The Challenge: Impact of Fragmented Services

Individuals and families who live in poverty tend to not only show lower-quality health indicators, but are also less likely to have access to either regular health care services or health insurance.

- Between 2000 and 2009, 40% of the U.S. uninsured population had incomes below 100% and 250% of the FPL. *90% of Care Alliance patients came from below 100% FPL.
- Mental health illness comorbidity is a problem. Nearly 65,000 people have moderate or severe mental illness in Cuyahoga County, while approximately 25% or 16,000 of the U.S. population suffers from a severe mental illness.2, 3

As Seek Refine We decided to focus on both adult and child patient populations at geographically-inclusive locations across Cleveland and Cuyahoga County.

1. Bridges to Housing

The model promotes real-time sharing of information through each agent's view of the linked systems, hematological creaming, and real-time coordination, and LCL cholesterol screening and control for these initiatives.

For example, Figure 1 depicts data for unique clients seen by Care Alliance providers at The Centers for Families and Children integrated clinic during the 4:1/2014-4:1/2015 time period (the calendar year).

Report on Evaluation

Through Uniform Data System reporting, Care Alliance tracks health outcomes, patient satisfaction with access and treatment; hematological test data; hypertension and cholesterol levels; and control, and LCL cholesterol screening and control for these initiatives.

2. Complete Physical-Behavioral Health Integration for Individuals Experiencing Homelessness and Living in Public Settings

Care Alliance and FLS further developed our partnership to serve Cleveland’s adult homeless population. Building on the experience implementing Bridges to Housing, Care Alliance developed a comprehensive, sustainable solution to provide integrated health services to our shared patient population. Care Alliance and FLS partnered to more closely integrate and co-locate services within our respective clinics.

Impact on Improved Access to Health Care

Our CHPI has evolved over time and greatly improved access to quality health care for our patients.

During the design of our CHPI initiative, our original objectives were to increase the number of chronically homeless people with severe mental illness receiving integrated physical and behavioral health care from 5% in CY 2010 to 15% by October 2013, as well as the number of such individuals transitioning to permanent supportive housing by similar increase.

- Adult Weight Assessment

Interpretation: If patients either had BMI within their healthy range or if their BMI was under/over their healthy range, we were counseled and offered smoking cessation.

- BP Control Measurement

Interpretation: If the CHPI’s unique clients, 45 had a hypertension diagnosis. 63% of those clients with the diabetes diagnosis had an HbA1c level < 8%.

- Tobacco Use/Cessation

Interpretation: In an additional report, we find that 99% of 265 unique clients were not using tobacco or if they did, they were counseled and offered smoking cessation.
Community Health Improvement Project (CHIP)  
EXPAND ORAL HEALTH ACCESS

Jamie Domfeld, Senior VP of Business Development & Innovations  
AUNT MARTHA’S

Problem Statement

The literature tells us that there are far fewer dentists than primary care physicians willing to work in public health settings, and current reimbursement rates for oral health services can make it difficult for community health centers to achieve financial stability without a highly developed infrastructure.

Unfortunately, for economic bottom-line of many community health centers, the immediate need for oral health services is so great that the decision to limit their availability borders on negligent.

At Aunt Martha’s, we recognized the need to make the investments necessary to adapt our business model to ensure that:

• Our dental suites are comparable to those in any private office; and,
• Our patients not only have access to dental services, but that their experience from the time they schedule their appointment to the time they leave our health center is one that is nothing short of exceptional.

Project Description

Expand access to everyone who needs oral health services in the communities we serve.

Goals

Increase access to care among our existing target population, and if possible, in communities where we were not providing oral health services prior to July 1, 2008.

Improve the quality of the oral health patient care experience across our healthcare network.

Objectives

Increase our target population’s access to services by maximizing the use of available capacity at sites where dental services were already being provided prior to July 1, 2008.

Increase our target population’s access to services by initiating dental services at sites and in communities where Aunt Martha’s was not providing services prior to July 1, 2008.

Improve the quality of the patient care experience by standardizing the provision of care and increasing the number of staff allocated to the delivery of oral health services.

