Public Health

GRAND ROUNDS

Improving Access to Primary Care in Mecklenburg County

March 21, 2024
5:30 pm - 7:30 pm
The DuBois Center at
UNC Charlotte Center City

An ongoing series sponsored by The Academy for Population Health Innovation (APHI), a collaborative effort of Mecklenburg County Public Health and the UNC Charlotte Department of Public Health Sciences

As Public Health Director for Mecklenburg County, Dr. Raynard Washington is responsible for leading more than 900 interdisciplinary public health professionals who work daily to protect and promote health among county residents with an emphasis on improving health equity. Prior to this role, he served as the Deputy Health Director, overseeing internal operations, and leading many aspects of local response to the COVID-19 pandemic. Before moving to Charlotte, Dr. Washington served as Chief Epidemiologist and Deputy Health Commissioner for the City of Philadelphia, where he made significant progress in expanding and integrating public health data systems, led the development of the city's community violence prevention strategy, and completed the first-ever regional Community Health Assessment in partnership with nine healthcare systems covering a five-county region. Dr. Washington earned his undergraduate and graduate degrees from the University of Pittsburgh.

Raynard Washington, PhD, MPH

Public Health Director

Mecklenburg County Public Health

Public Health Grand Rounds

Improving Access to Primary Care in Mecklenburg County

Raynard Washington, PhD, MPH

Public Health Director

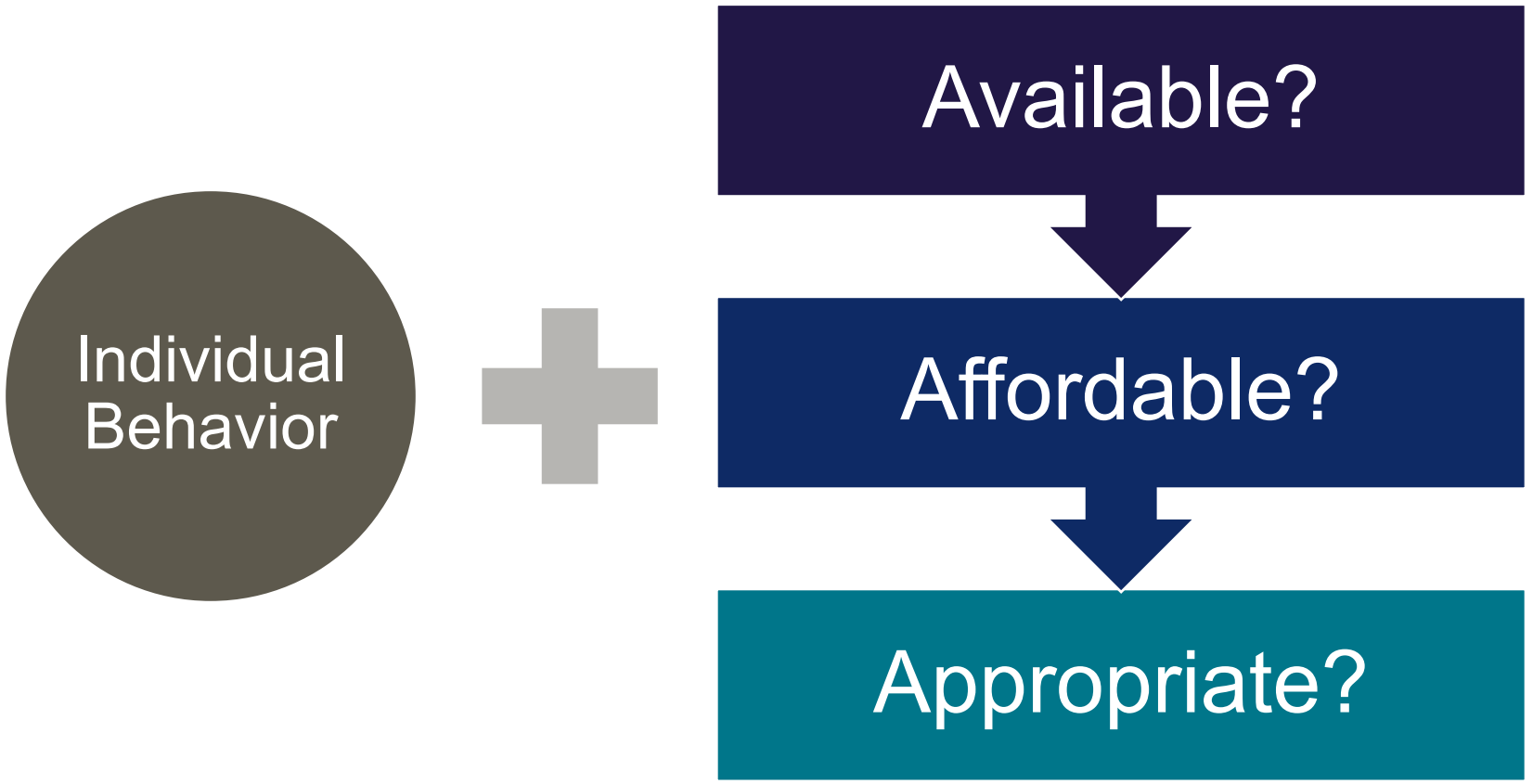
March 21, 2024

MECKLENBURG COUNTY
North Carolina

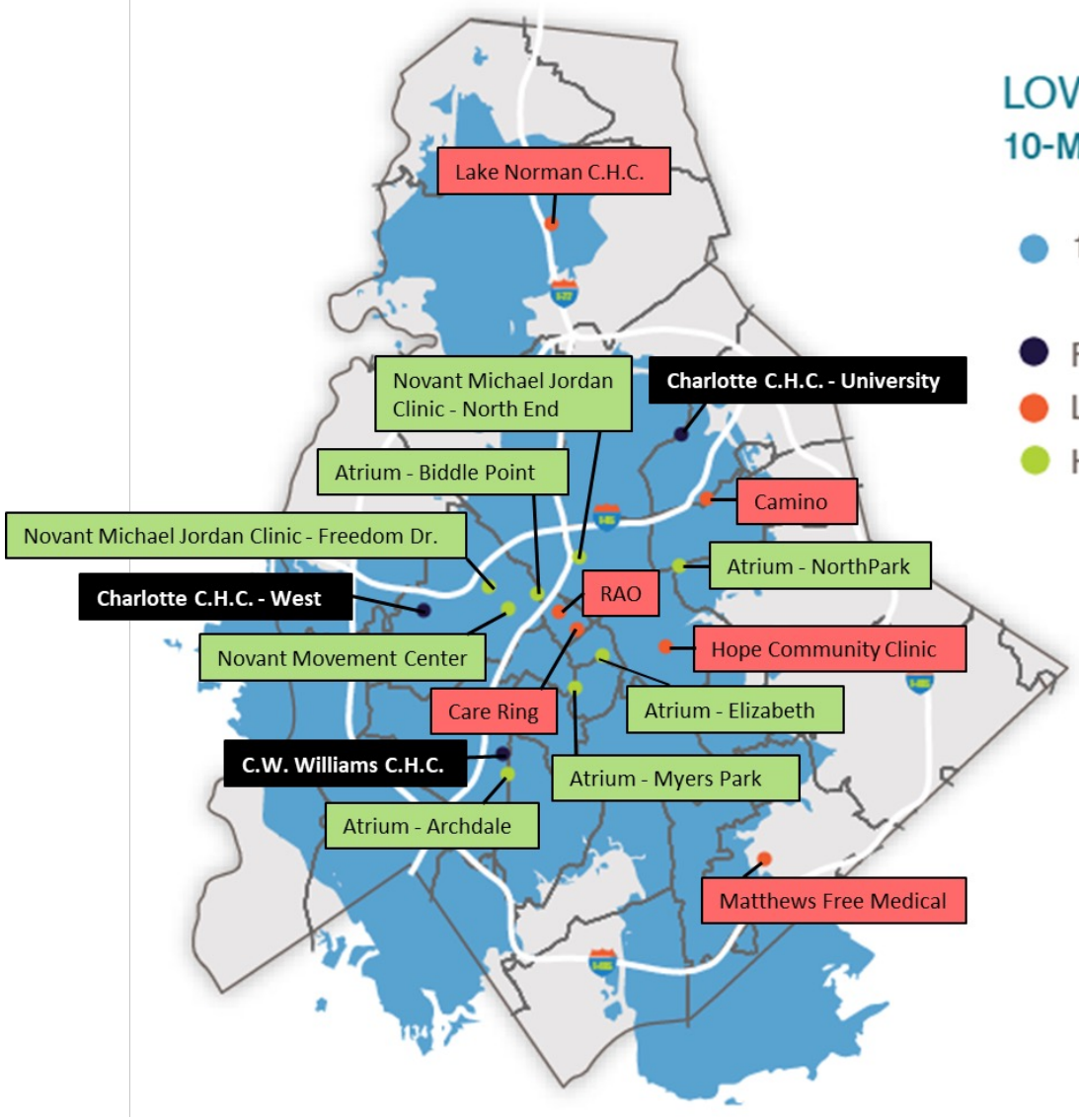
Primary Care

- Primary care is fundamental to ensuring the health of individuals and families.
- People who routinely access primary care are more likely to:
  - **Maintain a healthy lifestyle**
  - **Identify disease early**
  - **Manage chronic conditions**
  - **Avoid costly complications and hospitalizations**
- Improving access to care remains a top community health priority.

