



Improving Population Health

Advancing Health Equity

2017 - 2020 Projects

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Message from the President and CEO



Dear Colleagues,

We are pleased to share with you a summary and update of projects completed in 2020 by organizations participating in the RCHN Community Health Foundation population health improvement program.

This is an adaptive, encompassing effort, launched in 2015, 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 primary care association partners, who completed these projects as an unprecedented global pandemic raged and affected every aspect of care delivery and operations.

My special thanks are extended to our advisors and colleagues David M. Stevens, M.D., FAAFP and Paul Melinkovich, M.D., for their invaluable expertise, leadership and ongoing collaboration. We also acknowledge the important contributions of the late Merle Cunningham, M.D., MPH and the late David Hartzband, D. Sc, both of whom were instrumental in designing the program and working with our earliest cohort of grantees.

Finally, we are grateful for the opportunity to be part of a broader community of health care and philanthropy organizations whose work has motivated and helped shape our health center programs and grantmaking.

The organizations participating in the population health initiative demonstrated that there is great potential for addressing social drivers of health at the community level and improving population health at the same time. We hope these profiles summarizing the work of projects completed by our 2017-2020 cohort and the resources available on our website will inspire and inform your own work to improve community health.

Feygele Jacobs, DrPH
President and CEO

[Read about our earlier projects.](#)



WHERE WE WORK

Population Health Projects

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. They also serve as effective public health first responders, as demonstrated by their leadership in addressing crises including natural disasters, epidemics ranging from HIV/AIDS to Zika to opioid use, and presently, COVID-19.

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 both affordable care and far-reaching 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

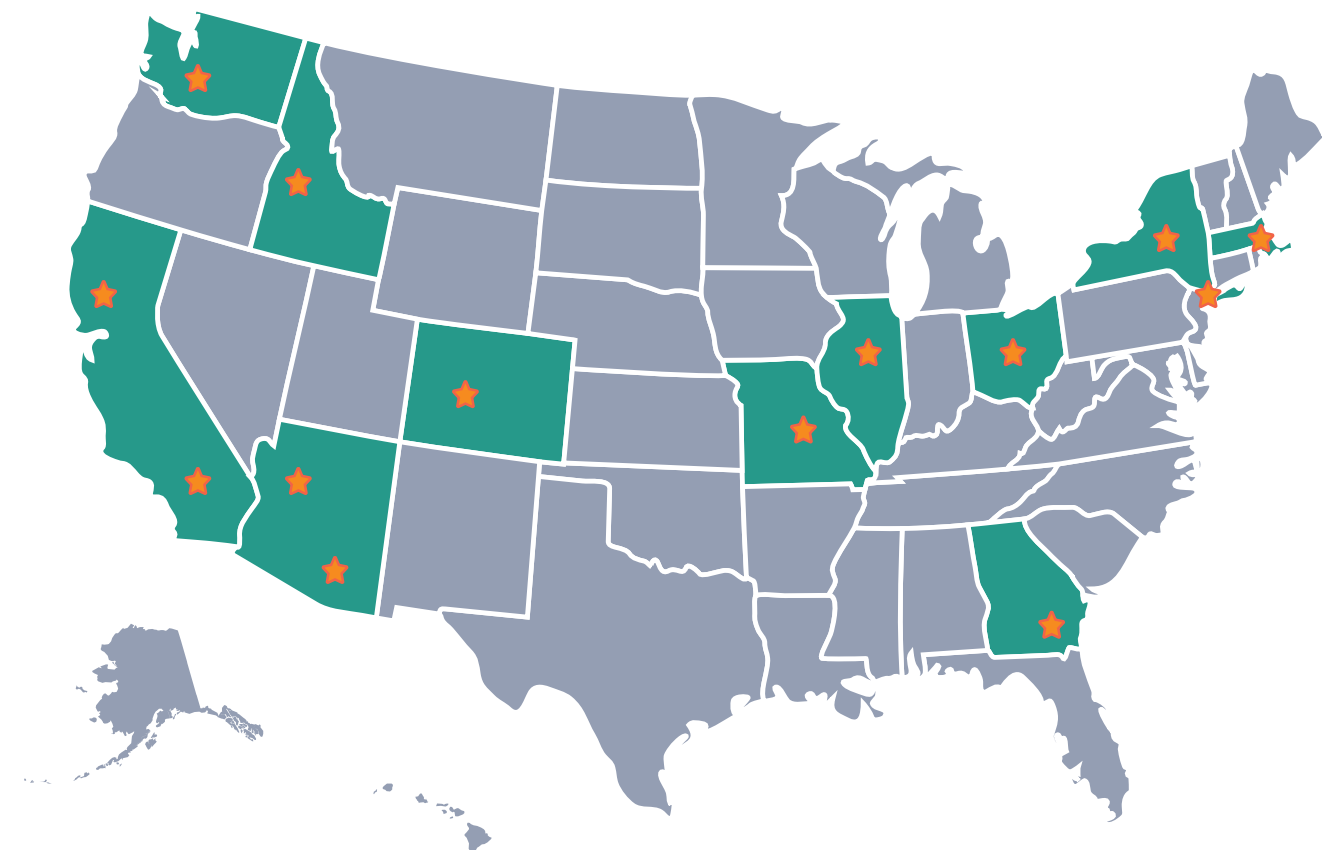
centers are to flourish in the evolving health reform environment, which emphasizes value-based primary care.

