

STRENGTHENING HEALTHCARE ALONG THE GULF COAST:

*The Gulf Region Health Outreach Program's
Primary Care Capacity Project*



EXECUTIVE SUMMARY

This report highlights the key strategies, activities and outcomes of the Primary Care Capacity Project (PCCP), one of four integrated Gulf Region Health Outreach Program (GRHOP) projects created and funded as part of the Deepwater Horizon Medical Benefits Class Action Settlement. From 2012 to 2018, the PCCP was designed and implemented by the Louisiana Public Health Institute (LPHI) in close partnership with the GRHOP Coordinating Committee and impacted communities in Alabama, Florida, Louisiana and Mississippi. Using a multidisciplinary public health systems approach, the PCCP expanded long-term access to high-quality, integrated, sustainable and community-based primary care with linkages to mental and behavioral health, and environmental and occupational health services.

The PCCP's guiding approach focused on investing in primary care access and infrastructure as well as systems of care to bridge healthcare services and public health. This multidisciplinary public health systems approach advanced healthcare capacity by drawing upon distinct community-based assets including Federally Qualified Health Centers, primary care associations, public health institutes and health departments. This network of strategic partners strengthened current healthcare delivery and practice, and fostered opportunities for additional growth and expansion throughout the Gulf Coast region.

To engage impacted communities and facilitate community input, LPHI initiated the program by conducting a series of mixed-method, in-depth assessments. Through facilitated key informant prioritization meetings and evaluation of state, county and sub-county data on a wide range of topics, the assessments successfully integrated the community perspective in project planning, design and implementation. Additionally, the assessment process advanced guiding principles for decision-making including utilization of data-informed processes and leveraging existing resources.

The assessments ultimately identified and prioritized 15 community health centers serving 17 Gulf Coast counties and parishes for targeted clinic capacity-building. LPHI aligned its funding and technical assistance strategy with evidence-based models and national efforts to improve primary care. Key strategies included the Patient-Centered Medical Home model "whole person" approach to delivering integrated services; data-driven clinical quality improvement; enhanced referral relationships with specialty and social services providers; and strengthened business operations. Through strategic funding that complemented and enhanced other funding, such as increased investments from the Human Resources and Service Administrations, the PCCP contributed to the community health centers' growth and expansion over the six-year period resulting in increased access to care, types of services provided and financial stability.

Complementing primary care capacity building and increased access to high-quality care, the PCCP also supported advancements in health information exchanges in Alabama, Louisiana and Mississippi. With PCCP funding, the Mississippi Health Information Network, Mississippi's health information exchange, strengthened care coordination through data exchange by establishing an electronic notification system between Coastal Family Health Center and local hospitals. As the exchange and patient follow-up care expands, this system is expected to lead to a reduction in hospital and ED readmission rates.

The PCCP also engaged in other system development projects by designing and implementing the nation's first demonstration of the Prevention Institute's Community-Centered Health Home (CCHH) model. The CCHH model provides a framework for primary care, and healthcare organizations in general, to advance health equity and community resiliency by collaboratively addressing social determinants of health within the community that impact the health of the broader population. Through the CCHH pilot program, participating community health centers engaged community partners to pursue a range of data collection, analysis and community prevention activities resulting in new and improved community linkages.

Through strategic partnership building, the PCCP fostered connections to other systems and established mechanisms to support and sustain growth beyond the project period. Key state partners such as primary care associations, departments of health and public health institutes maximized investments in impacted communities, provided state-level policy education and information, and promoted sustainable partnerships for communities and their primary care service providers. The value of these partners is demonstrated through the Emergency Management Initiative which enhanced the training and technical assistance the four state primary care associations provide to community health centers in areas of emergency management and community resilience. This unique and braided approach better positioned primary care associations to support community health centers with readiness around emergency management, in addition to developing and promoting their critical role in supporting community resilience. Ultimately, this initiative will contribute to a more coordinated and regional approach to emergency management and resiliency along the Gulf Coast.

The PCCP embraced GRHOP's dual focus of addressing the health needs of communities impacted by the Deepwater Horizon oil spill and establishing partnerships with communities, public health departments, public health institutes and primary care associations to achieve sustainable population health improvements. The strategies and activities developed and implemented over the six-year project period aligned to forge strong bonds needed to reinforce the health infrastructure of communities across the Gulf Region. By investing in access, infrastructure and systems of care, PCCP has ensured that healthcare partners in the Gulf Region are better prepared to address current health challenges and future disasters.

ACKNOWLEDGEMENTS

This report was prepared by the Louisiana Public Health Institute (LPHI). It encompasses the work of many organizations and individuals involved in the Primary Care Capacity Project: community health centers, state partners and GRHOP partners. Most importantly, LPHI expresses gratitude to the residents of priority communities for their collaboration and trust.

A list of organizations and LPHI staff that contributed to the Primary Care Capacity Project is included in Appendix A.

The Gulf Region Health Outreach Program (GRHOP) was funded from the Deepwater Horizon Medical Benefits Class Action Settlement which was approved by the U.S. District Court in New Orleans on January 11, 2013.

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INTRODUCTION AND OVERVIEW

Deepwater Horizon Explosion and Spill

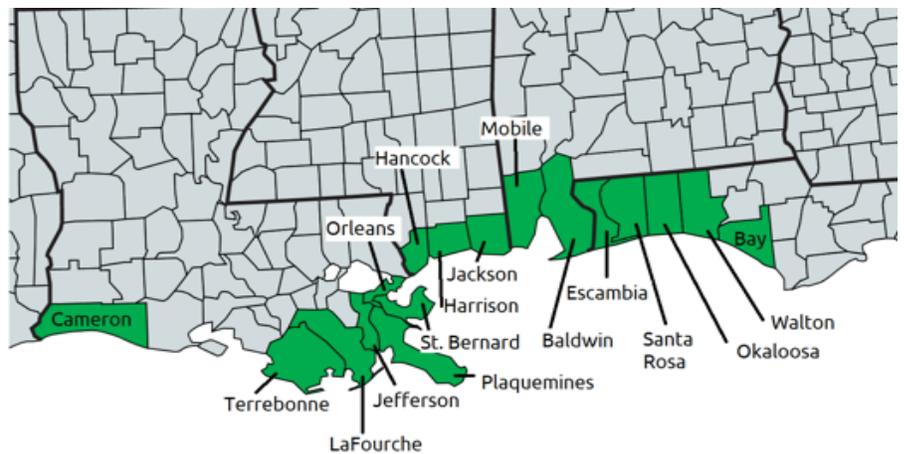
On April 20, 2010, an explosion on the Deepwater Horizon offshore oil drilling platform in the Gulf of Mexico, approximately 41 miles from Louisiana, killed 11 workers and started the largest marine oil spill in U.S. history. Crude oil gushed from the wellhead on the sea floor until the wellhead was capped almost three months later on July 15, 2010. In addition to loss of human life, the event adversely impacted the environment and residents of Gulf Coast communities.

Gulf Region Health Outreach Program

The Gulf Region Health Outreach Program (GRHOP) was developed jointly by BP and the Plaintiffs’ Steering Committee as part of the Deepwater Horizon Medical Benefits Class Action Settlement, which was approved by the US District Court in New Orleans on January 11, 2013, and became effective on February 12, 2014. The GRHOP was overseen by the court and funded with \$105 million from the Medical Settlement. **The GRHOP consisted of four integrated projects** collaboratively lead by multiple institutions. The GRHOP also incorporated a community involvement project that worked in cooperation with project leaders. The projects were designed to strengthen healthcare capacity and increase health literacy. Each project was independently administered by one or more lead institutions and overseen by the GRHOP Coordinating Committee.

Primary Care Capacity Project	Mental and Behavioral Health Capacity Project	Environmental Health Capacity and Literacy Project	Community Health Workers Training Project
<ul style="list-style-type: none"> Louisiana Public Health Institute 	<ul style="list-style-type: none"> Louisiana State University Health Sciences Center University of Southern Mississippi University of South Alabama University of West Florida 	<ul style="list-style-type: none"> Tulane University Association of Occupational and Environmental Clinics 	<ul style="list-style-type: none"> University of South Alabama’s Coastal Resource and Resiliency Center
Alliance Institute: Community Involvement Project			

The target beneficiaries of the GRHOP were residents, especially the medically underserved, of **17 coastal counties and parishes** in **Alabama** (Baldwin, Mobile), **Florida** (Bay, Escambia, Okaloosa, Santa Rosa and Walton), **Louisiana** (Cameron, Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard and Terrebonne) and **Mississippi** (Hancock, Harrison and Jackson).





The GRHOP provided the Louisiana Public Health Institute (LPHI) a unique opportunity to expand its engagement with Gulf Coast communities through administration of the Primary Care Capacity Project (PCCP). Unlike direct victim compensation aspects of the medical settlement, GRHOP represented an attempt by the federal court system to impact broader community health issues. This approach necessitated committed program oversight by content experts and public health professionals, such as LPHI, to ensure accountability and adherence to program goals.

The Louisiana Public Health Institute, founded in 1997, is a statewide 501(c) (3) nonprofit organization that translates evidence into strategy to optimize health ecosystems. LPHI focuses on uncovering complementary connections across sectors to combine the social, economic and human capital needed to align action for health. LPHI connects and empowers sectors to champion health with people, for people through systems change and innovation in the southeast region. By fostering collaborative endeavors in the areas of health information, public policy, applied research and community capacity enhancement, LPHI works to develop community-oriented solutions to improve health. Based in New Orleans, Louisiana, LPHI contributed to significant advancements in rebuilding the primary care delivery network post-Hurricane Katrina. Many of the lessons learned and skills gained from that experience were transferrable to the capacity building opportunities that were present in the aftermath of the Deepwater Horizon event.