Barriers to Accessing Primary Care



Low-Cost Primary Care



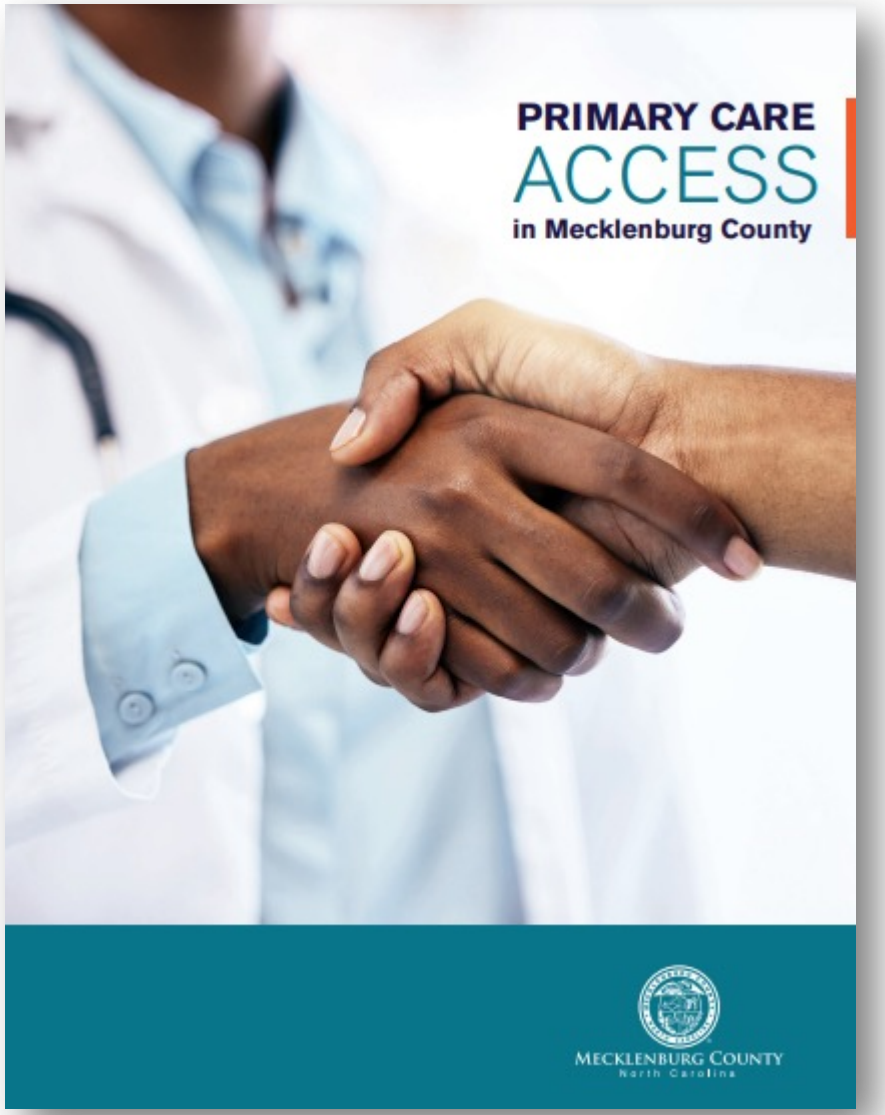
LOW AND NO-COST CLINICS:

10-Minute Drive Time

- 10-Minute Drive Time
- FQHC
- Low and No-Cost Clinic
- Hospital Associated

Together these entities serve approximately *42,000* residents each year.

Improving Access to Primary Care



WHAT CAN BE DONE

Increasing access to primary care is challenging and success will require innovative solutions that engage the entire community.

These strategies include:

1. **reducing the uninsured population in the County;**
2. **increasing the capacity of the current primary care system to serve under- and uninsured residents;**
3. **educating the public on the importance of primary care; and**
4. **expanding awareness of current resources available.**

Key Partners

- **Health systems can:**
  - Expand low-cost primary care services in underserved areas
  - Promote awareness of low-cost primary care services and financial assistance programs
  - Expand collaborative relationships with primary care providers to reduce hospital utilization

- **FQHCs and other providers can:**
  - Establish new FQHC and other low-cost primary sites in underserved areas
  - Adopt Primary Care Medical Home model
  - Promote awareness of low-cost primary care services

- **Managed care organizations can:**
  - Promote utilization of primary care
  - Supply comprehensive primary care provider networks
  - Implement value-based reimbursement that rewards utilization of primary care

- **Everyone can:**
  - Utilize primary care consistently
  - Support Medicaid expansion

Carolyn Allison began her career as a Research Biochemist at the University of Chicago, studying RNA and DNA genomes. As a result of her growing interest in Public Health, Ms. Allison earned her MPH degree, with a concentration in Health Care Administration, from the University of Illinois in Chicago. She has over 30 years of health care administrative experience, including hospital administration, managed care, and over 20 years of experience managing community health centers/federally qualified health centers (FQHCs). Ms. Allison is currently the CEO at the Charlotte Community Health Clinic, Inc. (CCHC), whose mission is to provide effective and efficient primary health care services for low-income underserved and uninsured individuals. CCHC was incorporated in 2001 and funded as a community health center in June, 2015. With locations in north Charlotte, west Charlotte, and two in east Charlotte, CCHC provides primary care, dental, and behavioral health services to all life cycles, as well as healthcare for the homeless at the Urban Ministry Center. Ms. Allison also provides operational consultation to community health centers in multiple states, and is the proud recipient of The Network Journal Business Magazine Top 25 Influential Black Women Award.