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 were to:

- Support health center-level progress toward improving population health management capacity and outcomes for both health center patient populations as well as for a defined community at large;
- 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; and
- Enhance the potential for the sustainability of interventions, partnerships and population health management capacity.

Working on locally-defined priority issues, our health center and primary care association population health grantees developed and implemented innovative strategies to deepen capacity, enhance services and collaboration and promote sustainability to address specific challenges and improve health at both the patient and community level. By taking direct aim at social and environmental drivers of health, they strive to improve and elevate the health of their communities.

Although each has a distinct programmatic or clinical focus, the diverse initiatives we support, in communities across the country, all have shared a 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.



2015-2017

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

2017-2020

- ACCESS Community Health Network (Chicago, IL)
- Fenway Health (Boston, MA)
- Georgia Primary Care Association (Decatur, GA)
- Idaho Primary Care Association (Boise, ID)
- Mariposa Community Health Center (Nogales, AZ)
- Northwest Regional Primary Care Association (Seattle, WA)
- St. John's Well Child and Family Center (Los Angeles, CA)



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ACCESS Community Health Network

CHICAGO, IL

ACCESS' Integrated Health Home

ACCESS Community Health Network, one of the nation's largest health center networks with 35 sites spread across two Illinois counties, provides primary and preventive care services to the communities' predominantly low-income Hispanic and African American populations.

Chicago's South and West Side communities are characterized by high rates of poverty, trauma, poor health outcomes, and a disproportionate burden of serious mental illness (SMI) and substance use disorder.

In anticipation of a major state-wide Medicaid initiative to establish integrated health homes (IHH), ACCESS launched a two-year pilot program to transform care and improve outcomes for clinically complex patients with SMI or substance use disorders.

A significant proportion of ACCESS' patient population has high-risk behavioral health needs. In 2016, as this initiative was being planned, approximately four percent of ACCESS' patients had a SMI diagnosis and the health center provided medication assisted treatment (MAT) services to 700 patients with opioid addiction; ACCESS was driven by the goal of enhancing care for this population. Grounded in the health center's patient-centered medical home model and utilizing a trauma-informed approach, ACCESS served as the lead agency working in collaboration with local health and social service organizations. The IHH pilot offered integrated crisis

management, primary medical care, inpatient and outpatient mental health treatment, recovery coaching, and services to address challenges related to housing, employment, transportation and food insecurity.

To improve the opportunities for successful outcomes, project partners instituted a multidisciplinary "weekly huddle." Shared workflows, and single, shared longitudinal care plans were developed to insure a cohesive, cross-functional system of care across all providers. Recognizing that data transparency and interoperability would be essential to the success of the pilot, the IHH adopted a single consent form for sharing patient data.



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

KEY OUTCOMES

Functionality was added to the health center's electronic health record (EHR) to allow all members of the care team from partner organizations to view a common record, and allow limited documentation by all IHH team partners directly in the medical record.

At the conclusion of the first program year, ACCESS conducted an in-depth analysis of the pilot, and developed an evaluation framework utilizing the Consolidated Framework for Implementation Research approach (CFIR). With some adaptations to accommodate changes in the state's Medicaid plan and timeline for IHH implementation, ACCESS successfully scaled the program in year two, expanding both the number of health centers providing direct IHH services and the availability of community resources, and reaching 163 patients. While the state modified and then delayed its IHH program, ACCESS produced a white paper for stakeholders documenting findings from the pilot and putting forward recommendations for the state-wide launch of the IHH.

Project partners included Sinai Health System, Catholic Charities of the Archdiocese of Chicago, Trilogy, Inc., Behavioral Healthcare, Gateway Foundation and Lurie Children's Hospital of Chicago.



9 sites

In year two, ACCESS expanded the number of health centers providing direct IHH services to 5 additional sites, for a total of 9 sites.

40 patients enrolled in Year 1



76 patients enrolled in Year 2



Decreased turn-around for housing placements from 30 days to 10 days through common access to the EHR.





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Fenway Health

BOSTON, MA

Reducing ER Visits and Hospitalizations Among Fenway Health High-Acuity Patients

Fenway Health, located in Boston, MA, provides culturally-affirming care for lesbian, gay, bisexual or transgender individuals, and is the only health center with an LGBT focus in the Boston area.