Outcomes

Outcomes Achieved

Numbers

From 2007 to 2010, the number of patients receiving dental services increased by 88% and the number of dental visits provided increased by 146%.

Personalized Care

Implementation of a dental care manager model improves access and education.

Cultural Competency

About 70% of our dental staff are bilingual (English-Spanish).

Efficiency

Additional support staff leads to better focus on the task, or patient, at hand.

Today

The state of Illinois has cut Dental Medicaid coverage for adults. As a result, we have had to decrease our dental services.

We have a scalable model so we are able to increase, decrease, or suspend dental services at most of our sites depending on demand and reimbursement.

We have been able to successfully recruit and retain dentists.

Lessons Learned

The investments made by Aunt Martha’s result in a short-term increase in the average cost per dental patient, but a long-term investment in oral health services.

The quality of every decision made in health centers is critically dependent upon the availability of accessible, accurate, relevant, and current information.

Strong clinical leadership is essential for all health center services.

Being recognized as the largest FQHC provider of oral health services in the state leads to many incredible opportunities.

Even when reimbursement seems low, it can get worse.

My Organization

Aunt Martha’s is Illinois’ leading provider of coordinated health care, child welfare and social services, impacting the lives of more than 60,000 children and adults from more than 650 communities every year. No health center in Illinois provides dental or behavioral health services to more patients than Aunt Martha’s.

In 2013, Aunt Martha’s became the first community health center in Illinois to receive the Joint Commission’s Primary Care Medical Home certification.

Contact Me

Jamie Domfeld
Senior VP Business Development & Innovations
Aunt Martha’s
jdomfeld@auntmarthas.org
(708)932-4177

San Benito Health Foundation
Community Health Improvement Project (CHIP)
Achieve Recognition as a Provider of Choice; Asset to Employees, Patients and the Community

Rosa Vivian Fernandez, MPH, CEC, FACHE - President & CEO

Statement of Problem
San Benito Health Foundation celebrated 40 years in May 2015. As with many community health centers, the organization was founded through a community organizing effort and amidst great controversy in the community. Throughout its early years the clinic continued to attract controversy which became more prevalent as the health care environment increased in competition. In 2007, the organization became federally funded and thus starting a new phase in its existence as a viable corporation which was to provide services to all members of the community in a new era of service delivery. The proposed CHIP project was to develop a new community relations and marketing plan.

Project Description
San Benito Health Foundation (SBHF) under the leadership of its CEO engaged in a Community Health Improvement Plan (CHIP) which is aimed at improving the organization’s public image and visibility as a provider of choice within the community through an organized marketing plan. This marketing plan aligned with one of the organization’s primary goals to “Have the Foundation recognized as an asset by the patients we serve, our employees, and the communities in which we operate”.

Goal
The proposed CHIP was to develop a new community relations and marketing project. The goal of the Board was for the organization to become “The Provider of Choice and to be perceived as an Asset to Employees, Patients and the Community”.

Objectives
• Increase organizational visibility.
• Increase knowledge of the community of services provided by the organization.
• Increase number of people accessing the services offered by the organization.

Outcomes
Initial Outcomes
This is an ongoing project which has evolved as we implemented new developments in the health care field. However, the organization did achieve more visibility through radio and television PSA’s. We have increased our client base both through our marketing and word of mouth efforts. Our Board has become more aware of their role as advocates for the organization and community health centers in general. And we are ultimately considered a major player for service delivery under the affordable care act by patients, community members, funders, and political leadership which in turn has positively impacted our financial stability and future viability.

Intermediate outcomes
SBHF Achieved recognition as a Patient Centered Medical Home which helped focus our efforts and define our goals for the future. This effort is a continuous process of service redesign and improvement.

Staff selection has been refined to accommodate the mission and vision of the organization, hiring for organizational cultural fit and not just skill sets. Enhanced communication with staff through huddles, all staff, and management meetings.

Aligned messaging for all external communication including web site, television, radio, and special events.

Looking forward...
The future is exciting as we continue to implement the Affordable Care Act. We look forward to innovative approaches and a more cohesive service delivery system. We will serve all our community with a shared responsibility for positive outcomes.

“The SBHF is a leader among alliances and partnerships that foster a climate of thoughtful change and create solutions for maintaining our community safe and healthy.”