Carolyn C. Allison, MPH

Chief Executive Officer

Charlotte Community Health Center, Inc. (CCHC)

Charlotte Community Health Clinic, Inc.

Carolyn C. Allison, MPH

Chief Executive Officer

March 21, 2024

2001 | *Charlotte Community Health Clinic, Inc. (CCHC) was founded by* ***Dr. Ophelia Garmon-Brown*** *and operated as a Free Clinic.*

2015 | *CCHC became a Community Health Center/Federally Qualified Health Center* ***(FQHC)***

As a community health center, services were expanded (medical, behavioral health, homeless healthcare, and dental)

Improving Access to Care

3 locations | East Charlotte, West Charlotte, & North Charlotte/University area

New Sites in 2024:

February 6th CCHC opened its **4th** location, a Pediatric Clinic at the Thompson Child & Family Focus, Wendover Rd. facility.

June 2024 CCHC will open its **5th** location on the Aldersgate campus in partnership with OurBridge for Kids and Carolina Migrant Network.

Improving Access to Care

Adult medicine
Pediatric services
BCCCP | mammography and cervical screenings
Integrated Behavioral Health
Express Care Clinic (same day services)
Access to Specialty Services
Ryan White Clinic
Dental services for families
School-based Oral Health
Healthcare for the Homeless (at Roof Above & CCHC sites)
Pharmacy
Care Management/Care Coordination
Insurance Navigator
Community Health Workers (CHWs)

Improving Access to Care

~ Services ~

2022 UDS Report Data

- ❑5, 667 **Total Patients**
- ❑ 4,472 medical pts
- ❑ 1,195 dental pts
- ❑ 205 homeless pts*

(included in total medical patient number)

- ❑ 11,179 **Total** Medical Visits
- ❑ 3,527 **Total** Dental Visits
- ❑ 1,778 **Total** Behavioral Hlth Visits

Improving Access to Care

~ Impact ~

2022 UDS Report Data

Ethnicity:

Hispanic | **63%**
Non-Hispanic | **34%**
Unknown | **3%**

Race:

African American | **22%**
White | **42%***
Other | **34%**

**(many Hispanic pts. identified as White)*

Improving Access to Care

~ Demographics ~

Improving Access to Care

~ Quality Impact ~

In-house Pharmacy at the Medical Plaza/University location
(projected opening – > June 2024)

Opioid Settlement Grant– expansion of Medication Assisted Treatment (MAT) program

Ryan White (Part A) Grant:
Certified HIV physician joined CCHC in 2023 after leaving Atrium where she started and ran the HIV Clinic for approximately 20yrs. A second experienced Certified HIV provider joined CCHC in February 2024.

Improving Access to Care

~ Expansion Projects ~

Thank you!

carolynallison@cchc-clt.org

Keila Marlin directs and implements innovative program, policy, and systems-level change strategies to improve and strengthen the Community Health Worker (CHW) workforce in Mecklenburg County. She is a certified CHW and has experience working to reduce race and health inequities in the Black and LGBTQ+ communities by providing health education, linkage to care, and policy and systems-level change advocacy. Keila continues to leverage her expertise in new spaces as a committee and board member, where she co-authored an APHA policy in 2022 and was named 40 under 40 in Public Health by the de Beaumont Foundation in 2023. She holds two degrees and is currently a doctoral student specializing in health policy, administration, and leadership at East Carolina University.

Keila Marlin, MPH, CCHW

Community Health Worker Initiative Program Manager
Mecklenburg County Public Health

What is a Community Health Worker?

A community health worker (CHW) is a **frontline public health worker** who is a trusted member of and/or has an intimate understanding of the community served. This relationship enables the CHW to **serve as the bridge or link between health and social services** to facilitate better access to care by improving the quality and cultural competence of service delivery.

-definition adapted from the American Public Health Association's CHW Section

CHW is an umbrella term that includes a range of titles…

What do CHWs do?

- ✓**Cultural Mediation**
- ✓**Health Education and Information**
- ✓**Service Coordination and Navigation**
- ✓Coaching and Social Support
- ✓Advocacy
- ✓Individual and Community Capacity
- ✓Direct Service
- ✓Individual and Community Assessments
- ✓Outreach
- ✓Evaluation and Research

-CHW roles from the CHW Core Consensus Project

Job Outlook

- Projected to grow 14% from 2022 to 2032, much faster than the average for all occupations
- About 8,000 CHW openings are projected each year

Source: U.S. Department of Labor Bureau of Labor Statistics

Impact

- **Improve population health**
  - Increased likelihood of obtaining primary care, increased mental health improvements, and reduced likelihood of multiple 30-day readmissions from 40% to 15.2% (Kangovi, 2014).
- **Reduce health disparities**
  - Emerging literature showcases that CHWs provide culturally responsive access to healthcare services for marginalized communities (Torres et al., 2014).
- **Advance health equity**
  - Interventions by CHWs appear more effective when compared to alternatives and are cost-effective for certain health conditions, particularly among underserved communities (Kyounghae et al., 2016).

