# Community Health Best Practices, LLC

## PROVIDING VALUE & IMPACT FOR COMMUNITIES WE SERVE

Community Health Best Practices, LLC is a nonprofit network of **16** leading Federally Qualified Health Centers (FQHCs) partnering to improve the health of communities across **11 states**. We provide comprehensive primary care and behavioral health services to all patients regardless of their ability to pay. Many of our patients are uninsured, underinsured, or insured through Medicaid or Medicare.

As individual FQHCs, and as a network, we provide tremendous value and impact for our communities, as described in this report.

### IN 2019, WE:

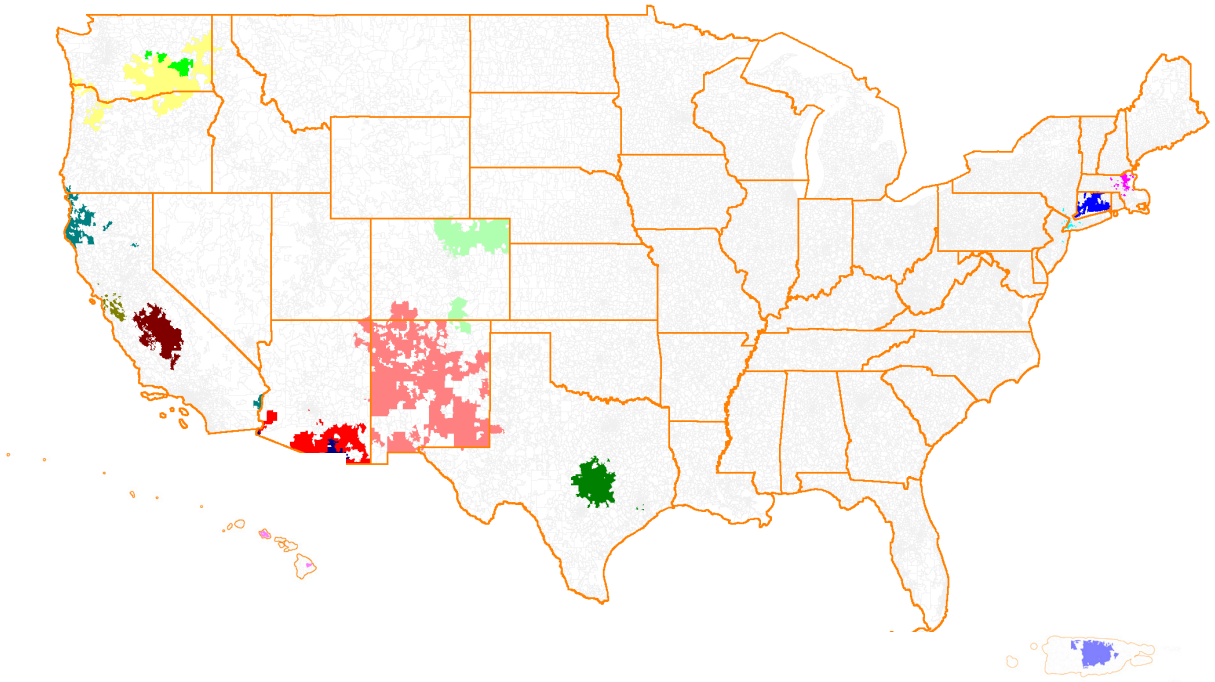
**SERVED 1-IN-21 FQHC PATIENTS NATIONALLY**

**EMPLOYED 1-IN-19 FQHC STAFF MEMBERS**

**OPERATED 625 SITES**

### Community Health Best Practices, LLC Service Areas

Source: UDS, 2019



# The Value and Impact of
# Community Health Best Practices, LLC

Sixteen **Community Health Best Practices, LLC** health center members provide tremendous value and impact to the communities they serve through, including **CARE FOR VULNERABLE POPULATIONS**, **SAVINGS TO THE SYSTEM**, **ECONOMIC STIMULUS**, and **STATE-OF-THE-ART PRACTICES** and **INTEGRATED CARE** with a focus on **MANAGING CHRONIC CONDITIONS**, **PREVENTATIVE CARE**, and **QUALITY HEALTH OUTCOMES**.