Lessons Learned
Marketing is a process and not an outcome.

We must continuously educate staff, patients and community about our role, potential and limitations, to align our services with realistic client expectations.

My Organization
The San Benito Health Foundation (SBHF) is a non-profit 501 (c) (3) 330 HRSA Federally Qualified Health Center (FQHC) grantee. SBHF is both a migrant health center and a community health center. Established in 1975, SBHF was created to fulfill the healthcare needs of the Migrant Farmworker community in the San Benito County area and has evolved to services all community members. The organization is governed by a community-based Board of Directors who represent patients, local businesses, government, civic, and community organizations. Recognized as a Patient Centered Medical Home the health center employs professionally trained clinical and support staff who works in a multi-disciplinary environment of care. The main facility is located at 351 Felice Dr. Hollister, CA 95023. SBHF has a satellite clinic located at San Juan Bautista Windmill Market shopping center 301 The Alameda Suite K San Juan Bautista, CA 95045, and a Mobile Health Center. The Center provides Medical, Dental, Ophthalmology, Covered California insurance enrollment, Women Infant and Children (WIC Program) and other multi-disciplinary support services. The Mobile Health Center engages in educational outreach, screening and service health care delivery activities throughout the San Benito County to serve as a venue for health care entry and early access to care for the community.

Contact Me
For more information, contact me:
Rosa Vivian Fernandez, MPH, CEC, FACHE
President & CEO
San Benito Health Foundation
(831) 637-5306
Community Health Improvement Project (CHIP)
Pediatric Dental Program
Debbian Fletcher-Blake
Care for the Homeless

Statement of Problem
In New York City (NYC) 2.3% of the city’s population under age 18 spent at least one night in a municipal shelter system. Reports from the Centers for Disease Control and Prevention indicate homeless children had higher BMI and caries rates than the national averages. The social impact of oral diseases in children is substantial. Dental-related illnesses account for the loss of more than 51 million school hours each year. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families.

Disparities in accessing and utilizing oral health care are extremely prominent among people experiencing homelessness. Homelessness in turn complicates oral health problems.

Project Description
Expand and develop an oral health program to treat homeless children.

goal
Provide comprehensive dental services to homeless children and their families at a CFH clinic site in Queens, New York.

output-oriented objectives
- Research funding opportunities.
- Develop funding proposal and secure funding.
- Negotiate a lease for space to add dental clinic.
- Apply to NYS Department of Health for licensure for the clinic site.
- Hire a dental director.
- Advertise the services.

outcome-oriented objective
- By January 2015 establish a pediatric/family dental clinic.
- By December 2015, provide oral health services to 100 pediatric patients.

Outcomes & Outcomes
outputs achieved
- Funding obtained.
- Lease secured and 4 dental operatories built.
- Application to NYS DOH was filed in 2013 with ongoing discussions and meetings continuing.
- Dental director hired Jan 2014.
- Advertising is ongoing.

expected outcomes
- Final approval from NYS DOH to operate the clinic site by September 2015.
- Provision of oral health services to pediatric patients by December 2015.
- Integration of pediatric oral health into primary care

Lessons Learned
- Collaboration with multiple agencies is required to accomplish lofty goals.
- Implementation timelines are influenced by many factors especially the external environment and should have built-in flexibility.
- Working with Bureaucracies such as governmental agencies requires strategy and patience.
- Project delays do not signify failure.

My Organization
Care for the Homeless (CFH) is a non-profit federally qualified health centers located in New York City. Founded 30 years ago, CFH provides health care services to homeless men, women and families across the age spectrum. Services are provided in places where homeless people live or congregate including shelters, drop-in centers, on the streets, safe havens. Additionally, CFH provides shelter services to homeless women at a shelter in the Bronx.

Mission Statement
Care for the Homeless fights homelessness by delivering high-quality and client-centered healthcare, human services and shelter to homeless individuals and families, and by advocating for policies to ameliorate, prevent and end homelessness.