More than 40 percent of the health center's patients identify as LGBT and 11 percent are transgender and non-binary people; many have high-acuity needs, including behavioral health conditions that reflect and are exacerbated by the pervasive discrimination in housing, healthcare, and employment experienced by members of this community.

To improve outcomes for its high-acuity patients with behavioral health and substance use disorder (SUD) diagnoses, Fenway Health piloted an initiative to reduce unnecessary emergency department (ED) visits and hospitalizations by enhancing care coordination and expanding access to behavioral health and substance use disorder care and services.

In the first program year, the health center identified an eligible cohort of 450 individuals for program engagement, focusing on those insured by MassHealth, the Medicaid program for the state of Massachusetts. A High-Acuity Medical Case Manager was hired to work with the most at-risk patients, and tailored care plans were developed for a risk-stratified patient cohort. The health center added walk-in behavioral health services to mitigate the long wait times for appointments.

In addition, a low-barrier Medication Assisted Treatment (MAT) program, which combined medication with behavioral

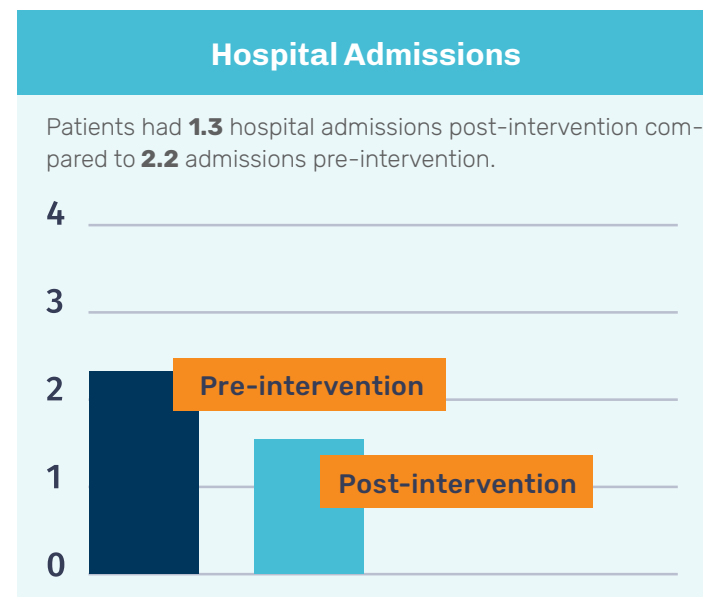
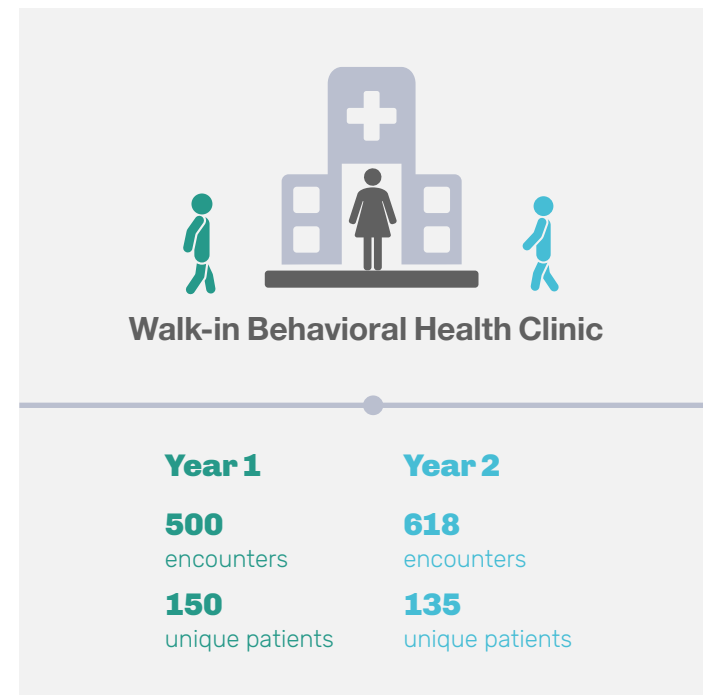
therapies, was integrated into the primary care practice for those with substance use disorder.

In the second program year, criteria for program participation were expanded to include high ED and hospital utilizers, irrespective of diagnosis or insurance type. In addition, Fenway piloted a new model of nurse case management to identify the highest-frequency ED/hospital users and engage patients through enhanced care plans, clinical support, and service referrals to address housing, food insecurity and other socio-economic barriers.