This report highlights their **2019 savings and contributions.**

## SAVINGS TO THE SYSTEM

**24%**
LOWER COSTS FOR HEALTH CENTER MEDICAID PATIENTS

**$1.8 Billion**
SAVINGS TO MEDICAID

**$2.6 Billion**
SAVINGS TO THE OVERALL HEALTH SYSTEM

## ECONOMIC STIMULUS

**23,640**
TOTAL JOBS

- **13,571** HEALTH CENTER JOBS
- **10,069** OTHER JOBS in the community

**$3.6 Billion**
TOTAL ECONOMIC IMPACT of current operations

- **$1.9 Billion** DIRECT HEALTH CENTER SPENDING
- **$1.7 Billion** COMMUNITY SPENDING

**$431 Million**
ANNUAL TAX REVENUES

- **$89 Million** STATE & LOCAL TAX REVENUES
- **$342 Million** FEDERAL TAX REVENUES

## CARE FOR VULNERABLE POPULATIONS

**1,428,155**
PATIENTS SERVED

**6,660,936**
PATIENT VISITS

**6%**
4-YEAR PATIENT GROWTH

**90%** of patients are LOW INCOME

**513,278** of patients are CHILDREN & ADOLESCENTS

**76%** of patients identify as an ETHNIC OR RACIAL MINORITY

**1%** of patients are VETERANS

**12%** of patients are AGRICULTURAL WORKERS

**4%** of patients are HOMELESS

# INTEGRATED CARE

**1,247,731** patients received **MEDICAL** care

**348,081** patients received **DENTAL** care

**143,725** patients received **BEHAVIORAL HEALTH** care

**62,003** patients received **VISION** care

**120,051** patients received at least one **ENABLING SERVICE** to overcome barriers to care

Patients also received non-clinical services to connect them to community resources such as **HOUSING, JOB TRAINING, AND CHILD CARE**

# MANAGING CHRONIC CONDITIONS

**72,986** patients were diagnosed with **ASTHMA**

**36,763** patients were diagnosed with **CORONARY ARTERY DISEASE**

**117,221** patients were diagnosed with **DIABETES**

**197,078** patients were diagnosed with **HYPERTENSION**

# PREVENTIVE CARE

**218,251** children attended **WELL-CHILD VISITS**

**576,235** patients received **IMMUNIZATIONS** and **SEASONAL FLU**

# STATE-OF-THE-ART PRACTICES

**100%** of health centers have installed and currently use an **ELECTRONIC HEALTH RECORD (EHR)**

**86%** of health centers are currently participating in the Centers for Medicare and Medicaid Services **EHR INCENTIVE PROGRAM "MEANINGFUL USE"**

**75%** of health centers are using **TELEHEALTH TO PROVIDE REMOTE CLINICAL CARE SERVICES**

# QUALITY HEALTH OUTCOMES

**100%** of health centers met or exceeded at least one **HEALTHY PEOPLE 2020 GOAL FOR CLINICAL PERFORMANCE**

Capital Link prepared this Value & Impact report using 2019 health center audited financial statements and Uniform Data System information. Economic impact was measured using 2018 IMPLAN Online.

CAPITAL LINK

www.caplink.org

## REFERENCES AND DATA SOURCES

- Savings to the System: Nocon et al. *Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings*. American Journal of Public Health: November 2016, Vol. 106, No. 11, pp. 1981-1989.
- Economic Stimulus: Economic impact was measured using 2018 IMPLAN Online from IMPLAN Group LLC, IMPLAN System (data and software), 16905 Northcross Dr., Suite 120, Huntersville, NC 28078, www.IMPLAN.com. Learn more at www.caplink.org/how-economic-impact-is-measured.
- "Low Income" refers to those who earn below 200% of federal poverty level guidelines.
- Care for Vulnerable Populations, Integrated Care, Managing Chronic Conditions, State-of-the-Art Practices: Bureau of Primary Health Care, HRSA, DHHS, 2018 Uniform Data System. Note: UDS data collection for telehealth began in 2016.
- Quality Health Outcomes: Bureau of Primary Health Care, HRSA, DHHS, 2019 Uniform Data System, and relevant Healthy People 2020 targets at www.healthypeople.gov/2020/data-search.
- Full-Time Equivalent (FTE) of 1.0 is equivalent to one full-time employee. In an organization that has a 40-hour work week, an employee who works 20 hours per week (i.e., 50 percent of full time) is reported as "0.5 FTE." FTE is also based on the number of months the employee works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).