Key LPHI program strategies and activities that contributed to the success of the PCCP included:

- **Strategic project design and management**

Managing and administering a large, federal court settlement required careful navigation and coordination with multiple external partners. This was accomplished by LPHI's multi-disciplinary team of technical experts and project managers who created and implemented standardized tools, protocols and strategies to achieve the project objectives across multiple states and a diverse network of stakeholders. Consistent and transparent partner communications, actionable work plans and ongoing assessment and feedback channels were critical to successfully managing this large, complex project.

- **Responsive and targeted technical assistance**

Several inputs were considered when designing, delivering and monitoring technical assistance. The LPHI team utilized the Patient-Centered Medical Home model as a framework for determining priority goals, and included feedback from clinic assessments, surveys and progress check-ins with community health center staff to inform additional opportunities for technical assistance delivery and content. As the project progressed, technical assistance focused on advancing performance on quality measures and aligning with community health centers' revenue generating operations.

- **Effective convener**

Facilitating a collaborative learning environment is a cornerstone of LPHI's approach to building a community that can affect change. The learning community model has demonstrated effectiveness in coalition building, network development and dissemination of best practices and key findings. Through the PCCP, LPHI provided a variety of opportunities for convening and peer exchange: large in-person forums, webinars and facilitated small group settings. These engagements fostered and advanced connections that created innovative and shared learning opportunities among community health centers, public health officials, primary care associations and other community health partners.

PRIMARY CARE CAPACITY PROJECT

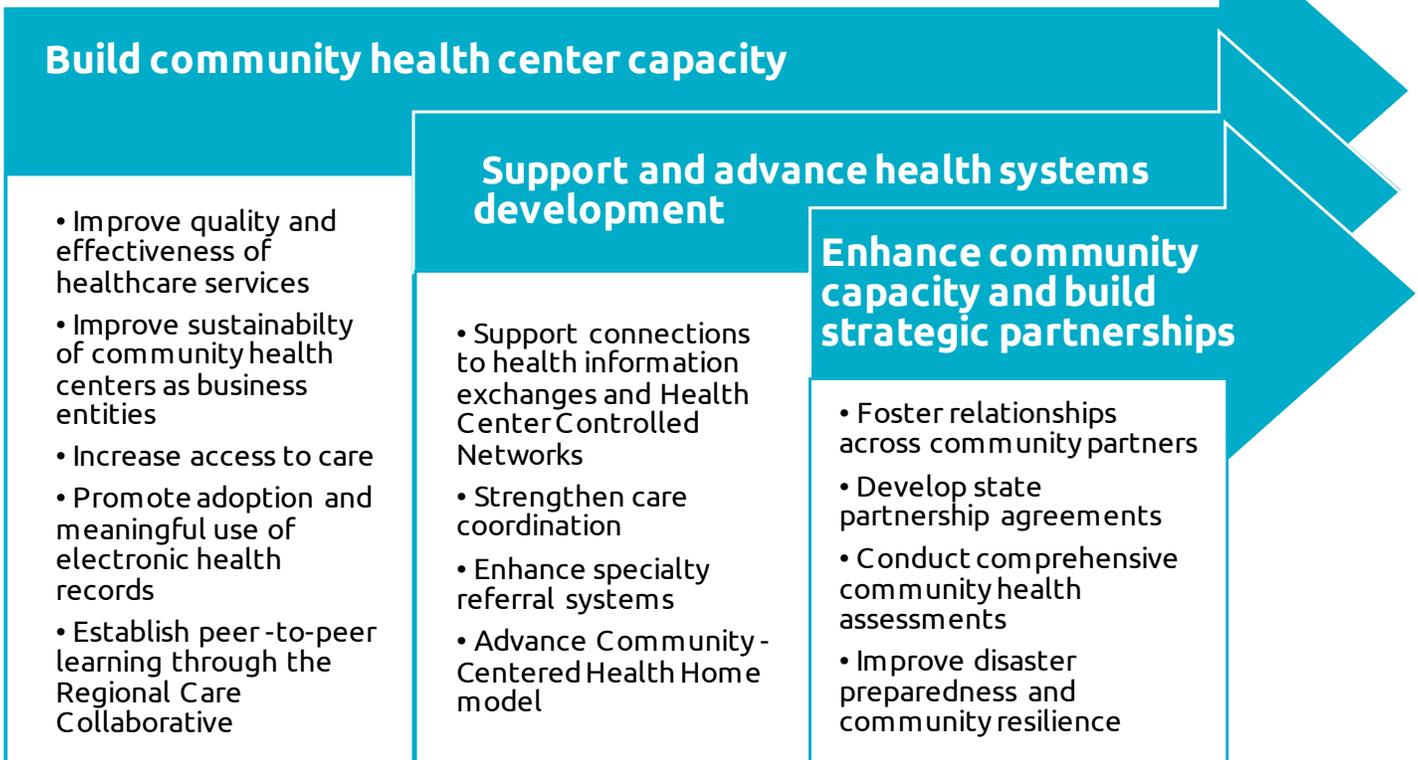
LPHI received \$46.7 million over a six and a half year period (May 2012 to November 2018) to develop, implement and administer the PCCP. State-specific funding allocations varied and were set by the GRHOP Coordinating Committee at the beginning of the project in order to effectively communicate and distribute the resources without communities competing across state lines for additional investments. Although the PCCP operated over a six and a half year project period, community investments were made throughout the project period and varied on contract length.

The PCCP funding focused on expanding access to high quality, integrated and sustainable community-based primary care, including partnerships with behavioral health and environmental and occupational health services. Investments focused on both primary care access and infrastructure in addition to systems of care in order to bridge healthcare services and public health.

Key program strategies included:

- 1 Build community health center (CHC) capacity through direct funding and customized group and individual technical assistance.
- 2 Support and advance health systems development through direct funding for health information exchanges, infrastructure investments and technical assistance.
- 3 Enhance community capacity and build strategic partnerships to improve health through partnership engagement activities and technical assistance to non-clinical partners.

PCCP's guiding approach combined three complementary strategies.



Assessing Community Needs

An initial step in the project design was to assess primary care capacity and healthcare infrastructure in the 17 coastal counties and parishes through engagement of key stakeholders in a series of community health assessments. Stakeholders included community residents, public health officials, health systems, behavioral health service providers, academic institutions, social service organizations and community-based organizations.

PCCP employed three assessment strategies:

• Primary Care Clinic Capacity Assessments

An assessment tool developed in collaboration with GRHOP partners gathered information from community health centers on their current operations. Information was collected on characteristics such as: location, staff, services, connections to other social services and health information technology applications.

• Rapid Community Health Needs Assessment

Existing state, county and parish and sub-county data from multiple sources were summarized and analyzed to create community profiles for each county and parish. Profiles characterized a community's demographic composition, health status, healthcare access, social environment and oil spill impact. These profiles were then used to facilitate a community prioritization process with county stakeholders. Stakeholders representing multiple sectors of the community participated in focus groups and a group consensus building activity to determine the health priorities for their counties and parishes.

• Comprehensive Regional Community Health Assessment

These reports were an extension of the Rapid Community Health Needs Assessments. They incorporated information derived from the data review and community stakeholder prioritization with a comprehensive review of existing data sources related to population and demographic trends, current health outcomes and disparities data, community healthcare needs and environmental and occupational health issues.

The assessments served multiple purposes:

- Provided authentic community feedback
- Informed communities of project funding decisions
- Focused policy-making and capacity-building strategies
- Guided individualized CHC work plans
- Established a baseline for setting community health objectives and measuring change over time.

Overall, the assessments prioritized two main health concerns for the impacted communities: limited access to care, particularly behavioral healthcare, and high prevalence of chronic conditions, such as diabetes, hypertension and obesity. Responding to these issues, funding strategies focused on hiring primary care and behavioral healthcare providers and expanding clinic access. Management of chronic conditions was addressed through funding and technical assistance on development and maintenance of population health management strategies such as team-based care, care coordination systems and infrastructure and electronic health record optimization.

Strategy 1: Build Capacity of Community Health Centers

To maximize the impact on population health and health equity, PCCP prioritized investments in projects and infrastructure that would foster high quality, sustainable primary care for the communities served. **PCCP selected Federally-Qualified Health Centers (FQHC) and FQHC Look-Alikes to receive direct funding** because of their community mission, sustainable infrastructure, and long history of providing comprehensive primary care, preventive services and public health outreach to underserved populations. In rural communities without FQHC or Look-Alike services, PCCP partnered with hospital district primary care clinics.