Contact Information
Debbian Fletcher-Blake, APRN, FNP
Assistant Executive Director
Care for the Homeless
30 East 33rd Street
New York, NY 10010
dfletcher@cfhnyc.org
212-366-4459 ext 207

Sustainability
- Develop relationships with a dental residency program to provide internship opportunities to dental residents.
- Expand pediatric dental services to other CFH clinic sites in other NYC boroughs.
Community Health Improvement Project (CHIP)  
Friends/Amigos of Breaking the Cycle  
Creation of a Discretionary Revenue Stream Through Community Collaborations to Increase the Donor Base

Gail Petersen Hock, MS, RN, PHCNS-c (former program director)  
Breaking the Cycle Community Health Care (a Title X Family Planning Clinic) – Arizona State University

Statement of Problem

Breaking the Cycle Community Health Care was an Academic Nursing Center with the primary revenue stream through the Office of Population Affairs as a Title X Family Planning Clinic. At the time of the development of the CHIP the HRSA funding that supported clinical rotations for nursing students was nearing the end of the grant period. The client population was comprised, primarily, of recent immigrants from Mexico who were uninsured and not eligible for Medicaid. Funding instability led to the development of the CHIP.

Project Description

The development and implementation of a marketing plan to serve as a springboard to diversify revenues by increasing the donor base.

goal
Sustain and grow the revenues that support the clinical rotations for undergraduate and graduate nursing students while increasing discretionary funds for clinical services

output-oriented objectives
• Initiate an account through the ASU Foundation to receive donations from private sources by September, 2002
• Procure clinic signage that can be seen from the street by December, 2002
• Develop a marketing brochure, in collaboration with a student from the W.P. Carey School, by January 2003
• Hold a kick off event for the community at large to introduce “Friends/Amigos of Breaking the Cycle” in May, 2003
• All objectives met!

Additional Outcomes

• Recipient of the UCLA/ J & J CHIP Award 2003
• Materials used to develop an annual appeal
• Television coverage on PBS
• Collaboration with additional academic units
• Trade journal coverage
• Phoenix Business Journal Health Care Hero finalist
• Newspaper & magazine articles
• Conference presentations
• Expansion into more community collaborations

Expansion into “Art for Health!”  

Contacts

For more information, ghock@brandman.edu  
602-578-2812

Proactive Steps - Be Ready!

• Create a press packet
• Take pictures and carry photo releases
• Invite local and state legislators to tour facilities
• Develop opportunities for donors to meet and mingle
• Collaborate with organizations whose missions intersect with yours
• Share your enthusiasm

More than $425,000 raised
Statement of Problem

The landscape of health care is rapidly changing from a volume based care to value based care. Throughout the country health centers are actively having to demonstrate their value to provide quality care at a reasonable cost to their funders, including, Medicaid, Medicare and commercial insurers. Health Centers must demonstrate clinical health outcomes for the over 29 Million individuals they serve across the country. Moreover, increasingly health centers must be asked to provide demonstrative clinical health outcomes for these patients as well as show cost savings to the health care system for the care provided.

Population Health Management is the new paradigm in health care. Health Centers will need aggregate data analytic tools to assist them in performing population health management and to demonstrate their value.

Outcomes & Outcomes

outputs achieved

MACHC provided initial meeting on CCIC with MACHC Board to gain buy-in from Board, September 2014.

Secured 600K funding for CCIC project from State of Maryland, October 2014.

Hosted Kick off meeting, Nat 2015

expected outcomes

MACHC anticipates the following expected outcomes:

Health Centers will have a better health understanding of their data and be able to improve health outcomes of patients as a result.

Health Centers will utilize selected HEIDIS Measures to compare across all facilities in both states.

Health Centers will be able to provide Population Management in at least 4 different chronic diseases.

Health Centers will be able to demonstrate their value relative to improved health outcomes and cost savings to the overall health system in both states.

looking forward...

Performing the first set of data extraction for the project, which will commence in August, 2015. Providing our first report out by those participating in the Pilot to the larger health center audience about lessons learned, population management, health outcomes and cost savings

Partnering with managed care partners to negotiate enhanced contracts based on value based purchasing for the pilot health centers.

Lessons Learned

Integrated dispirit systems is complex and requires special training and skills.

Uniting around a shared visions is the best method to provide buy-in.