**SUMMARY OF 2019 ECONOMIC STIMULUS**

| | | Economic Impact | Employment (# of FTEs*) |
|---|---|---|---|
| Community Impact | Direct | $1,876,561,232 | 13,571 |
| | Indirect | $635,327,558 | 3,676 |
| | Induced | $1,084,268,911 | 6,393 |
| **Total** | | **$3,596,157,700** | **23,640** |

**SUMMARY OF 2019 TAX REVENUE**

| | | Federal | State |
|---|---|---|---|
| Community Impact | Direct | $212,004,768 | $36,082,463 |
| | Indirect | $50,443,360 | $15,397,618 |
| | Induced | $79,378,886 | $37,460,520 |
| **Total** | | **$341,827,014** | **$88,940,601** |
| **Total Tax Impact** | | **$430,767,615** | |

## ACKNOWLEDGEMENTS

This report was created by Capital Link and funded by Community Health Best Practices, LLC for its members.

Capital Link is a non-profit organization that has worked with hundreds of health centers and primary care associations for over 25 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. We provide an extensive range of services, customized according to need, with the goal of strengthening health centers—financially and operationally—in a rapidly changing marketplace. Capital Link maintains a database of over 13,000 health center audited financial statements from 2005 to 2019, incorporating approximately 80% of all health centers nationally in any given year. This proprietary database is the only one of its kind as it exclusively contains health center information and enables us to provide information and insights tailored to the industry. For more information, visit us at www.caplink.org.

COMMUNITY HEALTH | BEST PRACTICES

## Innovation & Community Response

The numbers and statistics contained in this report, while compelling, tell only a minor part of the "Best Practices" story. Listed below are just a few of the innovative programs and unique characteristics of our health centers that demonstrate, above all, our dedication to the communities we serve.

**Family Health Centers at NYU Langone** – *PrEP Virtual visits & The Table Food Pantry*

*PrEp Virtual Visits* - The Family Health Centers at NYU Langone (FHC) is a federally qualified health center network with 8 clinical sites in Brooklyn, NY, primarily serving a low-income, immigrant community. Since 2016, FHC has operated a focused outreach program regarding PrEP for HIV prevention, and has used social media, print and electronic advertising, community partnerships, and peer-based strategies to promote PrEP to individuals at high risk for HIV. Historical data shows that over half of the patients engaged in PrEP services through this program were new patients to the FHC, who were not engaged in ongoing care elsewhere.

To expand on our success in reaching these high-risk communities with our PreP program, especially admist the COVID pandemic, FHC launched a PrEP Virtual Visits program. Offered in both English and Spanish, this initiative allows patients to start on PrEP for HIV prevention without an in-person clinic visit. We developed clinical and patient navigation workflows to enable patients to initiate and continue PrEP through virtual visits. For necessary labs, patients were supported in identifying a lab collection site convenient to their home. Patient navigation staff played a key role in risk reduction education, benefits navigation, and facilitating compliance with labs and virtual care. This program not only expands access to a high risk community but it also helps FHC to expand our geographic reach, and dovetails with a PrEP initiative within our Virtual Urgent Care.

*The Table Food Pantry* - With over 100,000 patients seen throughout the Family Health Centers each year, medical providers who identify food insecurity during patient visits are able to make a referral to FHC's The Table emergency food pantry directly through the electronic health record. The Table Food Pantry of the Family Health Centers at NYU Langone provides emergency food to over 5,000 people each month through a client-choice model, providing a variety of self-stable foods, fresh produce and dairy products. Participants are also connected to a continuum of wrap-around services, including access to SNAP food stamps and other benefits that will ensure long-term food security and support the health, stability and self-sufficiency of the entire family.