Current Public Health Efforts

A Guided Journey

Collective Impact Workgroups

Mobile Units

In her current role with Advocate Health, Jennifer Snow provides system-wide strategy, development and program management around community-based health, and leads development of the enterprise-wide Social Drivers of Health strategy and care model, as well as providing direction for the national Community Health team. Since joining Atrium in 2020, Ms. Snow has been instrumental in designing and building a new team structure supporting their growing work, including the launch of mobile health units. With over 9 years of healthcare leadership experience and 7 years of public relations, client management and government relations experience, she manages a diverse portfolio of activities spanning community and social impact, community health strategy and advocacy, strategy execution and innovation, and strategic partnership development. Her earlier work included the development of a unique, three-tiered model for population health management that goes beyond the traditional healthcare provider platform to increase access to care and enable residents to improve their health. She previously served as the Executive Director of Accountable Communities with Prisma Health in South Carolina, where Ms. Snow's team implemented innovative care delivery models for the uninsured and underinsured, and built resources to take into communities where at-risk patients reside. Her Patient-Centered Medical Neighborhood Model won America's Essential Hospitals' 2018 Gage Award in Population Health.

Jennifer Snow, MBA

Vice President of Community Health
Advocate Health

HEALTH EQUITY PILLAR

Equity in Access

We have addressed the following issues:

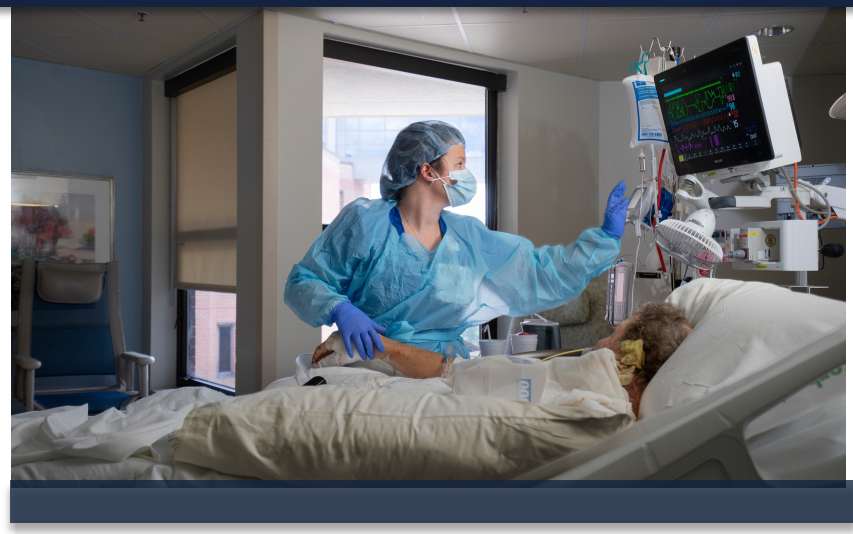
- **Community Clinics**
- **Virtual Visits**
- **Mobile/Home Based**
- **Teammate Onsite Care**

What is Access to Care and How Can We Influence It?

Access to health care means having “the timely use of personal health services to achieve the best health outcomes.”

AVAILABILITY

ACCESSIBILITY



ACCEPTABILITY

Past
Traditional
Physical Clinics

Future
Redefining care delivery

Community Clinics

Mobile Clinics

Virtual Care

In-Home Care

We are transforming traditional care access points by redefining care delivery for the future.

Community Clinics

Atrium Health provides **equitable, convenient, and accessible care** to medically underserved communities through our 8 community clinic locations. Our equity-driven focus allows Atrium Health to identify underserved areas with concentrated social and health risk factors.

In Fiscal Year 2021, Atrium Health **invested over $6 million** in five of our community clinics across the Charlotte region.

Atrium Health provides the most health care to residents throughout North Carolina and is **the state's largest safety net provider** for the Medicaid and uninsured populations.

Downtown Health Plaza | Atrium Health Wake Forest Baptist (wakehealth.edu)