Community Health Center (CHC)*	Report Name	County/Parish**
Alabama		
Bayou Clinic	Bayou Clinic	Mobile
Bayou La Batre Area Health Development Board	Mostellar	Mobile
Family Oriented Primary Health Center***	MCHD	Mobile
Franklin Primary Health Center	Franklin	Baldwin Mobile
Florida		
Community Health Northwest Florida****	Escambia	Escambia Santa Rosa
North Florida Medical Centers	NFMC	Okaloosa
PanCare of Florida	PanCare	Bay Walton
Walton Community Health Department Florida Department of Health in Walton County	Walton CHC	Walton
Louisiana		
Access Health Louisiana	Access Health	Plaquemines St. Bernard
Hackberry & Johnson Bayou Rural Health Clinics West Calcasieu Cameron Hospital	Cameron RHCs	Cameron
Jefferson Community Health Care Centers	JCHCC	Jefferson
New Orleans East Louisiana Community Health Center	NOELA	Orleans
Plaquemines Primary Care	Plaquemines Primary Care	Plaquemines
Teche Action Clinic	Teche Action	LaFourche Terrebonne
Mississippi		
Coastal Family Health Center	CFHC	Hancock Harrison Jackson
<p>*Additional CHCs received funding through PCCP system investment projects described in Strategy Two. **The location reflects sites within the PCCP jurisdiction in 2012. Several CHCs had multiple sites outside the PCCP jurisdiction. Those clinic sites are not included in this table. ***Mobile County Health Department changed its name to Family Family Oriented Primary Health Center in 2015. ****Escambia Community Clinics changed its name to Community Health Northwest Florida in 2018.</p>		

Key inputs

The PCCP utilized key inputs to determine CHC funding: community assessments, clinic assessments, clinic requests and attributes of high performing clinics as identified by the PCMH model. High performing clinic attributes include: engaged leadership, PCMH recognition, meaningful use of electronic medical records, integration with specialty services, patient registries, team-based care, financial management and operational efficiency. From these inputs, LPHI and partner CHCs negotiated budgets and scopes of work that aligned with program goals and sustainable capacity-building strategies. Annual review of cooperative agreements further evaluated progress, priorities and sustainability plans. When necessary, budgets were modified in response to shifts in organizational priorities.

Key investment strategies included:

- Improve quality and effectiveness of healthcare services consistent with evidence-based practice and Patient-Centered Medical Home (PCMH) model.
- Improve sustainability of CHCs as business entities with increased organizational capacity, clinical quality and efficiency.
- Establish a regional network (the Regional Care Collaborative) of participating community health centers to increase knowledge and share ideas and best practices.
- Promote adoption of electronic health records (EHRs) and achievement of meaningful use of electronic health data.



“From the very beginning, sustainability was the mantra.”
- CFHC

Overall, the **15 CHCs received approximately \$21 million in funding**, although CHCs varied in their funding amount and investment profile. The intentional funding variability recognized differences in CHCs' patient volume and operational capacity. Most CHCs were funded for a four-year project period.

Examples of PCCP funding investments for CHC capacity building	
Healthcare Professionals	Primary care, mental and behavioral, dental, pharmacy, clinic support
Physical Infrastructure	Site renovations, emergency generators, telephone systems
Medical Equipment	Mobile units, x-ray, mammogram, dental, optometry
Health Information Technology	EHR software, computers, IT servers, analytics software
Services	Staff training and development: PCMH, EHR/HIT, financial

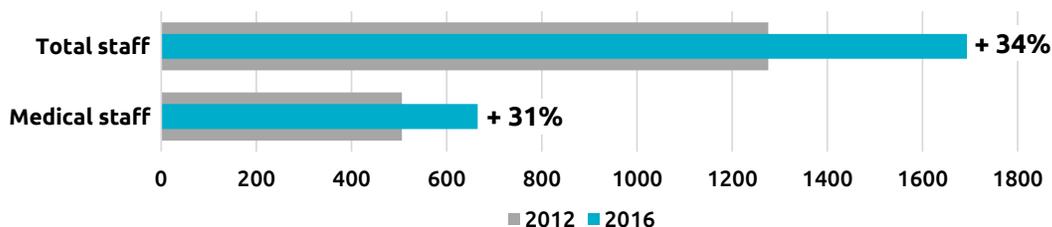


Increased access to care

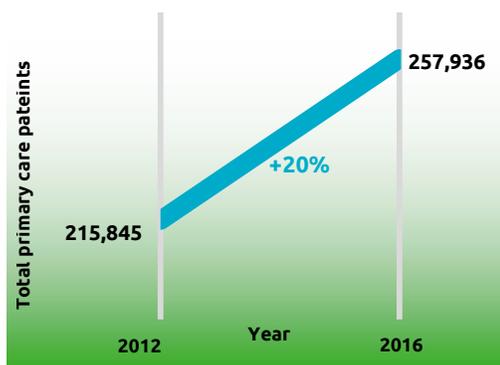
CHCs experienced considerable growth and expansion during the project period resulting in both an increase in access to care and services provided. PCCP investments contributed to this growth by providing direct clinic funding and customized group and individual technical assistance. Investments, including new staff, renovated and expanded clinic space and new mobile medical and dental clinics, led to increases in patients served and medical visits provided.

Almost all CHCs used funds to hire primary care providers with several CHCs noting that PCCP funds were essential to covering physician salaries during the lengthy credentialing period when physicians are prevented from billing third party insurers. This flexible spending consideration helped to address chronic recruitment and hiring constraints faced by many CHCs.

CHCs increased total staff 34% and medical staff 31%



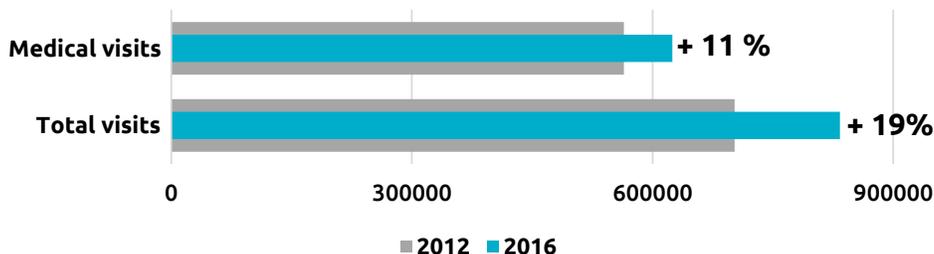
Medical staff includes physicians, nurses and laboratory personnel. Total staff includes dental and mental health.



CHCs' patient population increased 20%, resulting in more than 42,000 new patients. The average growth of a CHC's patient population was 37%, varying from a 1% increase to increases more than 120%.

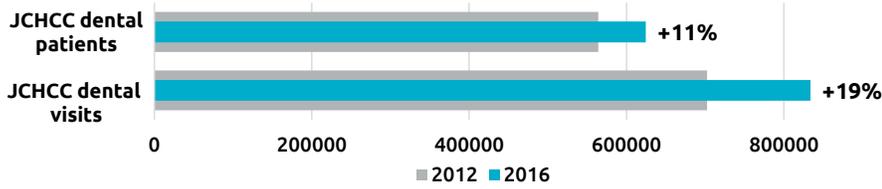
As CHCs increased their capacity and expanded services to include dental, optometry and pediatrics, the number of medical visits increased 11% and total visits increased 19%. Approximately 75% of the CHCs had an increase in medical visits and 85% of CHCs had an increase in total visits which includes additional services such as mental and behavioral health and dental.

CHCs' medical visits increased 11% and total visits increased 19%.



Several CHCs had notable growth in their patient volume and medical visits.

JCHCC increased dental visits and patients



JCHCC

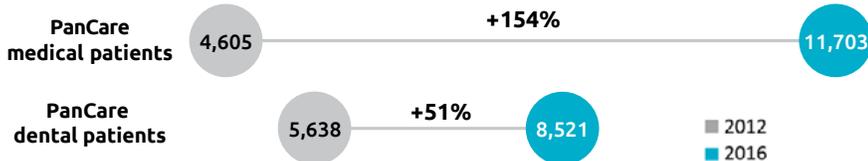
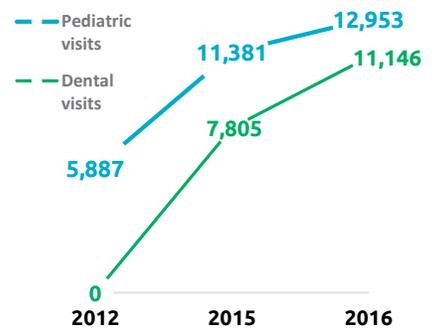
JCHCC introduced new dental services at both its mobile clinic and fixed-site clinics. To improve children's access to dental care, the mobile unit went to local schools to provide general dental care and

cleanings. Patients needing more complicated work, such as fillings, were referred for follow-up dental services at the fixed-site clinics.

Escambia

Escambia established a community dental program to replace the state-run dental program. By leveraging PCCP funds to secure additional funding resources, Escambia ultimately developed a wide-reaching dental health program with three fixed-site clinics and a mobile clinic serving Escambia County schools and Head Start programs. Escambia also opened new pediatric sites by leveraging PCCP funds to gain additional community funds, making pediatric services available in previously unserved or underserved areas of the state.

