best practices.

Working on local priority issues, our health center and PCA population health grantees have developed and implemented innovative strategies to strengthen capacity, enhance services and collaboration and promote sustainability to address specific challenges and improve overall health. By taking direct aim at social and environmental drivers of health, they strive to improve and elevate the health of their communities. Although each may have a distinct programmatic or clinical focus, the diverse initiatives we support, in New York City and across the nation, all have a shared mission and a common theme – to improve health and strengthen the community on a local level - and a commitment to excellence and equity deeply centered at the heart of the community health center movement.

POPULATION HEALTH PROJECT PARTNERS

2015 - 2017

1. ACCESS Family Care (Neosho, MO)
2. Adelante Healthcare, Inc. (Phoenix, AZ)
3. Charles B. Wang Community Health Center (New York, NY)
4. Colorado Community Health Network (Denver, CO)
5. Erie County Community Health Center (Sandusky, OH)
6. Hudson Headwaters Health Network (Queensbury, NY)
7. Santa Rosa Community Health (Santa Rosa, CA)

2017 - 2019

1. Access Community Health Network (Chicago, IL)
2. Fenway Health (Boston, MA)
3. Georgia Primary Care Association (Decatur, GA)
4. Idaho Primary Care Association (Boise, ID)
5. Mariposa Community Health Center (Nogales, AZ)
6. St. John's Well Child and Family Center (Los Angeles, CA)

COMPREHENSIVE PCMH INTEGRATION

ACCESS FAMILY CARE (NEOSHO, MO)

Diabetes, a widespread condition among older adults and in low-income, minority and other vulnerable communities, runs rampant in the Ozarks section of Southwest Missouri, where ACCESS Family Care serves more than 20,000 people each year. At ACCESS, about 14% of those served have diabetes, as compared with 9% nationally, and patients living with the illness have high rates of avoidable emergency room visits and hospital admissions. ACCESS Family Care designed a comprehensive intervention to streamline patient care and create stronger linkages between the hospital, home and community. A dedicated Community Resource Coordinator was assigned to facilitate communication with hospital partners, identify persons with poorly-controlled diabetes at discharge, and assist patients in identifying and accessing services to help better manage their condition and avoid the hospital. The health center established a regional Transitions of Care Network, and took the lead to collaborate with providers over several counties to coordinate care for patients.

On site, the health center established an eye service and initiated diabetic vision screenings, integrated oral health across all sites, and incorporated behavioral health specialists and pharmacists into the care management team so that patients could benefit from the expertise of a wide range of supporting professionals. New documentation management processes were introduced to ensure that reliable data was available for analysis and action. After a pilot launch, the project was expanded from its original location to the center's six sites, with a focus on reducing the percentage of all patients with poor diabetic control and an emphasis on expanding the capacity to operate as a high-performing Patient Centered Medical Home.

KEY PROJECT OUTCOMES

Poorly-Controlled Diabetes

Overall, the percentage of people with poorly-controlled diabetes (HbA1c>9 or untested) decreased from 38% to 28%.

Integrated Health Homes

Patients in the Health Home Initiative had the greatest and most sustained improvement. Percentage with poor diabetic control decreased from 29% to 18%.

Annual Eye Exams

With implementation of a system-wide on-site screening program utilizing retinal fundus cameras, the percentage of people with diabetes receiving annual eye exams increased from 47% to 76%.

ADVANCING IMPROVEMENTS IN CANCER SCREENING

ADELANTE HEALTHCARE, INC. (PHOENIX, AZ)

Adelante Healthcare serves a diverse population at high risk for colorectal cancer, the third most prevalent cancer and the nation's second leading cause of death. The communities served by Adelante, including a sizable number of migrant and seasonal agricultural workers and their families, are at increased risk for colorectal and other cancers that disproportionately affect minority populations. Yet, Adelante observed that the patient population was extremely difficult to reach, screen and retain for preventive care.

Building on a successful collaboration with Arizona State University College of Nursing, Adelante launched a multi-disciplinary, evidence-based program to improve screening, follow-up and ongoing care, initially focused on colorectal cancer.