Admist the pandemic, The Table has seen a 700+% increase in the number of people seeking food assistance. Adequate food is essential to keeping our community healthy and resilient in these turbulent times, and the FHC's The Table food pantry has stepped up to meet the unprecedented need for emergency food. During the pandemic, while some pantries were forced to close, the Table has been able to keep the doors open, ensuring safety and increasing the volume served through an outdoor grab-and-go model. Food packages were carefully planned by a team of nutritionists and Table staff to include a variety of essential pantry items, dairy products and fresh produce. The Table is also working with NYU Langone-Brooklyn hospital to supply packs of groceries to COVID-19 patients upon discharge from NYU Langone-Brooklyn hospital.

To ensure that families have access to nutritious fruits and vegetables, The Table has established a unique relationship with The Brooklyn Grange, a rooftop farming business located in Sunset Park. Through this partnership, the Brooklyn Grange provides The Table with a bountiful standing order of culturally specific market crops that are selected based on client feedback. This past year, the Table gave out over 9,000 lbs of locally-grown produce to families.

**Open Door Community Health Centers** – *Pregnancy Services*

For many years Open Door Community Health Centers (Arcata, CA) operated one stand-alone pregnancy services site, delivering 300-400 babies annually at a single hospital. In recent years community need for access to high quality obstetrics has increased, due in large part to the loss of numerous private practices.

In 2018, with the addition of a 3400 sq ft health center in the south end of the region, Open Door was able to expand service to that community with the addition of continuity pregnancy services. The following year, the last private pregnancy services center in the area closed its doors, and Open Door recognized the need to coordinate our approach to ensure a clear vision and leadership over pregnancy services for our community.

Open Door leadership conducted a gap analysis. A human centered design change management framework was then applied through a series of meetings with multiple, disparate providers and care team members, resulting in a cohesive vision and direction for Open Door's expanded service line. Milestones include:

- Identification of a shared language and values statement: Open Door Pregnancy Services honors and empowers families through access, knowledge, and choice.
- Appointment of Open Door's first Pregnancy Services Medical Director (OB/GYN) to provide clinical leadership for the entire region.
- Secured call coverage in three regions of the county, coordinating with three delivering hospitals.
- Robust OB training for Humboldt County's first ever Family Medicine Residency program, training 18 physician residents each year.
- Partnerships with local midwifery practices, rural native american health centers, and remote clinics to further support access in the community and patient safety.
- Development of an integrated Medication Assisted Treatment/Substance Use Disorder program for prenatal and perinatal patients, led by physician champion recognized statewide for her efforts in this area.

Open Door is now the largest pregnancy service provider in Humboldt County with an anticipated annual delivery volume of 700-800 patients. Our programs are structured to ensure patient choice while also delivering consistent, high quality care, including behavioral health, lactation consulting, intensive postpartum depression support, and case management for social determinants of health.

**East Boston Neighborhood Health Center** – *Pediatric Mobile Vaccination Van*

In April of 2020, at the height of first surge of the COVID-19 pandemic in Massachusetts, the Pediatrics Department at East Boston Neighborhood Health Center (EBNHC) innovated to bring vaccinations directly to the homes of families in need.

With limited in-person care available due to high positivity rates in the community, the Pediatrics team grew increasingly anxious about gaps in care for their patients. Their fear was that the barriers to in-person care would create major delays in time-sensitive pediatric vaccinations, thus creating increased risk of other, non-COVID-related infections. In short, they were worried that one outbreak could lead to others. With families unable or unwilling to come to the health center, the Pediatrics team decided to bring the vaccines to them.

Using a repurposed van from EBNHC's Program of All-Inclusive Care for the Elderly (Neighborhood PACE), the Pediatrics Department worked to schedule home visits for children who were overdue for their vaccines. The visits were completed by teams of drivers and qualified nurses from the health center – dressed head-to-toe in Personal Protective Equipment. They hit the road in East Boston and surrounding communities, crisscrossing the service area to access patients who were afraid to leave their homes. Parents were thrilled with the team's commitment to going above and beyond for their children and, by the end of the project, over 220 visits were completed. This was all thanks to the innovative thinking and dedication of the EBNHC team.