Escambia expanded pediatric and dental services

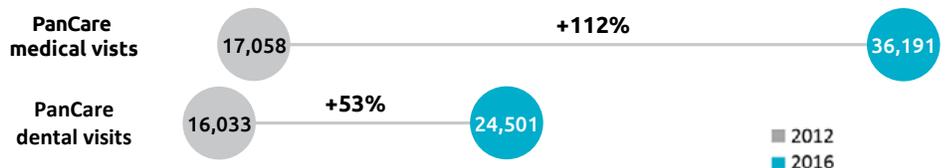


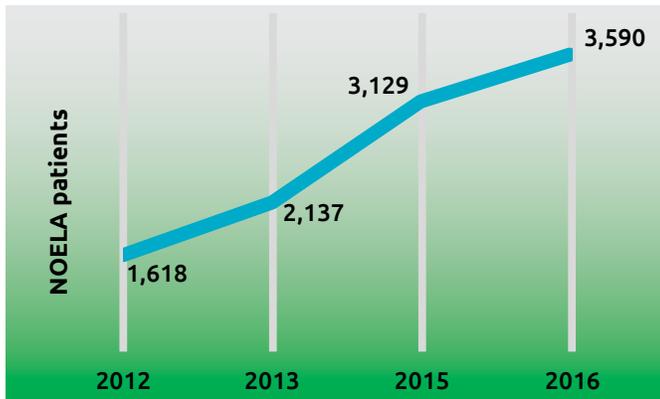
PanCare

PanCare expanded its service locations from two to nine counties. To increase access to care in rural communities, PanCare purchased two mobile units (medical and dental) that provided care to almost 1,000 new patients. PanCare's expanded medical and dental

services **increased dental patient volume by 51%** and **more than doubled the number of medical patients.**

PanCare's increase in patient volume **contributed to the robust growth of medical and dental visits.**





NOELA

PCCP funded infrastructure projects at NOELA, a health center located in New Orleans' Vietnamese community, led to improvements and expansion of clinical space. These changes drove growth of primary care services and development of new mental health services, thereby expanding the range of services available to the community. As a result, **NOELA's patient volume grew 122%.**

Expansion of services to underserved, rural areas of Louisiana

Access Health and Plaquemines Primary Care

Access Health and Plaquemines Primary Care expanded care to rural and underserved communities in St. Bernard and Plaquemines Parishes through dedicated funding for new staff and site renovations. Prior to this work, neither parish had a FQHC requiring residents to travel to New Orleans or Jefferson Parish to access a CHC. Plaquemines Primary Care additionally added clinical services to the rural, more remote area of the parish, especially critical mental and behavioral health services.

Cameron Rural Health Centers

Cameron RHCs were also able to increase access to services for a rural, remote community with limited healthcare and economic resources. With PCCP funding, Cameron RHCs improved care coordination of its diabetic and cardiovascular patients by hiring a care coordinator to routinely review registries and assess patient status.

CHCs sought community feedback to address operational issues

JCHCC: RFK Lafitte Clinic

Residents of Lafitte and other small rural communities along Barataria Bayou in Southeast Louisiana faced chronic challenges accessing primary care. JCHCC responded to this challenge by opening a new site in the center of Lafitte. Despite the availability of new services, the facility was underutilized by the local community with patient volume significantly below projected numbers. To explore issues of clinic access and utilization, PCCP partnered with the CHC to conduct a community assessment and onsite operational and workflow assessments. PCCP staff interviewed more than 70 community members and found that although the community expressed the need for clinical services and were aware of the site, there was an overall misunderstanding of clinic services and hours of operation. The assessments provided timely and critical information to shape the site's services and ultimately sustain the site's operations beyond the PCCP support. Key changes to clinic operations included improved signage, marketing and print materials, repositioning of staff and hours of operation tailored to meet the community's needs.

Teche Action

Through PCCP funding support, Teche Action opened a new clinic site in Galliano, Louisiana, to provide both primary and behavioral health services to lower Lafourche Parish. After the new location had low patient volume in the initial six months of operation, it partnered with PCCP to conduct a community-based assessment to inform future operational decisions. This assessment promoted the new site and revealed a serious unmet need for affordable mental and behavioral health services. Teche Action quickly responded by expanding its mental and behavioral health services resulting in an **increase of almost 300 new patients and 1,550 visits.**

Improvements to CHCs' operations and expanded service lines

CFHC

Although CFHC had modest change in its patient volume, its **revenue from patient services grew almost 70%** during the project period. Expansion of services was largely due to new equipment purchased through the PCCP including spot vital sign monitors and hemoglobin A1c point of care testing machines for all sites, fetal health monitors, obstetric ultrasound unit, exam tables and portable digital mammography units. PCCP funding was also used to open a new pharmacy at CFHC's Gulfport location, start mail order service for current patients and build its in-house pharmacy inventory. These additions significantly **decreased wait times to fill a prescription, increased the number of prescriptions filled and increased pharmacy-related revenue.**

NFMC

PCCP funds supported NFMC's consolidation of medical, dental and behavioral health services at a single location. By consolidating multiple service locations into one site, NFMC improved workflow efficiency, enhanced team building and communication and decreased supply inventory levels. All of these changes lead to **improved financial sustainability.**

Franklin

Franklin installed a centralized call center to standardize and consolidate key communication functions such as appointment scheduling, referral tracking and patient follow-up. Additionally, a creative staffing plan was implemented that stationed two nurses in the call center to respond to medical questions and issues. These changes **improved clinic operations and care coordination efficiency resulting in fewer missed appointments, less time spent calling patients and improved referral practices.**

CHC's improved emergency preparedness

Four CHCs directed PCCP funding for infrastructure and resources essential for maintaining clinical data and operations during emergency events, such as a hurricane or flooding. Generators purchased by Franklin were used to maintain clinic operations in the wake of Hurricane Nate which impacted Coastal Alabama in 2017. NFMC purchased and installed a natural gas generator that can supply backup power to building circuits at its main clinic site, protect refrigerated and frozen vaccine stocks and support service delivery during a power outage.

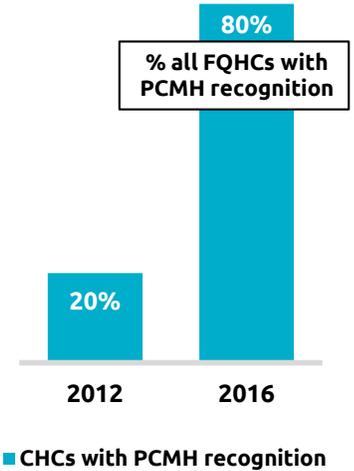


Improved quality of care

Patient-Centered Medical Home

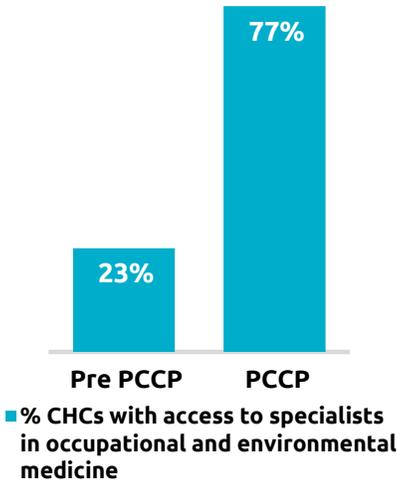
A strong indicator of CHCs' commitment to improved care quality and health outcomes was their pursuit and achievement of Patient-Centered Medical Home recognition. The overall proportion of CHCs with **PCMH recognition increased 60%** during the project period. In 2016, the proportion of PCCP CHCs with PCMH recognition (80%) was greater than the proportion of all FQHCs in the US with the recognition (70%). To earn recognition, primary care practices need to demonstrate competency in six areas: team-based care, population health management, patient-centered access, care management, care coordination and performance measurement.

Achieving PCMH recognition and implementing its values was a theme central to PCCP that was actively promoted through the Regional Care Collaborative and individual technical assistance offerings. Additionally, some CHCs used PCCP funds to hire staff or consultants to assist them with the PCMH recognition process.



Increased occupational and environmental health capacity

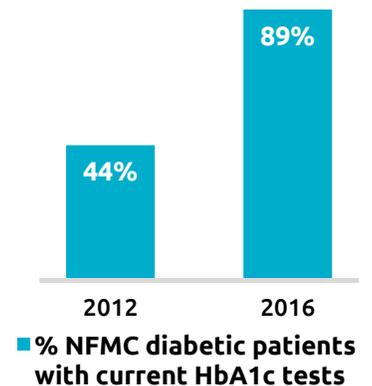
The GRHOP Occupational and Environmental Health Partners expanded CHCs' access to physicians and nurses trained in occupational and environmental medicine, increased staff understanding of the impact of work on health and connected CHCs with resources to address work-related issues.



Improved screening capacity and practice

NFMC used PCCP funds to purchase hemoglobin A1c (HbA1c) point of care instruments for all clinic sites. These instruments provided clinicians with real-time feedback to facilitate diagnosis, treatment and management of diabetes. During the project period, **NFMC increased HbA1c testing of diabetic patients from 44% to 89%**, resulting in improved care of their diabetic patients.