Quality coordinators were deployed to oversee outreach, care coordination, patient education, and data collection at the health center's nine practice sites, and health coaches were embedded into the care teams. Training curricula were developed for clinical staff and medical assistants to help them better identify, inform and test high-risk patients. Process improvements and workflow changes, including an expanded role for Medical Assistants to apply standing orders for cancer screenings, were implemented across the health center, and patient-centered outreach to at-risk community members was enhanced and expanded. Simultaneously, the center implemented new applications to enhance data capture, analysis and reporting capabilities in support of clinical and program objectives. The program was expanded to encompass screening for breast and cervical cancers.

KEY PROJECT OUTCOMES

In the first program year, screening rates were improved for colon, cervical and breast cancer across the patient population.

In the second year, screening rates were improved for cervical and colorectal cancers, with the most significant improvements in colorectal cancer screening rates achieved for Adelante's high-risk diabetic patients.

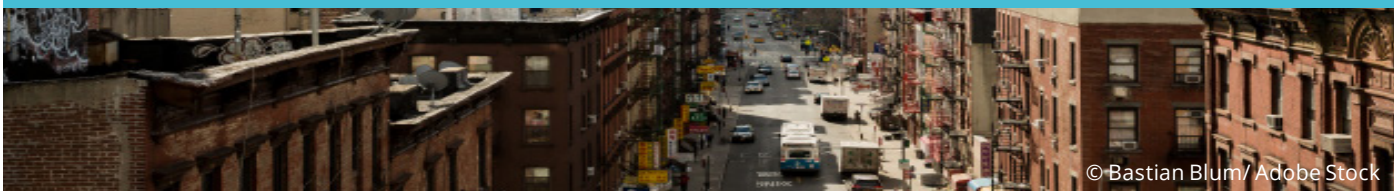
Year-Two Screening

number of patients screened for cervical cancer

number of patients screened for colorectal cancer

By establishing partnerships with local providers, Adelante was able to secure follow-up services for uninsured patients and ensure that those with positive screening results received appropriate follow-up.

COMMUNITY ACTION ON SMOKING & HEALTH



CHARLES B. WANG COMMUNITY HEALTH CENTER (NEW YORK, NY)

Tobacco use is the number-one cause of preventable death. Yet among Asian Americans, smoking is widely accepted, reflecting the social and economic stressors associated with tobacco use and the lack of targeted educational and cessation resources. Recent data for New York City put the smoking rate among Asian American men far above the citywide average, and indicated that lung cancer deaths among Chinese New Yorkers had actually increased between 2000-2014.

To address this disparity, and improve overall health, the Charles B. Wang Community Health Center worked in collaboration with community and academic partners serving the city's Chinese communities in Lower Manhattan and in Flushing, Queens.

The health center developed a bi-lingual survey to determine patient knowledge about the health risks of smoking and second-hand smoke, assess cultural views on smoking, and understand barriers to smoking cessation. They then developed multiple, bi-lingual strategies to tackle smoking and attendant risk. These included implementing a smoking cessation coaching program, training staff on smoking cessation resources, counseling and referral, creating a comprehensive anti-smoking campaign to deliver educational messages through print, television, radio and digital media platforms, and piloting a free Nicotine Replacement Therapy distribution program. The health center also engaged the area's private practice physicians, to support their adoption of tobacco screening, counseling, and referral protocols.

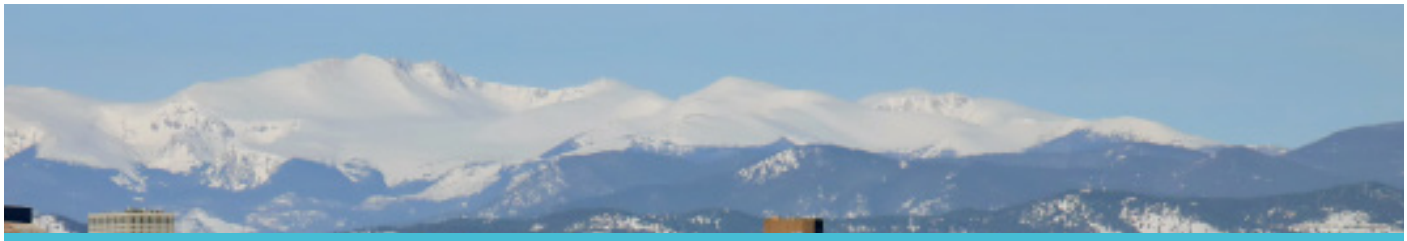
KEY PROJECT OUTCOMES

In conjunction with collaborating partners, the health center launched the first North American Chinatown Smoke-Free Day. Now in its fourth year, the initiative – with events in NYC, Boston, Los Angeles, San Francisco, Oakland, and Toronto – aims to raise awareness of smoking risks, provide community education, and offer support to physicians to engage in smoking cessation activities.