Lastly, to remove barriers to care and expedite treatment, Fenway piloted a new dual-intake process for medication assisted treatment and the health center's Addiction Recovery and Wellness Program (ARWP). ARWP provides counseling services for substance use, relapse prevention, HIV risk-reduction, tobacco cessation, problem gambling and complementary therapy for recovery.

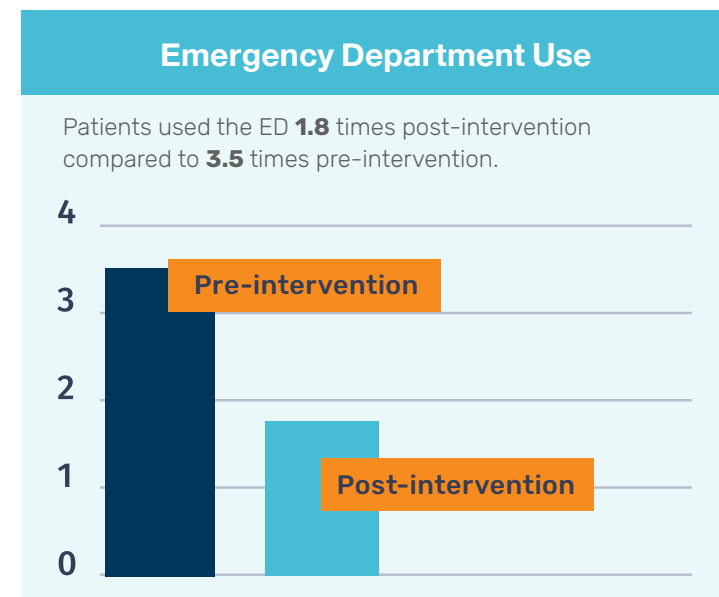
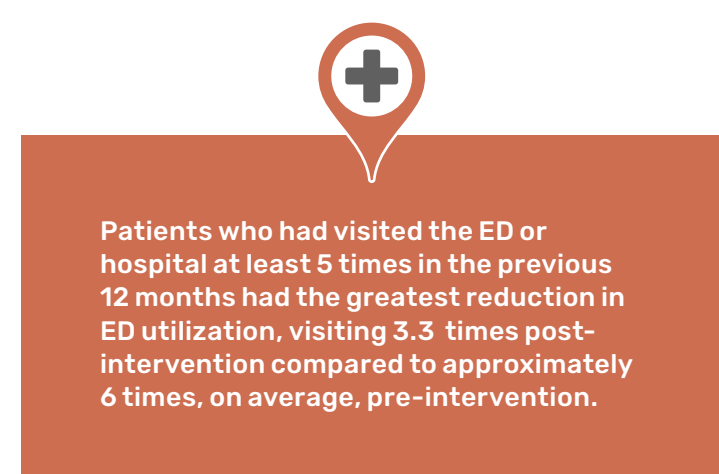
Fenway's MAT program grew steadily throughout the duration of the project, serving 151 unique patients in year 2, and maintained retention rates of approximately 75%. Despite the increased risk levels of new patients, the program reported zero overdose fatalities among those actively engaged in care.

The onset of the COVID-19 pandemic necessitated that the integrated MAT/BH dual-intake pilot end early, limiting the total number of participants; for 10 patients who participated in the pilot, 60 percent went on to receive one or more support services.



KEY OUTCOMES

To ensure continuity of care, Fenway established partnerships and collaborated with Community Care Cooperative (C3), a MassHealth Accountable Care Organization, to coordinate care management and planning services, and with Access: Drug User Health Program / AIDS Action for new referrals of individuals who had not previously been engaged in any level of care.





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Georgia Primary Care Association

SAVANNAH, GA

Planning Community Health Care Coordination for Youth in the Juvenile Justice System

Juvenile incarceration is associated with adverse health outcomes in later adulthood. But for many vulnerable youth, the root causes of poor health outcomes start much earlier.

Lack of access to consistent, comprehensive primary medical, oral, and mental health care is not only detrimental to long-term health, but impedes early development and exacerbates other social and economic stressors. Health practitioners have long observed the impact of poverty and health on development and social success for children and teens in their communities.

The Georgia Primary Care Association (GPCA), a 34-member organization which supports 229 community health center sites covering 129 counties, spearheaded a pilot program in conjunction with Savannah-based member Curtis V. Cooper Primary Health Care (CVCPHC) and the Chatham County Juvenile Court to provide comprehensive primary care services to youth in the juvenile justice system. Building upon an existing CDC-supported collaboration to coordinate youth access to family planning services, and starting with a planning grant phase, GPCA focused on creating and piloting systems to target the under-utilization of primary care services by youth involved with the juvenile justice system. In conjunction with the court and the health center, GPCA set the stage for a coordinated, full-scale effort to identify health and psycho-social issues and provide timely primary care, including

behavioral health and oral health care, create a medical home, and improve health and social outcomes for underserved teens.