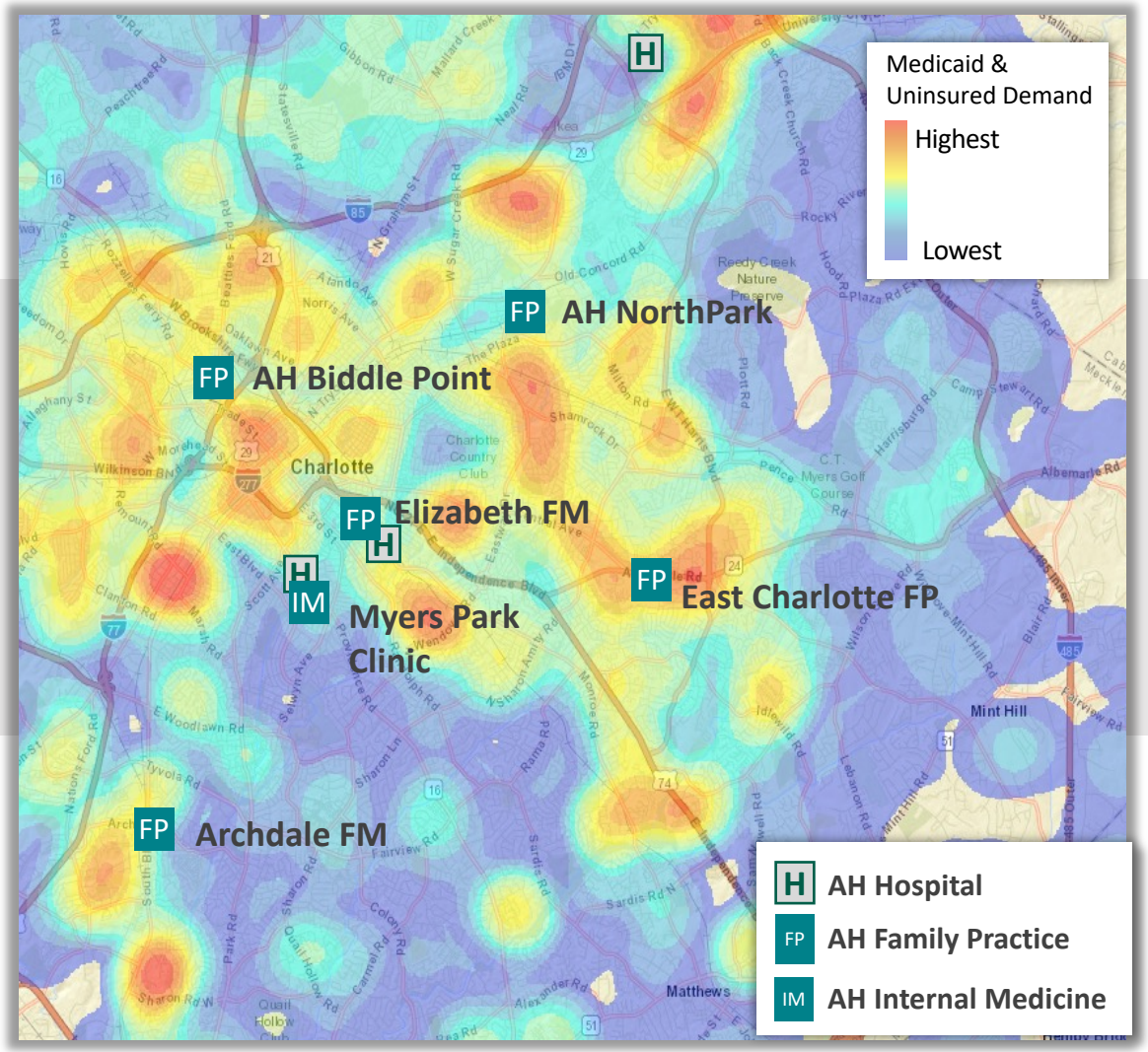
Atrium Health Greater Charlotte		Atrium Health Navicent	Atrium Health Wake Forest Baptist
Biddle Point Family Medicine	North Park Family Medicine & OBGYN	Anderson Health Center	Downtown Health Plaza
East Charlotte Family Physicians	Myers Park Internal Medicine, OBGYN & Pediatrics		
Elizabeth Family Medicine	Ed Brown Community Care Center		
Archdale Family Medicine			

Our Solutions are Community Guided

"My vision for the community is to have **equitable access to quality healthcare,** education, jobs and economic development."

"**We deserve health care** for our youth, families, and seniors that are **equal to other parts of the city**."

- YMCA Community Listening Session in Partnership with Atrium Health



Using a **data-driven approach** to meet the needs of our community, Atrium Health will expand our clinic footprint, increase non-traditional services and access points, and expand partnerships to increase access in our most underserved and historically marginalized communities. In January 2022, we opened our newest community care practice, **Atrium Health Community Care Primary Care Archdale.**

Bringing Care to Communities Where People Need it Most

Our mobile primary units provide **trusted** and **convenient** access to care in **high-need areas** by engaging community members to address **clinical and acute social needs.**

Equipped like brick-and-mortar practices, Mobile Health Clinics:

- Deliver basic acute and primary care services
  - ✓ Diagnosis, treatment of acute and chronic illnesses
  - ✓ Prescribe prescriptions
  - ✓ Provide patient education
  - ✓ Deliver vaccines and boosters as needed
- Provide access to resources that help address acute social needs
- Offer walk-up care ability
- Connect to primary care medical home
- Screen for social drivers of health and provide referrals
- Educate patients on individual health needs

Acute Social Needs

We are **improving economic and social factors** that influence health by assisting with:

- Housing
- Violence and Trafficking
- Food Access
- Unemployment

And providing resources like Referral Navigators, Community Health Workers and the Community Resource Hub