206/310 or two thirds of program participants stopped or reduced smoking through individual smoking cessation counseling services, including 18 who quit for six months, and 11 who quit for one full year.

CBWCHC's strong advocacy and leadership led to a commitment of resources by the New York City Department of Health and Mental Hygiene to a culturally relevant and language-accessible smoking campaign, and a series of anti-tobacco legislative bills, signed into law in 2017, aimed at reducing the number of smokers in New York City.

A subsequent evaluation of all outcomes for the smoking health coach intervention found that 15% of participants quit for at least 3 months.



ADVANCING IMPROVEMENTS IN WOMEN'S HEALTH

COLORADO COMMUNITY HEALTH NETWORK (DENVER, CO)

Cervical cancer is a largely preventable disease, yet Colorado has an estimated incidence of 160 new cases annually. The incidence rate nationally is higher among Latina women, at 9.3 cases annually per 100,000, and among all low-income women, reflecting social determinants and access barriers that delay early detection through screening, and timely treatment. Among Colorado's community health center patients - over 90% of whom have incomes below 200% of the Federal Poverty Level, and 35% of whom are Hispanic - just 59% of all adult women received cervical cancer screenings, a rate well below national targets.

Recognizing the elevated cancer risk for the those served by the state's CHCs, Colorado Community Health Network (CCHN) worked with a pilot group of health centers across the state to help them assess clinical workflow and adopt and share practice improvements aimed at increasing cancer screening rates, advancing team-based care, and improving cancer outcomes.

Building on the needs assessments, workflow and process changes were incorporated on a health-center-specific basis, these included: development of pre-visit planning reports; implementation of auto-indexing; daily team huddles; implementation of patient and provider focus groups; development of standing orders for Medical Assistants related to cervical cancer screening workflow; and creation of education materials, messaging and scripts for staff to use when discussing the importance of screening with patients. Several CHCs expanded Medical Assistant and Registered Nurse roles.

In year two, and building on the earlier practice transformation work, four centers in the initial cohort of six CHCs worked to develop comprehensive, integrated women's health services, while three new CHCs joined the project to implement the cervical cancer screening initiative.

KEY PROJECT OUTCOMES

At the end of year two, the four CHCs continuing from the initial cohort reported improvements in the cervical cancer screening rate, from a mean of 52.4% to 58.4%.

For these four CHCs, the percentage of women who completed the HPV vaccination series increased:

from 27.4% to 31.5% (ages 9-18)

from 21.7% to 24.9% (ages 19-26)

Meanwhile, in year two, two of three newly-added practice sites reported improved screening rates.

CCHN worked closely with the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Clinicians Advisory Network to align reimbursement for Long-Acting Reversible Contraception (LARC) with CHC needs and process; as a result, CHCs began billing for LARC services on a fee-for-service schedule as of July 1, 2017.

CCHN initiated and strengthened collaborative relationships with the Colorado Department of Public Health and Environment (CDPHE) Title X Family Planning Program, the Centers for Disease Control, and the Office of Population Affairs.

REDUCING AND PREVENTING INFANT MORTALITY

ERIE COUNTY COMMUNITY HEALTH CENTER (SANDUSKY, OH)

The infant mortality rate for African American babies in Ohio has ranked worst in the nation, tied for 50th place. It was highest in Erie County, located on the Lake Erie shore, where the infant mortality rate for Black babies was 35.4 infant deaths per 1,000 live births, as compared to 1.5 deaths per 1,000 for white babies. The staggering disparities reflected persistent poverty, lack of insurance, poor access to care, substandard housing and limited educational opportunities for community residents.