Essential to the success of the project was engagement of the court. A court liaison role was created to engage court staff, act as an ongoing source of information across the project partners, arrange court staff visits to the CVCPHC site, and identify opportunities for partnership with related programs.



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

To inform the development of program educational materials and resources, GPCA conducted surveys, interviews and meetings with court-involved teens and their family members, as well as with court personnel. GPCA partnered with the Work Readiness Enrichment Program (WREP) to test, implement and document primary care screening and referral processes for a rotating cohort of 15 youth.

Training materials were developed for judges and court personnel to increase referrals. To enhance and supplement the capacity of the court to assess and refer youth and families to healthcare services, GPCA deepened an existing partnership with The Front Porch, a multi-agency resource center, and established relationships with alternative school, work readiness, and diversion programs for court-engaged youth including the Youth Intercept program.



35 referrals
made to CVCPHC during the second program year



Georgia Primary Care Association



Chatham County Juvenile Court



Curtis V. Cooper Primary Health Care

KEY OUTCOMES



Developed a new, more streamlined medical referral form.



Created and implemented an updated referral process by the end of the project period.



Through ongoing training, technical assistance and collaboration, increased the capacity of the court to refer youth directly to primary care services.



In addition to the court-based liaison, CVCPHC appointed a designated liaison to assist with appointment scheduling for teens referred by the court.



Added mobile van program during the 2nd program year to provide primary and behavioral health care on-site at the court itself.



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



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Idaho Primary Care Association

BOISE, ID

FVRx Pilot Project for Diabetes Patients: Addressing Food Insecurity to Improve Outcomes

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 reduce food insecurity and improve health outcomes for high-risk patients with diabetes and other chronic conditions, the Idaho Primary Care Association (IPCA) developed a partnership with health centers and community partners to launch a Fruit and Vegetable Prescription Program (FVRx) to promote access to healthful, nutritious food and improve participants' diets.

The program was initially implemented at a Terry Reilly Health Services (TRHS) site in Nampa, where the proportion of patients with poor diabetic control far exceeded the state-wide average. The program targeted individuals and families with uncontrolled diabetes and comorbidities contributing to poor health outcomes.

In the second year of the program, IPCA supported the continuation of the FVRx program at TRHS, while extending the project to Valley Family Health Care (VFHC) sites in Payette, ID and Ontario, OR.

Building on the experience in year one, both health centers focused on enrolling high-risk patients with diabetes in the FVRx program, and providing healthful cooking and nutrition education classes. Bilingual (English / Spanish) educational

materials were also distributed to participants.

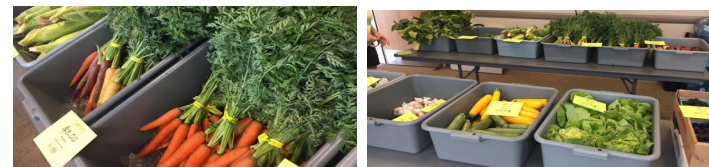
In the 2nd year, TRHS added the option of a pharmacist visit as an additional program component. Both TRHS and VFHC partnered with local farmers markets and grocers to provide access to fresh produce, and with the Idaho and Oregon Food Banks to provide Cooking Matters classes.

Over the course of two years, a total of 333 patients were enrolled in the program at the two organizations. Participation in the educational component of the program as well as voucher redemption rates were monitored to measure their impact on HbA1C levels among the program participants. Body Mass Index (BMI) was also measured.

Participants at both TRHS and VFHC achieved statistically significant changes in HbA1C levels and reduced BMI.

To assess the efficacy of the FVRx program, IPCA conducted an evaluation in collaboration with the Department of Nutrition and Dietetics at Idaho State University.

IPCA, TRHS and VFHC also shared best practices and challenges with other CHCs in Idaho to inform them about the FVRx program, share model policies and procedures, and promote food security-focused health programming.



In addition, the IPCA participated in the Food is Medicine Partner meetings sponsored by the Idaho Hunger Task Force and Family Medicine Residency of Idaho to increase awareness of food insecurity and related health challenges, and identify resources available throughout the state; a separate work group was convened to advocate the use of registered dietitians in community health center settings.



Through partnership with the Boise Mobile Farmers Market, IPCA provided access to fresh fruits and vegetables for program participants. This benefited the local economy resulting in the first program year in:

27.8 %

Increase in produce sales

\$5,527

Paid to local farmers

\$1,843

To help support the Mobile Market

KEY OUTCOMES

71%

Of **TRHS patients** who completed the program in year two and returned for a retest saw a decrease in their HbA1c by 0.5% or greater, and 35% decrease in BMI.



61 %

Of **VFHC patients** who completed the program and returned for a retest saw a decrease in their HbA1c, while 49% decreased BMI.