Value based care is the new paradigm across health care

MACHC is committed to the CCIC project and has the support of its membership to advance the industry.

My Organization

Mid-Atlantic Association of Community Health Centers (MACHC) is the regional primary care association that represents the interest of 17 health centers in Maryland and 3 health centers in Delaware. These health centers have 218 delivery sites across the states and serve over 500,000 patients annually. MACHC provides training, technical assistance and advocacy.

Contact Me

For more information, contact me:
Duane Taylor, CEO
Mid-Atlantic Association of Community Health Centers
duane@machc.com
(301) 577-0097 Ext. 124
Community Health Improvement Project (CHIP)  
EXPANDING ACCESS TO INTEGRATED CARE IN NORTHERN COLORADO

MARK E. WALLACE, MD, MPH  
CEO/CMO, NORTH COLORADO HEALTH ALLIANCE & BOARD CHAIR, SUNRISE COMMUNITY HEALTH

Statement of Problem
The North Colorado Health Alliance, through four of its main partner organizations, set the goal in 2004 of expanding and integrating the safety net to provide 100% access to comprehensive physical, behavioral, oral, and population health care for the underserved in northern Colorado by December 2009.

The worst met safety net access needs in 2004 were for adults in the areas of primary care, specialty care, and behavioral health. By December 2014, Sunrise Community Health, North Range Behavioral Health, Summit Stone Health Partners, and the Weld County Department of Public Health will have expanded integrated care services to over 135,000 patients registered in their shared community electronic health record representing a 285% increase over baseline and representing access to comprehensive by at least 95% of those living in poverty in the shared service area.

Expected Outcomes
Comprehensive shared strategic planning and resource allocation through a formal health alliance will ensure access to comprehensive integrated primary care for at least 95% of those living in poverty in the shared service area by December of 2009.

Looking Forward...
Disciplined fostering of trust-building to support ongoing shared governance, strategic planning, and clinical operations will sustain access to comprehensive health homes as Colorado expands Medicaid and coverage through a state-run insurance exchange.

Outputs & Outcomes
$7.2 million raised to build new 40,000 square foot facility by July, 2006.

Open 3 new primary care clinical pods (30,000 square feet) fully integrated with behavioral health specialists trained in new model of care by August, 2007.

School board approval and $300,000 in funding secured for comprehensive school-based health center on campus of district’s largest elementary school with highest percentage of children in poverty by August, 2005.

Fully developed plans for specialty service, information management, capital and operating financials, facilities, and shared governance by April 2005 to support goal of 100% access to comprehensive care.

Lessons Learned
Integrating health care services doesn’t happen by chance; it requires tremendous ongoing discipline and attention to trust building, shared vision, and selfless sharing of credit for success.

Be bold in vision and practical in implementation; stay focused on the end game even when timelines to achieve outcomes take longer than planned or desired.

Corporate self interest amongst partners isn’t a deal-breaker; these interests, and the associated resources to achieve them, can still be aligned to achieve the shared vision of an increasingly integrated health neighborhood.

Don’t underestimate the need for C-suite leaders to continuously re-engage around the shared vision; managers’ focus on implementation and operations is necessary but not sufficient.

My Organization
The North Colorado Health Alliance (NCHA) is a non-profit formal collaborative composed of public and private organizations committed to collectively generating health across northern Colorado as the foundation of thriving communities and economic vitality. Founded in 2002, NCHA exists to leverage synergy between its member partner organizations that include: Sunrise Community Health, North Range Behavioral Health, Summit Stone Health Partners, Banner Health, Kaiser Permanente, Weld County Public Health & Human Services, Centennial Mental Health, Colorado Access, University of Northern Colorado, United Way, and Northern Colorado Medical Society. NCHA partner organizations collectively generate health by expanding access, eliminating disparities, improving quality, controlling costs, improving experience, managing care, and focusing on population outcomes. We envision becoming the healthiest region in the healthiest state in the nation by serving and supporting thriving families in thriving communities.

Contact Me
For more information, contact me:
Mark E. Wallace, MD, MPH - CEO/CMO
North Colorado Health Alliance
mwallace.alliance@nocoha.org
(970)350-4674