The Erie County Health Department/Erie County Community Health Center (ECHD/ECCHC), a Co-Applicant Federally Qualified Health Center, partnered with the Hospital Council of Northwest Ohio to develop a community health assessment specific to women of childbearing age, and analyze data on access, coverage and utilization. The findings were released at a state-wide summit organized by ECHD/ECCHC, which served as the springboard for the formation of a multidisciplinary regional leadership group that worked collaboratively to reduce and prevent infant mortality in the region.

As part of this initiative, ECHD/ECCHC: established new partnerships; prioritized healthcare needs for pre-conception, prenatal, postnatal and pediatric services; initiated a new Community Health Worker (CHW) care model; enhanced health messaging; adopted population health management software to improve data collection and analysis; implemented an automated patient reminder and recall system; initiated school-based health care; and expanded pediatric services. The CHW offered home, off-site and health center-based visits to link at-risk women to information, health care, and community services, and provided resources including safe sleep educational materials, Cribs for Kids and Baby Boxes.

Project-specific quality improvement initiatives were implemented to reduce the incidence of premature birth, promote prenatal smoking cessation, and improve access to and utilization of Long Acting Reversible Contraceptives.

KEY PROJECT OUTCOMES

The center increased the number of well-child visits by 6% from 2016-2017.

ECCHC gained 173 new pediatric patients from January through September 2017.

In June 2017, the center was recognized by the Ohio Association of Community Health Centers (OACHC) as a top performer among Ohio's CHCs for the measures of prenatal entry into care in the first trimester and live birth weights <2500 gms.

ECCHC received recognition as a Level 2 Patient-Centered Medical Home (PCMH) from the National Committee for Quality Assurance (NCQA) in July 2017.

The area's first inpatient detox facility was subsequently opened, in 2018, implementing a center-developed, evidence-based protocol to effectively treat substance-addicted patients.

IMPROVING REGIONAL PEDIATRIC CARE MANAGEMENT

HUDSON HEADWATERS HEALTH NETWORK (QUEENSBURY, NY)

Hudson Headwaters Health Network (HHHN) serves a rural 5,000 square mile service area comprising the Lake George/ Adirondack and Glens Falls regions of New York State. HHHN staff identified alarming trends in emergency room (ER) use by the community's children and teens. The youngest, from newborns up to age 10, were seen in the ER largely for asthma or respiratory-related problems; children age 10 to 13 presented primarily with injuries that could be treated in a primary care or walk-in clinic setting; and among teenagers, most ER visits were due to depression or anxiety. Taking a deep dive into the data, HHHN estimated that two thirds of these ER visits were potentially avoidable.

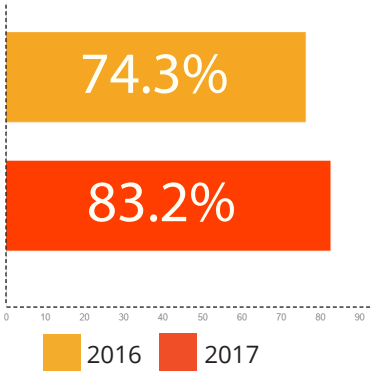
HHHN initially set out to decrease ER visits by children overall - especially the highest utilizers - while increasing appropriate utilization of primary care, improving coordination between primary care and behavioral and mental health providers, and laying the groundwork for a comprehensive pediatric health home model. A respected quality front-runner, HHHN built on its broad and deep data-driven and evidence-based experience implementing a patient-centered medical home model, and leadership of regional initiatives.

As part of the program, HHHN embedded pediatric care managers and Community Resource Advocates into the health center team, enhanced patient and provider education, and established a new data tracking system to facilitate timely monitoring and follow up. One year after starting the program, the health center documented a decrease in ER utilization of 15%. The program was broadened in its second year to address systems and resource barriers to care to improve access and outcomes.