Fresh produce from Boise Farmers Mobile Market (Boise, ID)



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Mariposa Community Health Center

NOGALES, AZ

Comer Bien (Eat Well)

Many low-income communities, including those situated along the U.S./ Mexico border, struggle with both food insecurity and structural barriers to health.

Nogales Arizona's Santa Cruz county, where Mariposa Community Health Center (MCHC) provides care to a predominantly Mexican-American population, is no exception. At the start of the project, nearly 14% of MCHC patients suffered from diabetes, and many had other chronic health conditions that are compounded by limited transportation options, high food costs, and limited familiarity with the importance of maintaining a sound, nutritious diet.

To address the social determinants of health that affect healthy eating and diabetic outcomes, MCHC developed and implemented the "Comer Bien" (Eat Well) initiative. Comer Bien aimed to improve health outcomes of patients with poorly-controlled diabetes (HbA1c >9) by increasing access to nutritious food with a comprehensive, evidence-based program incorporating prescriptions for fresh produce through a Fruit and Vegetables Prescription Program (FVRx), tailored diabetic-healthy food boxes, customized cooking classes, and transportation to the local Farmers market to make shopping for healthy options easier and more affordable. Eligible patients were identified by their providers and referred to the program.

In the 2nd year of the program, an exercise component was added. Also added in year two were changes in the workflow that allowed project staff to directly check participants' HbA1C utilizing the health center's electronic record system, as well as visit reminder follow-up calls to all participants; this

proved essential to encouraging patients to participate in program activities and keep scheduled follow-up appointments.

To strengthen the range of available services, and provide greater access to healthful foods, MCHC developed and sustained partnerships with grocers, the Southern Arizona Community Food Bank, Nogales Community Food Bank, and local markets.

Long a nationally-recognized leader in the integration of promotoras or community health workers (CHWs) in the health center's outreach programs, MCHC's intervention model relied on CHWs to conduct home visits, assess social determinants of health, identify needed services, and provide appropriate referrals. In addition to conducting 96 home visits, CHWs also provided care coordination to identify and address social determinants that interfered with blood sugar control and general health and wellness.



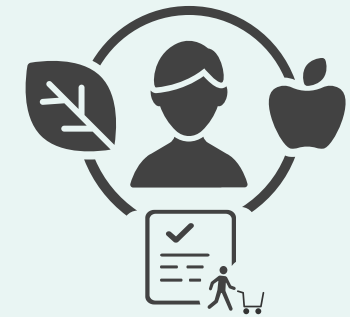
Mariposa CHC & RCHN CHF staff with FVRx program collaborators from Villa's Market (Nogales, AZ)

KEY OUTCOMES

Over the 2-year project period, 200 patients participated in the program. With these patient-focused interventions, and deep provider engagement and support, a majority of the program participants successfully reduced their HbA1c levels. Review by an external evaluation consultant determined that overall, the cooking classes had the greatest impact on participant knowledge and behavior, while FVRx vouchers had the greatest impact on HbA1c levels. Those who attended at least one class had the greatest success overall.

Participant Learning

Pre- and post- tests of both participant satisfaction and behaviors indicated both high levels of satisfaction with the program and increased attention to learned skills such as:



Adapting portion control

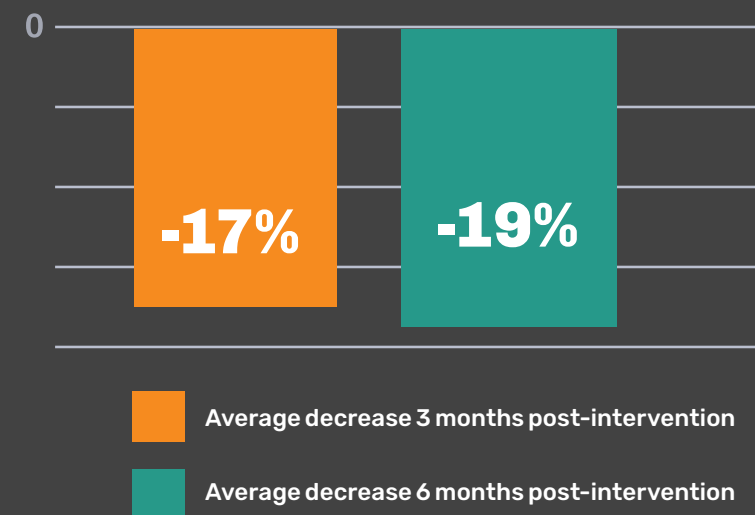
Using grocery lists while shopping

Reading nutrition labels

Improvements in HbA1C Levels

In year two, HbA1C was tested post-intervention for 89% of program participants. Among this group, 92% had a decrease in HbA1C following the program.