**Yakima Valley Farm Workers Clinic** – *Access Central Pharmacy*

YVFWC opened Access Central Pharmacy (ACP) on January 7, 2019, a 340b central fill and mail order pharmacy. The goal of ACP is to support the dispensing of thousands of prescriptions daily, increase accuracy, reduce staffing costs, and improving patient adherence to medication therapies by increasing access to needed medications including specialty medications which often may not be available at local pharmacies.

Our high-volume automated robotic processes has allowed YVFWC to mail approximately 250,000 prescriptions in just the second full year of operations. With the opening of APC, YVFWC's overall prescription sales have increased nearly 20% and have reduced lines and wait times at our pharmacies. This is due in large part to the fact that 35% of YVFWC's pharmacy volume has changed to mail order. These shorter pharmacy lines has led to increased patient satisfaction when utilizing our pharmacy services. Additionally, it has opened up the opportunity to more easily access prescriptions at locations where YVFWC does not provide pharmacy services and local options are limited. Particularly in our more rural and remote service areas.

In addition to 250,000 mail order prescriptions, in one year ACP has filled 200,000 scripts for YVFWC sites. With the automated robotics and staff, we will fill close to 65% of the organizations prescription volume at ACP with less than 25% of the employees dedicated to Pharmacy. Our active central fill process allows our pharmacists more time to work directly with patients and primary care providers to optimize medication therapies for the best possible outcomes and safety.

**Waianae Coast Comprehensive Health Center** – *Rapid Adoption of Telehealth & Food Distribution*

*Telehealth* - Waianae Coast Comprehensive Health Center (Waianae, HI) transformed quickly to the March 2020 COVID environment through the conversion of face-to-face visits to both telephonic and televideo encounters. Within 30 days of COVID onset the Center had acquired a system and trained over 100 medical providers. The Center launched community education programs and a COVID hotline to answer related questions. An elders council launched outreach and training programs. The Center secured interim funding for telephonic services. It is now acquiring remote patient monitoring equipment and projects at least 30% of post-COVID visits will continue remotely. To document the need to address disparities that create barriers to full adoption, the Center has surveyed and tracked approximately 400 patients who have declined telemedicine and documented the various conditions that lead to this lack of adoption. The Center is developing a set of enabling codes that are structured around solutions aimed at reducing these barriers. These codes will be supplemental to existing enabling codes and will help in value analysis. The Center is now opening up patient kiosks in frequented places such as the largest grocery stores where a facilitator can help patients access the full scope of our services on-line.

*Food Distribution Programs* - The impact of COVID has disrupted food sources for many families on the Waianae Coast. Particularly impacted are school children that often depended on school breakfast and lunch. The Center has distributed over 3 million pounds of food over the last 9 months. The Center opened a food warehouse in the largest mall in Waianae to enhance access, and Center staff have created weekend drive-through food distribution systems. Patients are scheduled by the hour similar to scheduling patient visits at our clinics. A short-range FM station was created to provide the latest information about the virus as well as services offered. Those waiting in food lines are advised to turn their headlamps on if they would like to speak with an outreach worker capable of enrolling them remotely into the Medicaid program.

**Community Health Center, Inc.** – *Weitzman Institute & Professional Development Initiatives*

At Community Health Center, Inc. (CHC), one of the best practices we engage in is learning from others, building upon that knowledge, and sharing it with a broader audience.

To do this, we established the Weitzman Institute, the first community-based research, education, and training center established by a Federally Qualified Health Center, National Nurse Practitioner Residency and Fellowship Training Consortium, and the National Institute for Medical Assistant Advancement (NIMAA).

For the past nine years, the Weitzman Institute has lead over 1300 Project ECHO sessions to health care professionals in all 50 states, Washington D.C., Puerto Rico, and Guam. The Weitzman Institute has participated in a wide array of research resulting in numerous publications in peer-reviewed journals. It has provided executive coaching to health care leaders across the country.