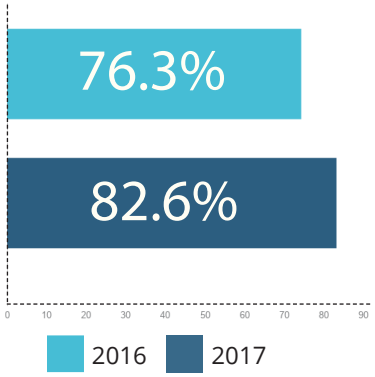
KEY PROJECT OUTCOMES

Program interventions resulted in improvements in pediatric care outcomes for key measures:

Children Using Appropriate Asthma Medications



Immunization Rate in Two - Year Olds



HOMELESS CARE COORDINATION PROGRAM

SANTA ROSA COMMUNITY HEALTH (SANTA ROSA, CA)

Sonoma County, California is an area of temperate weather, lush landscapes, beautiful vistas - and a large homeless population. High rents and low vacancy rates for affordable housing have contributed to an increase in chronic homelessness. Facing census estimates of more than 9,500 homeless individuals in their service area, Santa Rosa Community Health Centers (SRCHC) established a program to address the complex medical and social needs of vulnerable and chronically ill homeless persons, including many high-acuity, high-need individuals struggling with severe mental illness and/or long-term substance use.

Building on an existing intensive care management program, the health center aimed to develop a model for community and medical support of vulnerable people experiencing homelessness - a true medical home for the homeless - that increases access across the spectrum of care and improves general quality of life, while reducing excessive emergency room and inpatient utilization and hospital readmissions. The center extended its high-touch, early intervention care model and piloted new approaches designed to maintain contact with medically fragile patients.

Care Coordinators met patients as needed to help them navigate the health care and social services systems, schedule care appointments, arrange transportation, obtain prescriptions, support behavioral and lifestyle changes, and connect patients with mental health and substance abuse programs. Nurse case managers helped support patient education and self-management. The health center developed and tested data templates to capture care management and care transitions data. To strengthen the service base and ensure that those in their care remain medically stable, the health center also initiated or expanded relationships with local hospitals, community, and advocacy organizations, and successfully leveraged these partnerships to secure new sources of funding support.

KEY PROJECT OUTCOMES

For the final project period (Jan-Sept 2017), of 135 enrolled high-need, high acuity individuals:

72% attended PCP visit within 14 days of enrollment.

92% had no known hospital readmission within 30 days post-discharge, as compared with 70% at the start of the program.

74% had no known ER visit within 30 days post-discharge, as compared to a baseline figure of 60%.

A LOOK AT THE PROJECTS

1. Mariposa CHC & RCHN CHF staff with FVRx program collaborators from Villas Market (Nogales, AZ)

2. Erie County Mobile Health unit, part of their outreach services (Sandusky, OH)

3. GPCA and program collaborators outside Chatham County Juvenile Court (Savannah, GA)

4. RCHN CHF and GPCA staff alongside program collaborators (Savannah, GA)

5. Community Health Workers at St. John's Well Child and Family Center conduct home visits (Los Angeles, CA)

6. Project staff at Access Community Health Network (Chicago, IL)

7. Fresh produce from Boise Farmers Mobile Market for Idaho PCA & Terry Reilly Health Services FVRx program (Boise, ID)

8. Charles B. Wang CHCs "Community Action on Smoking and Health" initiative (New York, NY)

9. ACCESS Family Care staff (Neosho, MO)

ONGOING PROJECTS

ACCESS' Integrated Health Home
Access Community Health Network, Chicago, IL
Chicago's South and West Side communities are characterized by high rates of poverty, trauma, and poor health outcomes, and a disproportionate burden of serious mental illness and substance use disorder. ACCESS, one of the nation's largest health center networks, has launched a pilot program to transform care and improve outcomes for individuals with serious and persistent mental illness through a comprehensive community-based integrated health home model. The trauma - informed program, led by ACCESS in conjunction with hospital, behavioral health and social service providers, provides primary care, behavioral health and substance abuse services including crisis management and medication assisted treatment, inpatient mental health care, recovery coaching, and supportive social, housing and employment services.

Reducing ER Visits and Hospitalizations Among Fenway Health High-Acuity Patients
Fenway Health, Boston, MA
Fenway Health is a leader in providing culturally-affirming care for people who identify as lesbian, gay, bisexual or transgender and the only health center with an LGBT focus in the Boston area. More than 40% of the center's patients identify as LGBT; the health center currently serves more than 4,000 transgender and non-binary people and many have high-acuity needs, including behavioral health conditions that reflect and are exacerbated by pervasive discrimination in housing, healthcare, and employment experienced by members of this community. Fenway Health has launched a multi-faceted pilot to reduce avoidable ER visits and hospitalizations among its high-acuity patients with behavioral health and substance use disorder (SUD) diagnoses, with a special focus on people of transgender experience as well as those insured by MassHealth, the Medicaid program for the state of Massachusetts.