HbA1C Reduction Post-Intervention Among Tested Participants, Year 2



Comer Bien (Eat Well) program exercise demonstration (Nogales, AZ)



Northwest Regional Primary Care Association

AK, ID, OR, WA

Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration

Northwest Regional Primary Care Association (NWRPCA) is a membership-driven organization that serves community and migrant health centers in Alaska, Idaho, Oregon, and Washington (federal Region X).

NWRPCA offers a range of programs and services to support and strengthen capacity. In 2019, NWRPCA initiated a planning project to identify how Community Health Workers (CHWs) can be leveraged to enhance the effectiveness of integrated primary care and behavioral health (PC-BH) services in community health centers (CHCs).

Community Health Workers are trusted community members who work to improve health and reduce health and social inequities. CHWs usually share ethnicity, language, and life experiences with the community members they serve. Historically, CHWs have offered culturally-centered health education, outreach, direct service and advocacy at both the individual and community level. Evidence documents that CHWs are effective in facilitating access to care, improving chronic disease management, reducing unnecessary emergency room use, and organizing communities to address the social determinants of health (SDoH). Despite this recognition, efforts to train, integrate, and evaluate the efficacy of CHWs remain fragmented, suggesting the need for a more strategic and coordinated approach to maximize resources for training and sustainability of the CHW workforce.

NWRPCA worked closely with colleagues from Community Mental Health Centers (CMHC) to understand how CHWs, including peer support counselors/ specialists, are utilized in CMHC settings, and led an effort aimed at enhancing the effectiveness of CHWs in CHC settings, including integrated care models. With the support of a diverse advisory group, NWRPCA developed a bilingual English/Spanish tool to survey community health centers, community-based organizations and public health and related organizations. The survey received more than 200 responses (estimated response rate = 30%) representing 12 states and across a range of direct service and administrative rolls. With the engagement of project partners, NWRPCA also convened four focus groups, with a total of 57 participants from states in regions X and VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming), to assess current utilization of CHWs in PC-BH and identify training gaps.

Through this work, NWRPCA identified financial and systemic barriers to utilizing CHWs to support the delivery of behavioral health services, including: a lack of Medicaid/Medicare reimbursement for services provided by CHWs; differing perspectives on general wellness care and those direct behavioral health interventions that are more likely to be reimbursed; lack of clarity among providers about the roles of CHWs on care teams, the benefits they provide, their impact on patient outcomes, and value to the team; and provider reluctance to involve non-clinical staff in care teams. These findings support recommendations for training and resources needed to support CHW engagement in various settings.

KEY OUTCOMES

The key collaborators supporting the advisory group and staff team were the Latino Center for Health at the University of Washington, Vision y Compromiso, The Next Door, Inc., Sea Mar Community Health Centers, the Oregon Community Health Workers Association and the Washington Promotoras Network.



Survey Findings

Most common CHW behavioral-health related activities:

59.3 %
SDoH-related activities

58.9%
Promoting wellness and healthy living

57.4%
Outreach

Partnerships

Strengthened existing partnerships and built new organizational relationships to support CHW training and integration through continued engagement with the project advisory group.

Concept Paper

Produced a concept paper in conjunction with leading subject-matter experts to support effective deployment of CHWs in integrated PC-BH care models.

First-of-its-kind Community Health Worker Institute

Formulated plans to establish a first-of-its-kind Community Health Worker Institute which will serve as a training, technical assistance, and resource hub for community health centers to help them more effectively train, support, and integrate CHWs into care teams.



St. John's Well Child and Family Center

LOS ANGELES, CA

Healthy Homes Healthy Kids

In South Los Angeles, St. John's Well Child and Family Center (SJWCFC) provides a comprehensive medical home for more than 85,000 people, including thousands of children with asthma.

Social determinants of health exacerbate both the burden and severity of asthma; residing in substandard housing, which disproportionately affects the area's low-income and minority children, is a key culprit.

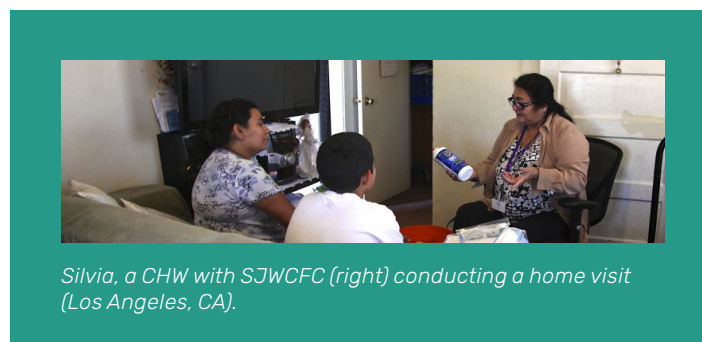
SJWCFC developed the Healthy Homes Healthy Kids project (HHHK) to intentionally address the housing environments that contribute to asthma exacerbations, improve participants' asthma control, and decrease preventable emergency department (ED) visits and hospitalizations. In addition to providing comprehensive care to pediatric patients, SJWCFC partnered with Strategic Actions for a Just Economy (SAJE), a community-based organization focused on tenant rights, healthy housing, equitable development, and legal aid, to promote tenants' rights and advocate for improved housing conditions.