Michael Dulin is the Director of the Academy for Population Health Innovation at UNC Charlotte – a collaboration designed to advance community and population health. He started his career as an Electrical and Biomedical Engineer and then received his MD/PhD from the University of Texas Medical School at Houston. After completing his residency training in Family Medicine, Dulin entered private practice in Charlotte. After working as a community-based provider, he became the Research Director and then the Chair of the Carolinas Healthcare System's Department of Family Medicine, where he founded and directed a primary care practice-based research network (MAPPR) that has had ongoing federal funding since 2006. Dulin also served as an executive at Atrium Health, where he led the system's analytics center of excellence as well as their center for outcomes-based research and evaluation. From 2020-2021, Dr. Dulin was a Fellow at the National Academy of Medicine where he supported the U.S. House of Representatives Energy & Commerce Committee working on policy issues related to the COVID-19 pandemic, public health data infrastructure, social determinants of health, mental health, and health information technology. His ongoing policy fellowship is funded by The Robert Wood Johnson Foundation and now focuses on bias in artificial intelligence. Dr. Dulin is a nationally recognized leader in the field of health information technology (HIT) and application of analytics and outcomes research to improve care delivery and advance population health. He has led projects funded by AHRQ, The Robert Wood Johnson Foundation, The Duke Endowment, NIH, and PCORI, and his technology innovations have been recognized by the Charlotte Business Journal, NCHICA, and Cerner. His work to build a centralized data and analytics team at Atrium Health was used by the Harvard T.H. Chan School of Public Health as a published case study.

Michael F. Dulin MD, PhD

Executive Director, Academy for Population Health Innovation
Professor of Health Management & Policy, UNC Charlotte

Access to Primary care

APHI / Public Health Grand Rounds March 21st 2023

Michael Dulin, MD, PhD

Primary Care and Health equity

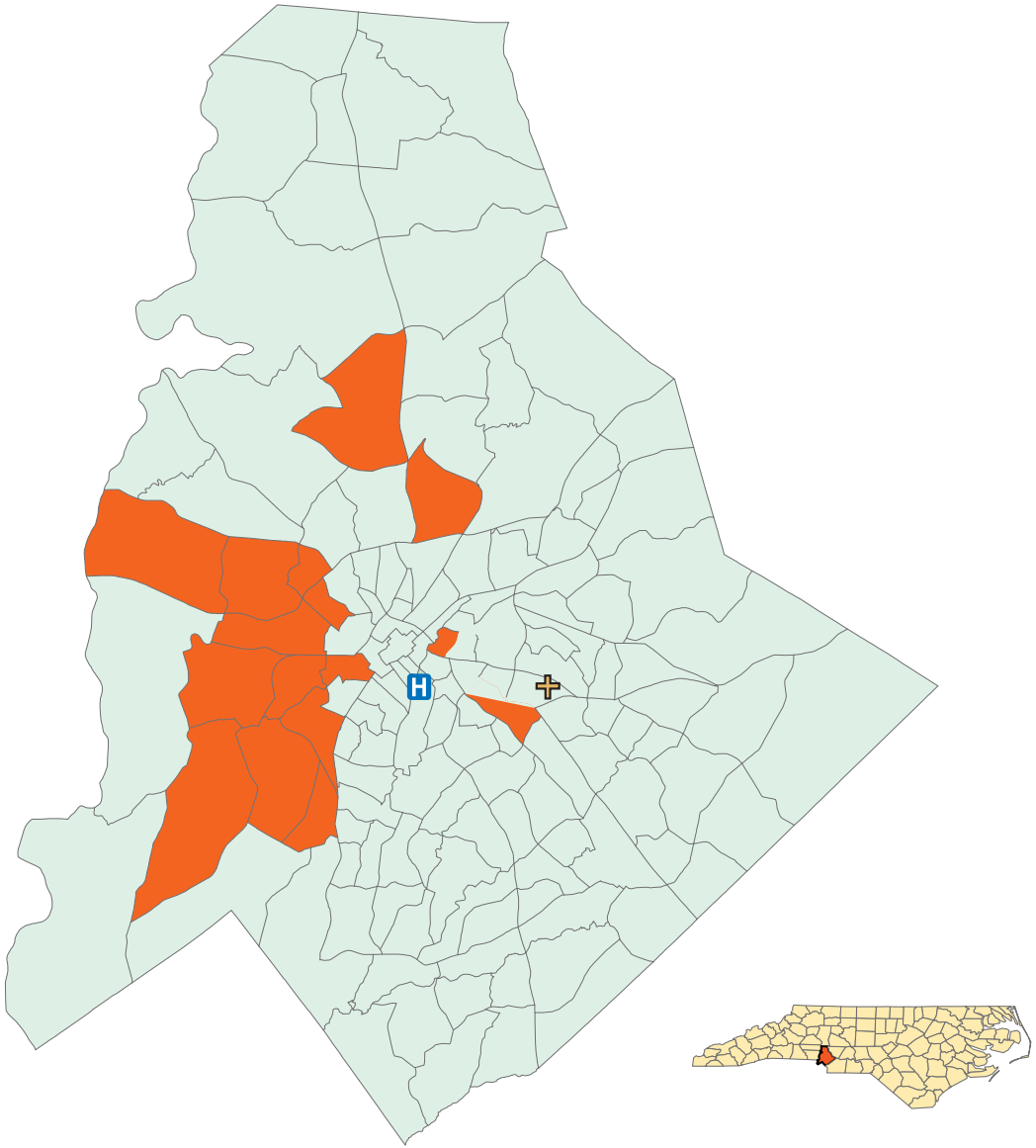
- Life Expectancy
- Maternal Outcomes
- Cancer Screening
- Vaccinations
- Access to Behavioral Health Care
- Care of Chronic Conditions
- Trust with the Healthcare System