Planning Community Health Care Coordination for Youth in the Juvenile Justice System
Georgia Primary Care Association, Decatur, GA
Juvenile incarceration is associated with adverse health outcomes in later adulthood, but for many vulnerable youth, the problems start much earlier. Lack of access to consistent, comprehensive primary, oral, and mental health care is not only detrimental to long-term health, but impedes early development and exacerbates other social and economic stressors. The Georgia Primary Care Association is spearheading a new pilot program in conjunction with Curtis V. Cooper Primary Health and the Chatham County Juvenile Court to provide comprehensive primary care services to youth in the juvenile justice system. The planning grant phase will set the stage for the full-scale intervention, aimed at engaging youth referrals in a medical home with screening and primary care treatment, including behavioral health and oral health, and improving health and social outcomes for underserved teens.

FVRx Pilot Project for Diabetes Patients: Addressing Food Insecurity to Improve Outcomes
Idaho Primary Care Association, Boise, ID

Deeply entrenched poverty, food insecurity and limited transportation options are the reality for many communities in Idaho, contributing to and exacerbating diabetes and other medical conditions. To tackle the problem, Idaho Primary Care Association (IPCA) is working with Terry Reilly Health Services and other community partners to launch the Fruit and Vegetable Prescription Program (FVRx), an evidence-based program that promotes access to healthful, nutritious food through partnerships between healthcare providers, local food suppliers and community members. The program is initially targeting people with uncontrolled diabetes and other co-morbidities, those at risk, and their family members. If successful, Idaho PCA plans to work with other community health center organizations to expand the program across the state.

Comer Bien (Eat Well)
Mariposa Community Health Center, Nogales, AZ

Mariposa Community Health Center in Nogales, Arizona, serves a predominantly low-income, Mexican-American community situated on the U.S. /Mexico border. Here, food insecurity is prevalent. Limited transportation options, high food costs, and a lack of awareness of diet and nutrition hamper healthful eating. Nearly 14% of the health center's patients suffer from diabetes, and many have other chronic health conditions. Mariposa has launched the "Comer Bien" (Eat Well) initiative to increase access to nutritious food, address food insecurity and improve health outcomes. The initiative includes prescriptions for fruits and vegetables through the FVRx program as well as home assessments by community health workers, cooking classes at a downtown commercial kitchen, care management, and transportation to take patients to participating grocery stores. An existing partnership with the Farmer's Market, established a few years ago by the health center and in conjunction with the local community development organization, will be expanded. The goal is to improve blood sugar control for people with uncontrolled diabetes, and implement strategies to involve the whole family to help patients adhere to the program.

Healthy Homes Healthy Kids
St. John's Well Child and Family Center, Los Angeles, CA

In South Los Angeles, St. John's Well Child and Family Center provides a comprehensive medical home for nearly 80,000 people, including thousands of children with asthma. The burden of asthma is exacerbated by social determinants including substandard housing, and disproportionately effects the area's low-income and minority children. The Healthy Homes Healthy Kids project (HHHK) is addressing housing-related asthma triggers, integrating in-home community health worker outreach, comprehensive case management and primary care. In partnership with Strategic Actions for a Just Economy (SAJE), a community-based organization focused on tenant rights, healthy housing, and equitable development, HHHK is addressing housing problems and engaging with landlords and city agencies to improve housing conditions that contribute to asthma exacerbations.

ABOUT THE FOUNDATION

The mission of the RCHN Community Health Foundation (RCHN CHF) is to support and benefit community health centers and the communities and patients they serve across America.

The Foundation's signature projects and programs focus on helping health centers enhance their capacity, strengthen operations, and expand access.

Our initiatives aim both to address the unique challenges that community health centers face today, and support the development of opportunities to sustain health centers in the future. The Foundation's work includes direct grant making, coalition building, and dedicated policy and health information technology research.