CFHC used PCCP funding to purchase portable digital mamography units. With the new mamography units, annual **breast cancer screenings increased from less than 100 to more than 2,500.**

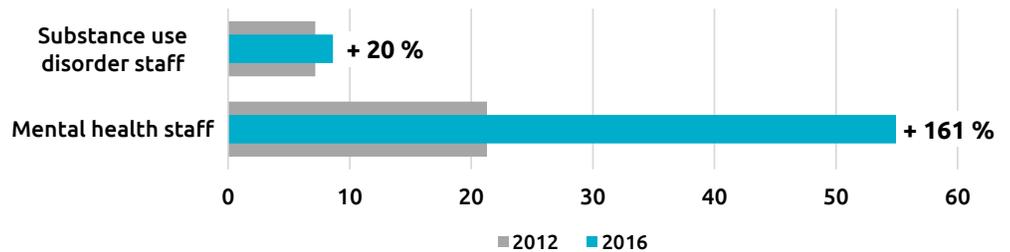


Enhanced capacity of primary care practices to respond to mental and behavioral health needs

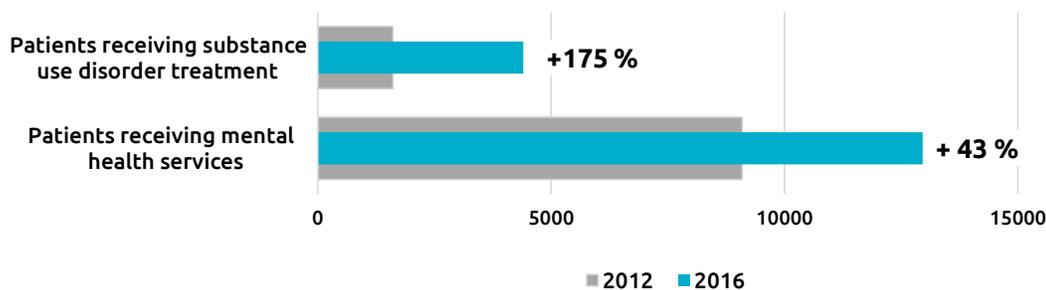
In collaboration with the Mental and Behavioral Health Capacity Project, CHCs worked toward replacing fragmented mental and behavioral care with an integrated care model that addressed patients' physical and mental healthcare needs in a medical home setting. PCCP funding for mental and behavioral health staff, such as psychiatrists and clinical social workers, contributed to **expanded services and increased volume of patients screened and treated for mental and behavioral health conditions.**

The increases in mental and behavioral health patients and services demonstrated the value of PCCP funding for implementing integrated healthcare. At the beginning of the PCCP, less than half of the CHCs had mental health staff. By the end of the project period, 77% of CHCs had mental health staff and the number of mental health staff more than doubled growing from 21 to 56 full-time equivalents.

CHCs increased substance use disorder staff 20% and mental health staff 161%.

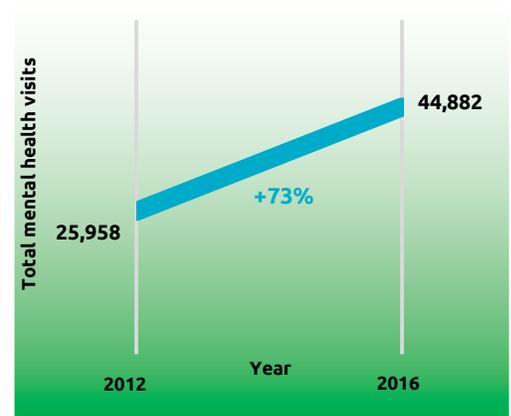


This growth led to an increase in patients and visits. The majority of CHCs' mental health patient volume increased.



CHCs increased patients receiving substance use disorder treatment 175% and mental health services 43%.

The increased patient volume and providers contributed to a **73% increase** (almost 19,000 visits) in **mental health visits.** On average, CHCs experience an increase of 1,750 in mental health visits during the project period.



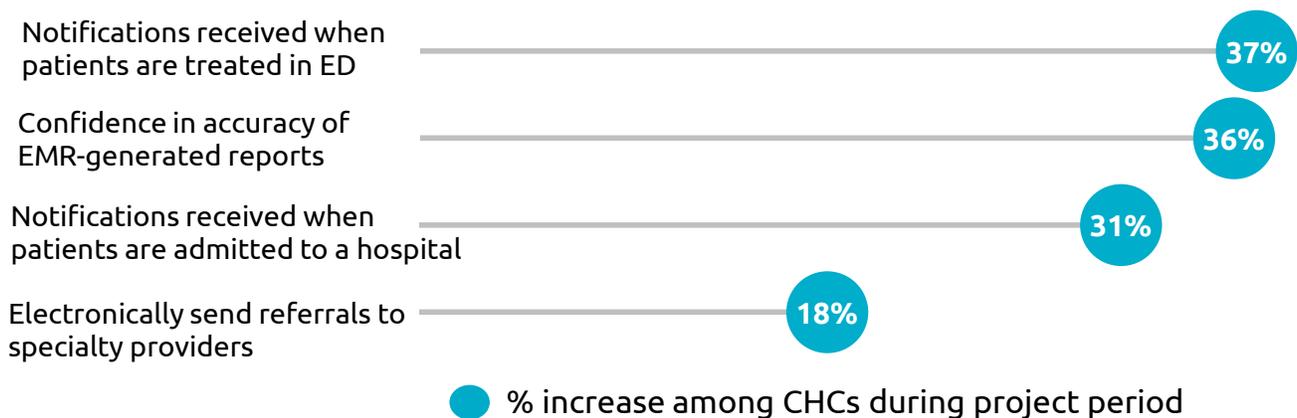


Increased optimization of health information technology solutions

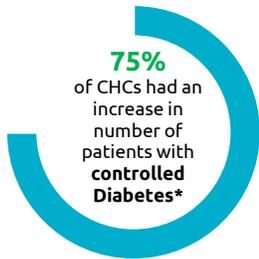
CHCs' advancements in health information technology helped to facilitate quality improvement and care management practices that led to improved care and patient outcomes, cost savings and greater engagement by patients in their own health. While most CHCs were using electronic health records (EHR) at the start of the PCCP, few CHCs had the necessary resources and training to take advantage of advanced EHR functionality needed to inform timely and proactive quality improvement activities. Over the course of the project, CHCs' improved their ability to effectively use HIT to support quality improvement activities and develop a practice culture committed to using data for quality improvement.

PCCP investments such as funding for HIT software and hardware, staff training and technical assistance contributed to improvements in clinical operations. Through these investments, CHCs established new processes and practices that harnessed the effective use of HIT. Examples include evaluating quality outcome measures across a patient panel on a quarterly basis; electronically sending referrals to specialty providers; and establishing systems to receive notifications when patients are treated at an ED or admitted to a hospital.

CHCs' improved use of HIT advanced quality improvement practices.



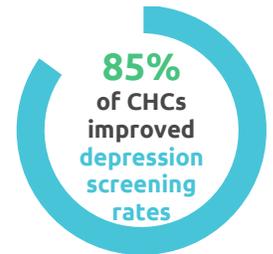
Improved care and patient outcomes



*Controlled diabetes defined as HbA1c < 8%

As CHCs' expanded their EHR utilization and increased their use of patient registries, they were able to target high risk patients and provide early intervention care. These improvements resulted in improved care and outcomes including **positive impacts on CHCs' diabetic patient populations.**

The percent of CHCs using an EHR to calculate their mental and behavioral health assessment score increased from 23% to 83%, and by the end of the project period 93% of CHCs were able to monitor changes in patient scores over time. These changes lead to **improved mental health practices including depression screening**: overall, 85% of CHCs increased rates of depression screenings among patients aged 12 and older.



Highlights:

- Mostellar had difficulty improving depression and colorectal screening rates despite a quality improvement data infrastructure and an active quality improvement committee. In response, the PCCP technical assistance team provided practice coaching including problem analysis and suggested actionable strategies to improve screening processes. Mostellar implemented these strategies with favorable results: **Mostellar's depression screening rate increased from 10% to 30%, and colorectal cancer screening rate improved from 10% to 26%.** By demonstrating notable improvement in clinical quality measures, Mostellar was awarded approximately \$15,000 from the Health Resources and Services Administration (HRSA) through a Clinical Quality Improvement Award.
- MCHD struggled to collect EHR data across its 42 clinicians providing care at nine fixed-site clinics and one mobile clinic. Following an in-depth workflow assessment by PCCP staff, measures to **increase efficiency of EHR utilization and standardize clinical processes** were implemented across all sites and providers.
- Bayou Clinic used PCCP funds to hire an EHR consultant to provide staff training and assist with optimization of its EHR system. This led to the **development of disease registries for patients with diabetes and cardiovascular disease.** The registries are used to proactively manage the care of these patients.



Improved financial performance and operational efficiency

As not-for-profit operations that rely on a combination of grant funding and variable reimbursements from public and private third-party payers, CHCs generally operate on lean budgets. Additionally, CHCs must meet HRSA's financial requirements and regulations. These challenging financial and operational conditions necessitate that CHCs maximize revenue by developing efficient and effective processes for all functions of the revenue cycle.

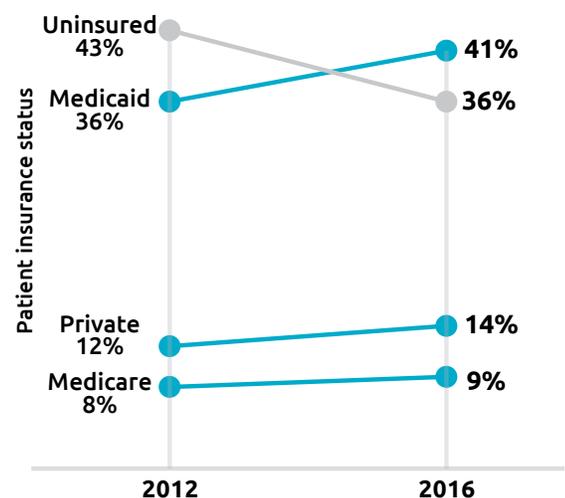
In response to these challenges, PCCP designed and implemented a range of tailored technical assistance to address organizational and financial issues, as well as sustainability of new staff and services. Technical assistance focused on accounting efficiency, billing and reimbursement, regulatory compliance and direct training to Chief Financial Officers and other financial staff. In-depth analysis at several CHCs benchmarked clinical and financial measures, examined staff productivity and recommended staffing models for enhanced care quality and provider productivity. CHCs also received electronic accounting systems training and support including vendor selection and system configuration and optimization.