In 2020 alone, the Weitzman Institute led a total of 64 webinars with 37,777 attendees. In 2020, we provided 2,113 Continuing Medical Education credits (AAFP) for our webinars and COVID ECHO sessions. We expect this number to increase, as we are now accredited by the Joint Accreditation for Interprofessional Continuing Education, starting January 2021. We also conducted executive coaching sessions for 78 leaders from over 60 organizations.

The Consortium was founded in 2010 as an informal group of early innovators and developers of postgraduate nurse practitioner residency programs. It was formally incorporated in 2015. The Consortium is a membership, advocacy, training, and accreditation organization for postgraduate NP & NP/PA training programs. The Consortium now has 166 members from 35 different states and has accredited ten postgraduate training programs, with several others in the pipeline for accreditation in 2021.

The National Institute for Medical Assistant Advancement was started as a collaboration with Community Health Center, Inc. and Salud Family Health Centers (also a Best Practices member) to prepare medical assistants for advanced primary care practices. Over the past four years, NIMAA has graduated 177 medical assistants, many of whom are now serving at FQHCs across the country. NIMAA's student outcomes include an 87% graduation rate and 81% credentialing exam pass rate. NIMAA satisfaction rates exceed 95% for students, graduates, clinical partners, and employers. NIMAA has provided subject matter expertise to the Weitzman Institute to offer UpSkillMA courses in team-based care topics to over 375 currently practicing MAs in 60 health center practices.

Professionals from all Best Practices health centers have joined participants from across the country in the Weitzman Institute's offerings. Several Best Practices Health Centers are currently participating in the Consortium and NIMAA.

**Presbyterian Medical Services** – *Comprehensive Safety Net for Rural & Frontier Communities*

Presbyterian Medical Services (PMS) has been serving the integrated health care and social service access needs of vulnerable populations in rural and frontier areas of New Mexico for over 50 years.

PMS provides critical safety net healthcare and social services to residents located in forty-three (43) communities across nineteen (19) New Mexico counties. The diversity of services includes fifty-one (51) community health centers providing primary care, oral health, behavioral health, and enabling services; and one community health center -- Totah Behavioral Health Authority-- providing traditional counseling services to Native American patients and clients, including a Sobering Center and Joint Intervention Program. PMS also provides on-site mental health therapy and dental screenings at over 20 elementary/junior high/high school sites located throughout the state. PMS health center programs include Healthcare for the Homeless and Public Housing clinics.

More than a health care provider, PMS has responded to community needs in numerous ways. Today we operate, for example, twenty-seven (27) Head Start and Early Head Start Centers covering four (4) counties and serving over 1,300 young children and their families; Early Head Start and Home Visiting programs for expecting and new parents in seven (7) counties; an Early Intervention program for families with young children who may not be meeting developmental milestones; a Developmentally Delayed Adult Community Inclusion Project; eight (8) Senior Centers; Veteran Support Services; and Supported Housing programs in numerous communities.

Throughout its history PMS has worked collaboratively with communities, school districts, local providers, hospitals, and local, state, tribal and federal government agencies to develop programs and services which meet the needs of the people living in our underserved communities. PMS proudly shares collaborative relationships with local human service agencies, food banks, homeless shelters, domestic violence shelters and numerous other social service agencies to assure that our most vulnerable residents have access to an array of services aimed at improving their lives.

## HEALTH CENTERS INCLUDED IN THIS ANALYSIS

Columbia Basin Health Association
Community Health Center, Inc.
East Boston Neighborhood Health Center
El Rio Community Health Center
Family Health Centers at NYU Langone
Family HealthCare Network
Lone Star Circle of Care
Mariposa Community Health Center
Morris Heights Health Center
North East Medical Services
Open Door Community Health Centers
Presbyterian Medical Services
Salud Family Health Centers
Salud Integral en la Montana, Inc.
Waianae Coast Comprehensive Health Center
Yakima Valley Farmworkers Clinic