Meanwhile, to tackle common housing-related asthma triggers, HHHK integrated an intensive in-home program of community health worker (CHW) outreach and family education with comprehensive case management and team-based primary care.

The team-based CHW also assisted with care coordination and referrals to SAJE, as needed. In year two of the project, workflow enhancements included the establishment of standardized referral criteria, new protocols for information-sharing between CHWs and clinicians, and modifications to the pediatric asthma quality improvement work plan.

In 2019, the asthma case management component of the HHHK program was integrated into the state Medi-Cal Health Homes initiative, which provides enhanced case management to eligible beneficiaries with complex medical needs and chronic conditions. This represents a major policy and clinical win, ensuring case management coverage for those eligible Medi-Cal managed care enrollees participating in the program.

To maximize the effectiveness of care coordination services, enhance advocacy and advance sustainability, SJWCFC also maintained strategic collaborations with Asthma Coalition of Los Angeles, Regional Asthma Management and Prevention (RAMP), Californians for Clean Air (CFCA), and Esperanza Community Housing Corporation.

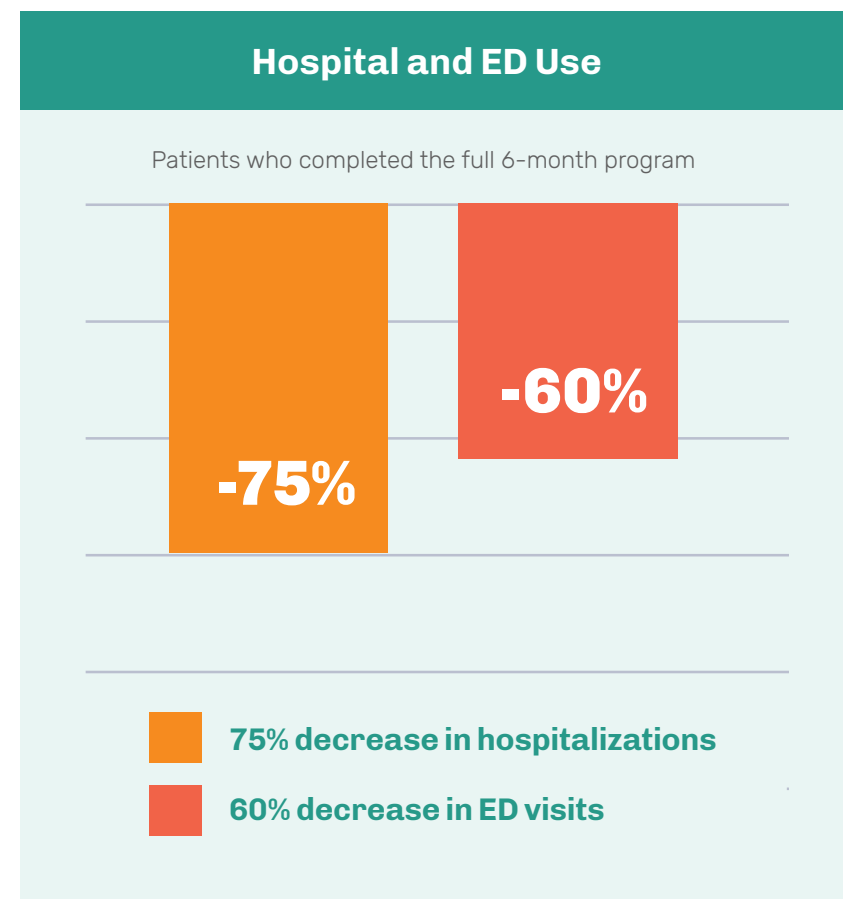


Silvia, a CHW with SJWCFC (right) conducting a home visit (Los Angeles, CA).



SJWCFC and RCHN CHF staff visit project partner, Strategic Actions for a Just Economy (SAJE), in Los Angeles, CA.

KEY OUTCOMES



100 families participated in year one, of whom 77 completed the 3-month assessment and 65, the 6-month assessment.



Caregiver Knowledge Increase

Caregiver knowledge about asthma symptoms and care increased, as measured by intake and interim assessments.

Improvement in Asthma Symptoms

All participants who completed the program showed an improvement in asthma symptoms as measured by the Asthma Control Test (ACT) and Core Caregiver Survey.



Strategic Actions for a Just Economy (SAJE), in Los Angeles, CA.

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.