Highlights:

- MCHD improved productivity by reorganizing staff to place registered nurse managers as administrative leads of clinical sites. The CHC employed this change across the organization and not only sustained the positions but also achieved a decrease in patient wait times due to improved staff efficiency.
- CFHC focused on system optimization to improve reporting capabilities and make workflows more efficient by using analytics software to monitor weekly data on key metrics such as no-show rates, provider productivity, as well as financial metrics. Increased visibility of clinic operations resulted in a three-fold increase in revenue collection.

CHCs' improved financial performance was demonstrated by the amount of money kept in reserve: 83% of CHCs increased the amount of months of reserve and the average months of reserve kept by CHCs increased by one month.

Improvements to CHCs' financial and accounting practices contributed to conversion of uninsured patients to insured status, resulting in greater cost reimbursement and financial stability. Change in insurance status was also positively impacted by Medicaid Expansion in Louisiana. Overall, CHCs averaged a 7.8% conversion rate with several CHCs experiencing a large decrease in their uninsured population: JCHCC (49%), Escambia (22%) and Teche Action (19%).



CHCs' insured patients increased and uninsured patients decreased.



Regional Care Collaborative

PCCP developed the **Regional Care Collaborative (RCC)** to facilitate regular communication and **networking** among CHCs through peer-to-peer learning events, continuing education sessions and other opportunities that encouraged interaction, collaboration and learning. The primary RCC modalities were webinars and the RCC Forum.

Webinars:

Quarterly webinars were developed and presented by the PCCP with input from the steering committee, an advisory group with representatives from GRHOP project partners, CHCs and the primary care associations from each state. The **webinars addressed timely and relevant topics related to issues impacting CHCs' operation and performance**. Webinars also served as venues for CHCs to share experiences and best practices with their peers.

Over the course of the project, 16 webinars were presented to CHCs and other GRHOP partners. Webinar highlights included:

- Switching to the ICD 10 medical coding system
- Preparing for the transition from fee-for-service to value-based care
- Sharing lessons learned from real experiences with flood response and recovery efforts along the Gulf Coast
- Incorporating social determinants of health into operations through the Community-Centered Health Home model
- Optimizing billing and workflows to receive reimbursement from the Medicare Chronic Care Management Program

RCC Forum:

The RCC Forum **facilitated networking and exchange among Gulf Coast partners in order to improve quality and effectiveness of healthcare services, increase organizational capacity and foster sustainability of the CHCs**. The RCC Forum complimented individual technical assistance and focused on linking CHCs with existing best practices and resources. Through a combination of keynote speakers, small break-out sessions and poster presentations, CHCs showcased their accomplishments, learned from their peers about programmatic strategies and developed collaborative approaches. PCCP facilitated qualitative interview exchanges between select clinical staff to explore specific issues at greater depth. These exchanges provided the PCCP team and interview participants with critical insights into the context within which clinics were operating.

The RCC Forum proved extremely valuable to CHC staff as it was the only in-person opportunity for them to engage with peers across state lines. Gulf Coast CHCs are not only connected through GRHOP, but also share similar and unique geographic, social and economic conditions. These unique characteristics and the challenges they create are not always reflected at state-level meetings and conferences, making the RCC Forum a unique, collective experience.

Forum themes and highlights included:

- **Advancing patient-centered care**

Sessions included National Council for Behavioral Health’s strategies for integrating behavioral health in FQHCs with break-out sessions on care teams and chronic care management.

- **Sustaining patient-centered care**

Sessions included aligning competing priorities (e.g., PCMH, federal program requirements, meaningful use) to streamline processes and improve efficiencies with interactive break-out sessions on care management workflows and population health.

- **Sustaining patient-centered medical home and improving population health**

Sessions included revenue cycle improvement, sustainable care coordination, telehealth in the primary care setting and sustainability of mental and behavioral health integration within CHCs.

- **Expanding patient-centered medical home: improving population health**

Sessions included transforming care to meet the needs of patients and practitioners, best practices in referral management and value-based care readiness.

- **Beyond sustainability: growing and thriving**

Sessions included patient engagement strategies and optimizing 340B drug discount program.



RCC Forum facilitated networking and improved healthcare services.

Planned to work collaboratively with other organizations as a result of the RCC

86%

Met someone at the RCC who they planned to contact for more information

85%

Believed content shared at the RCC will advance clinical transformation at their organization

80%

Reported the RCC forum content helped their organization achieve PCMH recognition

60%

● % of surveyed RCC participants



Data Sources

In addition to promoting data-driven clinical practices, the PCCP was itself a data-driven initiative. Data were routinely collected and evaluated to **identify project areas of focus, provide feedback and support for ongoing quality improvement approaches and evaluate the processes and outcomes of clinical transformation interventions**. PCCP utilized a mixed-methods project evaluation framework that integrated quantitative and qualitative data.

Quantitative data, such as measures of patient and service volume, insurance coverage and screening rates, were primarily obtained through the Health Resources and Services Administration's (HRSA) Uniform Data System (UDS). The UDS contains a core set of data on patient demographics, services provided, clinical indicators, utilization rates, costs and revenues. FQHCs are required to report annually on their performance to HRSA using the measures defined in the UDS; PCCP adopted a subset of UDS measures to track clinic performance. Additional measures of project performance not included in the UDS were captured in quarterly and annual web-based or in-person surveys. Content area included access to care, financial stability, health information technology, care coordination, quality improvement and integration of services.

Qualitative data were collected at several points in the project:

- Annual in-person clinic reflections provided unique opportunities for CHC staff to share project highlights, successes and challenges.
- Integrated assessments were used to explore clinic-specific issues using a two-stage approach: a four-day community-focused Rapid Assessment Process, followed by a two-day onsite operational and workflow assessment.
- Facilitated peer exchanges utilized dyadic interviewing to produce data through the interaction of two participants from different organizations. While all clinics participated in the annual clinic reflections, integrated assessments and facilitated peer exchanges were targeted to specific clinics.

Most data presented in this report are from UDS and close-out surveys. For most aggregated measures, data were not available for Cameron RHCs and Plaquemines Primary Care because of differences in their project scope and data collection procedures. Most notably, neither of these CHCs are required to submit UDS reports to HRSA because they are not FQHCs.

Strategy 2: Advance Health Systems Development

PCCP invested in systems to support clinic and community initiatives that advanced access to comprehensive primary care, enhanced community-level care coordination strategies and developed health equity and community resiliency from a health perspective.

Key principles guiding these projects included:

- Systems approach encouraging innovation
- Augmenting sustainability of other PCCP and GRHOP investments
- Supportive of regional collaboration

There was approximately \$8.7 million invested in six system development projects: four Health Information Exchange projects and two projects focused on other system initiatives.



Health Information Exchange Projects

Alabama Primary Healthcare Association

Investments made in health information technology (HIT) systems administered by the Alabama Primary Healthcare Association (APHCA) **positioned the primary care association and its membership to operate within a payment environment evolving toward value-based payment.** These system advancements assisted with infrastructure and backend management of health information, and contributed to APHCA's long-term vision of providing secure, meaningful and actionable data exchange and analytics to its members in order to improve population health within the communities served and statewide.

APHCA invested in two system infrastructure projects:

- The APHCA connected two coastal community health centers' electronic health records (EHR) systems to the Health Center Controlled Network (HCCN).
- The APHCA developed and implemented a project to a) create an advanced, bidirectional platform to provide a shared knowledge hub across primary care and mental health data sources, b) deliver timely information to the providers at the point of care and c) implement a shared healthcare analytics solution to identify performance gaps among providers. Ultimately, this project will lead to the development of a statewide, clinically integrated network.

Additional outcomes of the PCCP investment included: establishment of a clinical council to advise data-driven clinical workflow processes that integrate behavioral health; and development of partnerships with statewide agencies to advance clinically integrated network services.

Greater New Orleans Health Information Exchange

The Greater New Orleans Health Information Exchange (GNOHIE) is a community-shared information technology infrastructure that **enables efficient care coordination across health systems by making timely, accurate patient health information available at the point of care and by aggregating it centrally to support effective population management strategies**. Established using federal HITECH funds through the Office of the National Coordinator's Beacon Community Program, the GNOHIE infrastructure is managed by the Partnership for Total Health (PATH), a 509(a)(3) organization.

When federal funding for the GNOHIE ended in 2013, PCCP provided bridge funding for the continued operations of the HIE technical infrastructure, including hardware and software licensing support and the core operational staff required to operate and support the GNOHIE. These funds provided an important lifeline while the GNOHIE worked toward financial sustainability. Eventually, sustainability of GNOHIE was established through membership dues, funding from grants and a Cooperative Endeavor Agreement with the Louisiana Medicaid Program.