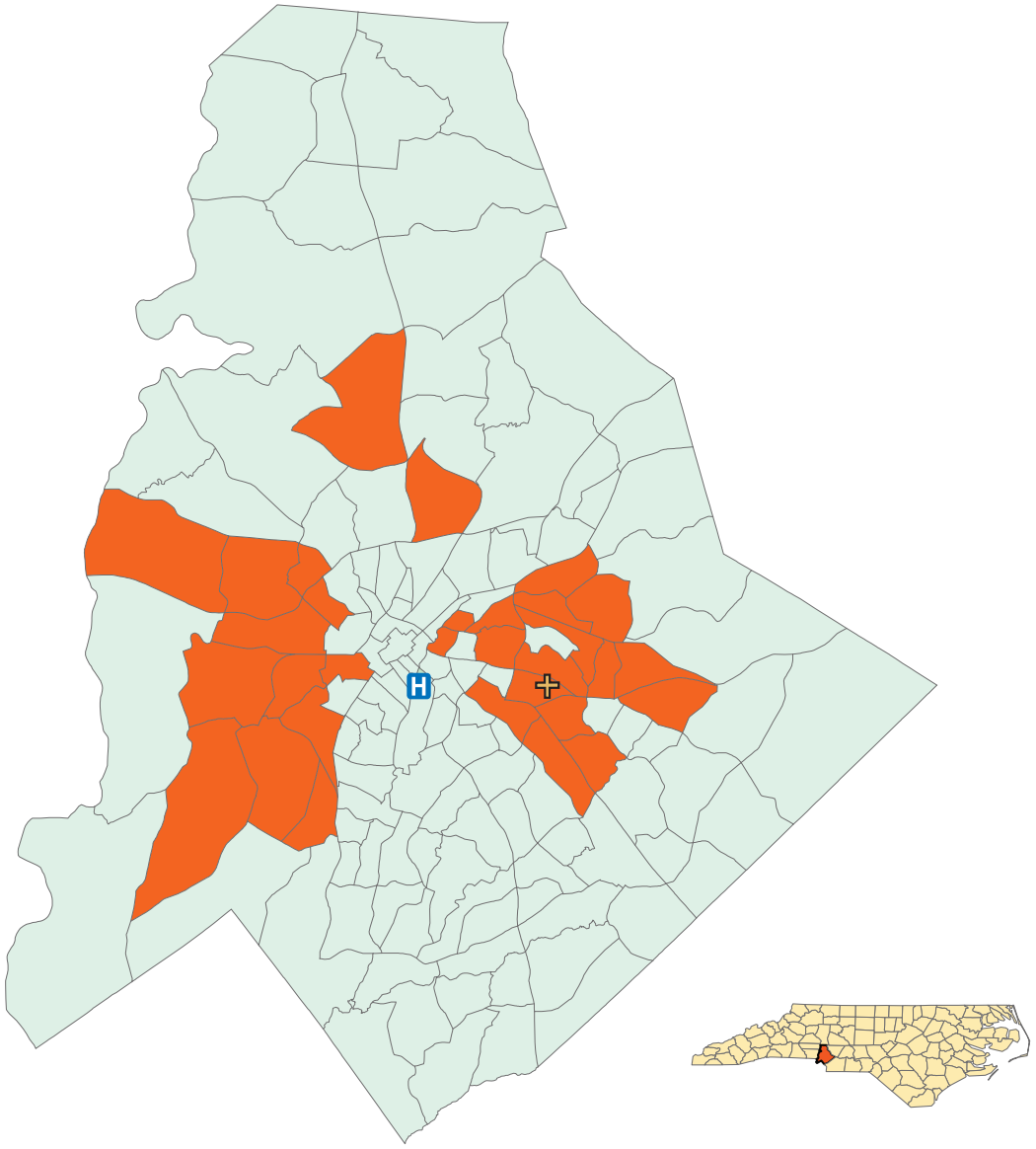
Mecklenburg County | Barriers to Access

- Trust
- Cost / Lack of Insurance
- Transportation
- Hours / Availability
- Language and Cultural Barriers
- Perception (Emergency Care is Better)

Interventions

- Community Engagement (CAB or PAB)
- Expansion of Coverage / Reduced Co-pays
- Culturally Competent Care
- Geographic Location
- After Hours Care / Access
- Telehealth
- Integrated Care Models (Behavioral and Social Services)
- Community Health Workers / Lay Health Advisors





Public Health

GRAND ROUNDS

Please join your fellow participants in the Atrium for a brief reception and the chance to keep tonight's important conversations about primary healthcare access going!