GNOHIE successes included:

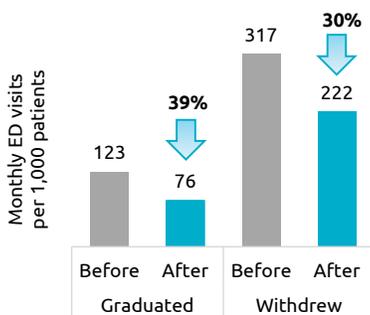
- Established interfaces to serve healthcare organizations with a range of EHR systems and supporting an average of 10,000 messages per month to member organizations with an event notification and continuity of care document describing healthcare services provided in hospital settings.
- Developed a live data feed with New Orleans Emergency Medical Services.
- Explored data sharing opportunities with the Orleans Parish Sheriff's Office in an effort to support improved care coordination after a patient is released from jail.
- Created a single sign on feature to allow providers at University Medical Center, one of the connected hospitals, to access patients' longitudinal records with a one click button within their EHR instead of logging into a separate provider portal.

Greater New Orleans Community Health Connection PCCP Quality Improvement Initiative

The Greater New Orleans Community Health Connection (GNOCHC) PCCP Quality Improvement Initiative, or GNOQii, was a two-year PCCP project that aimed to **improve health outcomes and healthcare utilization among a high-risk population in the Greater New Orleans area**. The target population was approximately 60,000 adults with household incomes at or below 100% of the Federal Poverty Limit who were enrolled in the Greater New Orleans Community Health Connection (GNOCHC), a Medicaid Waiver Program that covered primary care and behavioral health services but excluded emergency department (ED) and inpatient hospital services. Providers included ten FQHCs serving GNOCHC enrollees.

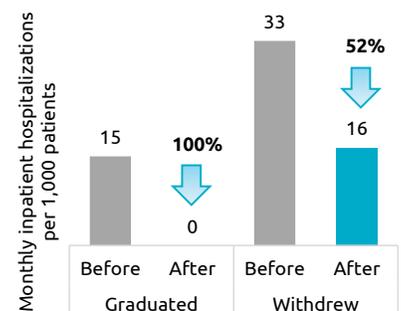
PCCP facilitated a range of intervention supports and technical assistance to help the FQHCs decrease ED visits and 30-day hospital readmissions, increase primary care appointments within 14 days of hospital discharge and increase depression screening rates. Interventions included:

- **Data and analytics:** PCCP developed an analytics package for providers and care managers to view key health- and risk-related metrics for GNOCHC patients on their panels.
- **Notifications and data sharing:** Each time a GNOCHC patient visited a GNOHIE-connected area hospital, an electronic notification and clinical summary was transmitted to the patient's FQHC primary care provider of record.
- **Base and incentive payments:** The program developed a creative payment plan based on each provider's baseline panel-size and hospital utilization. Two subsequent payments at one-year intervals incentivized improvements in outcomes relative to past performance.
- **Care navigation for high-risk patients:** FQHC providers referred high-risk, complex patients to the Catholic Charities Archdiocese of New Orleans (CCANO) Health Guardians program. The program provides intensive navigation support to patients at high-risk of avoidable ED visits or hospitalizations. Health Guardians work with patients, their families and social networks to create a plan and support network to assist patients in adhering to care plans developed with their health providers.



To evaluate impact, utilization rates three months pre and post enrollment in the program were compared. Patients were also stratified into two groups: patients who graduated from the Health Guardians Program and those who withdrew. The average length of enrollment for graduates was four months compared to three months for those who withdrew. **ED visits decreased 39% among patients who enrolled in the Health Guardians, and 30% for people who withdrew early from the program.**

Inpatient hospitalizations also decreased among patients who enrolled in Health Guardians. For graduates of the program, there were zero inpatient admissions three months post enrollment. Among patients who withdrew, there was a 52% decrease in inpatient admissions.

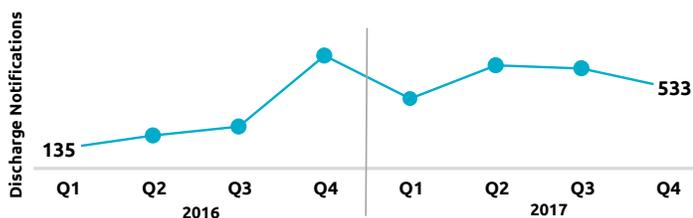


Mississippi Health Information Network

The PCCP funded enhancements to the Mississippi Health Information Network (MS-HIN), Mississippi's health information exchange, to **improve care coordination through data exchange**. The project integrated knowledge and resources of MS-HIN, CFHC, Mississippi Public Health Institute, University of Southern Mississippi and the Mississippi State Department of Health.

Development of the data exchange involved multiple steps:

- Technological infrastructure was created for CFHC to receive electronic notifications when their patients were admitted or discharged from three area hospitals.
- CFHC made changes to internal processes, such as EHR data entry, appointment scheduling and patient contact, to efficiently respond to notifications.
- CFHC did ongoing workflow and process evaluations to guide changes and improvements needed to accommodate the new notifications.

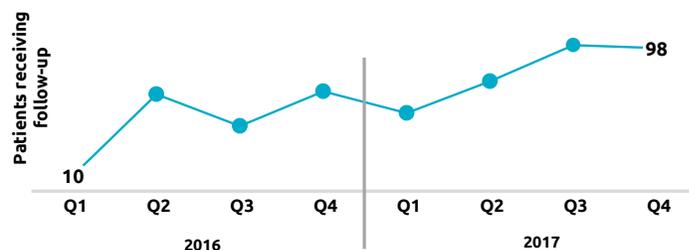


The data exchange increased CFHC's discharge notifications from 135 to 533.

The increase in notifications resulted in strengthened care coordination. **The number of patients receiving attempted follow-up post discharge increased from 10 to 98.** Despite difficulty contacting patients, nearly all patients who scheduled a follow-up appointment presented at their appointment. As follow-up care improves, this system is expected to reduce ED and hospital readmission rates.

PCCP funds were also used to **improve integration of health information between behavioral health and primary care providers.**

The exchange of patient data between health providers is necessary for continuity of care, especially during times of crisis. The project identified two primary challenges impeding data-sharing between primary and behavioral health providers: 1) technological constraints and 2) misinterpretation and confusion surrounding federal laws intended to protect behavioral health data. To address these challenges, PCCP funding was used to convene the Integrated Health Data Sharing Steering Committee with representation from University of Southern Mississippi, South Central Regional Medical Center, CFHC, Mississippi Department of Mental Health, Mississippi Public Health Institute, Mississippi State Department of Health and MS-HIN. The committee developed strategies to promote data-sharing between primary care and behavioral health providers using MS-HIN, and conducted a legal review of federal and state laws related to the sharing of health records. Based on the legal review, the committee created a **document for providers summarizing the type of patient data that can be shared between primary and behavioral health providers (Data Sharing of Protected Health Information).** The steering committee's data sharing document and strategies will continue to advance work on the exchange of behavioral health data in Mississippi.





Other System Development Projects

Community-Centered Health Home Demonstration Project

PCCP designed and implemented the nation's first demonstration of the Community-Centered Health Home (CCHH) model. The goal of the project was to assess if the model could be operationalized in a CHC setting. The CCHH model, developed by the Prevention Institute, **challenges healthcare organizations to assess and improve upstream factors that influence health, such as employment, housing and access to food**. The model puts forward three functional elements – inquiry, analysis and action – to guide healthcare organizations and their partners in the use of data to understand and prioritize community needs and work together to systematically address community conditions that affect individual health.

PCCP funded five CHCs - Escambia, MCHD, CFHC, Daughters of Charity and CrescentCare - to implement the model over a two-year period. With PCCP support and technical assistance, CHCs and their community partners pursued a range of activities:

- **Data collection:** Tools such as clinical intake questions, surveys, focus groups and community meetings were employed to assess the communities' perspectives and priorities.
- **Analysis:** PCCP supported the CHCs and their community partners to review, interpret and prioritize data findings.
- **Community Prevention:** The CHCs built new or strengthened existing partnerships with community organizations, including local government agencies, schools, social service providers, advocacy groups, business owners and community coalitions. Through these collaborations, the CHCs made changes in their communities: development of new and improved fitness resources; advocating with partners to fight discrimination of LGBTQ youth; and promoting healthy home renovations in a low-income housing complex.

"CCHH was a game changer for the way we operate internally and how we partner with community"
- Escambia

This project demonstrated that the CCHH model is a promising tool to help CHCs shift their thinking and practice to move beyond delivering healthcare to individual patients and begin responding to upstream community conditions that affect the health of all residents. As the healthcare system shifts from fee-for-service to value-based payment, patient health outcomes will have increasingly direct bearing on primary care revenues and financial sustainability. The CCHH model offers health centers another modality to affect the health outcomes of their communities.

504HealthNet

PCCP funding supported 504HealthNet to address several interrelated healthcare access and delivery issues: **improve Medicaid insurance coverage among low-income residents, promote healthcare options to residents and foster financial stability among nonprofit healthcare providers in the New Orleans area.** 504HealthNet is an association comprised of nonprofit and government organizations in the Greater New Orleans area that provide primary care or behavioral health services irrespective of a client's ability to pay.

In 2013, the uninsured rate in the greater New Orleans area was 21%. Many of the uninsured did not know their health insurance options, where to access primary care, or how to navigate the healthcare system. This resulted in delayed care, and unnecessary and costly emergency room visits. For many stand-alone organizations, treating low-income and often uninsured residents caused financial concerns. In addition, the lack of networking among organizations led to unnecessarily duplicated efforts and missed opportunities to share best practices.

504HealthNet approached these challenges from multiple angles starting with educating stakeholders and decision makers about the importance of the Greater New Orleans Community Health Connection (GNOCHC), a Medicaid Waiver Program that provided insurance to low-income enrollees. Through various communication modules, the value of this program to patients, health centers and the economy was demonstrated. When Louisiana established Medicaid expansion in 2016, 504HealthNet implemented procedures to ensure GNOCHC enrollees moved onto Medicaid without a gap in coverage. Furthermore, 504HealthNet provided timely and critical feedback to state health officials on Medicaid enrollment and coverage issues and concerns identified by patients and providers.

504HealthNet's wide ranging strategies had multiple impacts:

- 504HealthNet created and implemented a campaign to help residents in the Greater New Orleans area establish a relationship with primary and behavioral health providers using social media, bus advertisements, billboards and radio. The program successfully **enrolled 62,000 patients in healthcare coverage contributing to a drop in New Orleans uninsured rate to 12%**, an increase in the use of CHCs and a decrease in use of emergency rooms for routine, non-emergent care. Increased insurance coverage contributed to CHCs' improved financial stability.
- Through shared services programming, 504HealthNet collaborated to create a more extensive and cohesive network of community health service providers in order to share best practices and resources, and negotiate contracts that leveraged economies of scale.

Highlights Included:

- Improved CHCs' financial stability and efficiency: 504HealthNet successfully negotiated a reduced price for billing and coding audits which improved CHCs' revenue generation.
- Increased medication compliance and decreased financial burden for low-income patients: 504HealthNet negotiated a reduced price for patient assistance programs' enrollment software that allowed more health centers to use this service for their patients.
- Improved efficiency: An online shared platform for courses ("504HealthLearn") trained more than 1,200 staff across member organizations increasing the competency and skill level of employees.

Strategy 3: Enhance Community Capacity and Build Strategic Partnerships

PCCP identified and linked critical stakeholders through community prioritization meetings, peer exchanges and partnership building. Establishing relationships with key state partners such as primary care associations (PCAs), departments of health and public health institutes maximized investments in impacted communities, provided state-level policy education and information and promoted sustainable partnerships for communities and their primary care service providers. In addition, state partners served as local advocates for the project and provided necessary information and linkages related to statewide efforts that allowed for the transfer of knowledge, capacity and resources across all stakeholders. Formalizing relationships with state partners not only benefited the PCCP communities but also established a framework for ongoing, regional collaborations.

Key strategies for state partnerships:

- Build and advance capacity of PCAs to deliver high quality emergency management planning and resiliency efforts.
- Support community health centers, local and state public health leaders and their partners on community health assessment, planning and implementation processes.
- Increase capacity to develop and manage public and private partnerships.



Emergency Management Initiative

PCCP's partnership with PCAs in Alabama, Florida, Louisiana and Mississippi resulted in improved emergency planning and resiliency efforts. PCAs are membership organizations that provide training and technical assistance to CHCs in their jurisdiction. A key PCA focus for Gulf Coast states is providing guidance, training and resources for CHCs to develop and implement effective emergency preparedness plans. The PCCP developed the Emergency Management Initiative (EMI) to **enhance the current state of PCAs emergency management programming in order for them to better train and build capacity of their CHCs.**

The EMI was a shared priority for multiple reasons. CHCs along the Gulf Coast are more engaged in emergency preparedness activities due to increased frequency and cost of recovery of natural and manmade disasters. Additionally, new policies from the Centers for Medicare and Medicaid Services significantly increased regulatory requirements for health centers. These requirements address safeguarding human resources, maintaining business continuity, protecting physical resources and improving coordinated disaster response.

PCCP convened local, regional and national experts to develop a comprehensive emergency management framework that focused on primary care emergency preparedness in addition to community resilience and recovery. Key project partners included the RAND Corporation, Primary Care Development Corporation and the PCAs from the four states within the PCCP area.

EMI activities included:

- In-person networking and communication
- Training in social network analysis to measure strength and scope of partnerships
- Assessments of emergency preparedness readiness
- Development and distribution of *Emergency Management and Community Resilience: A Capacity-Building Toolkit for Health Centers*. This document is a comprehensive tool and coaching guide that promotes best practices and approaches for timely recovery and long-term community resilience. It includes workplans, resources and templates that can be tailored to meet the needs of CHCs and PCAs.



**“a wonderful opportunity to
move emergency
management forward
within Florida and
the entire region”
- Florida Association of
Community Health Centers**

Conclusion

The PCCP's multi-disciplinary, public health and systems approach created a network of sustained partners across 17 Gulf Coast counties and parishes that strengthened primary care capacity and built a sustainable framework to advance public health and resiliency in the region. The project's success was guided by complimentary and integrated strategies that connected and engaged communities, CHCs, state-based organizations and other community assets. These strategies reflected GRHOP's integrated cross-systems approach that recognized and funded multiple interdependent projects to address and strengthen healthcare in a vulnerable region impacted by the Deepwater Horizon oil spill and repeated natural disasters. GRHOP's integrated approach was further supported by LPHI's mission to connect and empower sectors to champion health with people and for people through systems change and innovation.

While many programs aim to improve public health, they often fail to produce systemic and sustained changes. To address this challenge, the PCCP developed guiding principles that were incorporated throughout the project's design, implementation, monitoring and evaluation. First, the project's primary commitment was the impacted communities. Engagement strategies such as key informant meetings, peer-to-peer regional learning exchanges and collaborative state partnerships, ensured the community voice was integrated in all aspects of the project.

Second, the program aimed to create lasting community benefit by employing a systems approach that focused on policy changes, systems development and organizational culture shifts. This approach benefited from a long project period, a flexible and responsive funding model with an emphasis on sustainability and a suite of integrated projects that strengthened multiple, complimentary components for improved primary care capacity and community health.

The third guiding principle, building on existing assets, was rooted in the importance of aligning and leveraging PCCP activities with current community-based assets in order to develop a strong and connected cross-sector, regional network to support and sustain change. This approach was integral to strengthening the impacted communities and region as it built on communities' human, social and physical capital. Building strong partnerships with a diverse group of stakeholders early on and throughout the project life cycle provided a unique perspective and knowledge transfer among partners, resulting in legacy benefit.

Fourth, as an evidence-based project, the PCCP used leading standards, guidelines and credible practice models to guide and influence project activities. Widespread adaptation of models, such as PCMH and CCHH, not only improved clinical operations and patient and community outcomes but also facilitated changes to value-based care. Additionally, PCCP's mixed-methods project evaluation framework informed project priorities, emphasized experiences and needs of the community and CHCs and contributed to ongoing quality improvement. An added value of the participatory nature of the qualitative methods was the opportunity for peer exchange, data sharing and data-informed action. These opportunities greatly benefited communities and clinic providers, and supported community responsiveness.

Ultimately, the PCCP transformed challenges into a stronger healthcare system with potential for future regional opportunities. Residents of the affected region now have expanded access to high-quality, sustainable and community-based primary care. This success resulted from the connected and committed work of multiple partners. Through the continued strength of these partnerships, Gulf Coast communities are better prepared to operate within the evolving healthcare environment and collaborate on regional convenings, emergency management and community resiliency efforts and other community-oriented initiatives.

Appendices

A.) List of PCCP Organizations and Staff

Louisiana Public Health Institute

Eric Baumgartner, MD
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Kyla Mor, MSPH
Tiffany Netters, MPA, PMP
Melody Robinson, MPH
Heather Sandoval, MPH
Clayton Williams, MPH, FACHE

Community Health Centers

Access Health Louisiana
Bayou Clinic
Bayou La Batre Area Health Development Board
Coastal Family Health Center
Community Health Northwest Florida
CrescentCare
Daughters of Charity Health Center
Family Oriented Primary Health Center
Franklin Primary Health Center
Hackberry and Johnson Bayou Rural Health Clinics | West Calcasieu Cameron Hospital
Jefferson Community Health Care Centers
New Orleans East Louisiana Community Health Center
North Florida Medical Centers
PanCare of Florida
Plaquemines Primary Care
Teche Action Clinic
Walton Community Health Center | Florida Department of Health in Walton County

State Partners

Alabama Department of Public Health
Alabama Primary Health Care Association
Catholic Charities Archdiocese of New Orleans Health Guardians
Florida Association of Community Health Centers
Florida Department of Health in Bay County
Florida Department of Health in Escambia County
Florida Department of Health in Okaloosa County
Florida Department of Health in Santa Rosa County
Florida Department of Health in Walton County
Florida Institute for Health Innovation
Louisiana Primary Care Association
Louisiana State University Health Sciences Center
Mississippi Health Information Network
Mississippi Primary Health Care Association
Mississippi Public Health Institute
Mississippi State Department of Health
University of Southern Mississippi

Strategic Partners

504HealthNet
Partnership for Achieving Total Health
Prevention Institute
Primary Care Development Corporation
RAND Corporation

GRHOP Coordinating Committee:

Non Affiliated Members

Ayanna V. Buckner, Chair, MD, MPH
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Leslie M. Beitsch, MD, JD
Florida State University

Bernard D. Goldstein, MD
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Primary Care Capacity Project

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Louisiana Public Health Institute

Community Involvement

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Alliance Institute

Community Health Workers Training Project

Steven Picou, PhD
University of South Alabama

David Johnson, PhD
University of South Alabama

Mental and Behavioral Health Capacity Project

Jennifer Langhinrichsen-Rohling, PhD
University of South Alabama

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