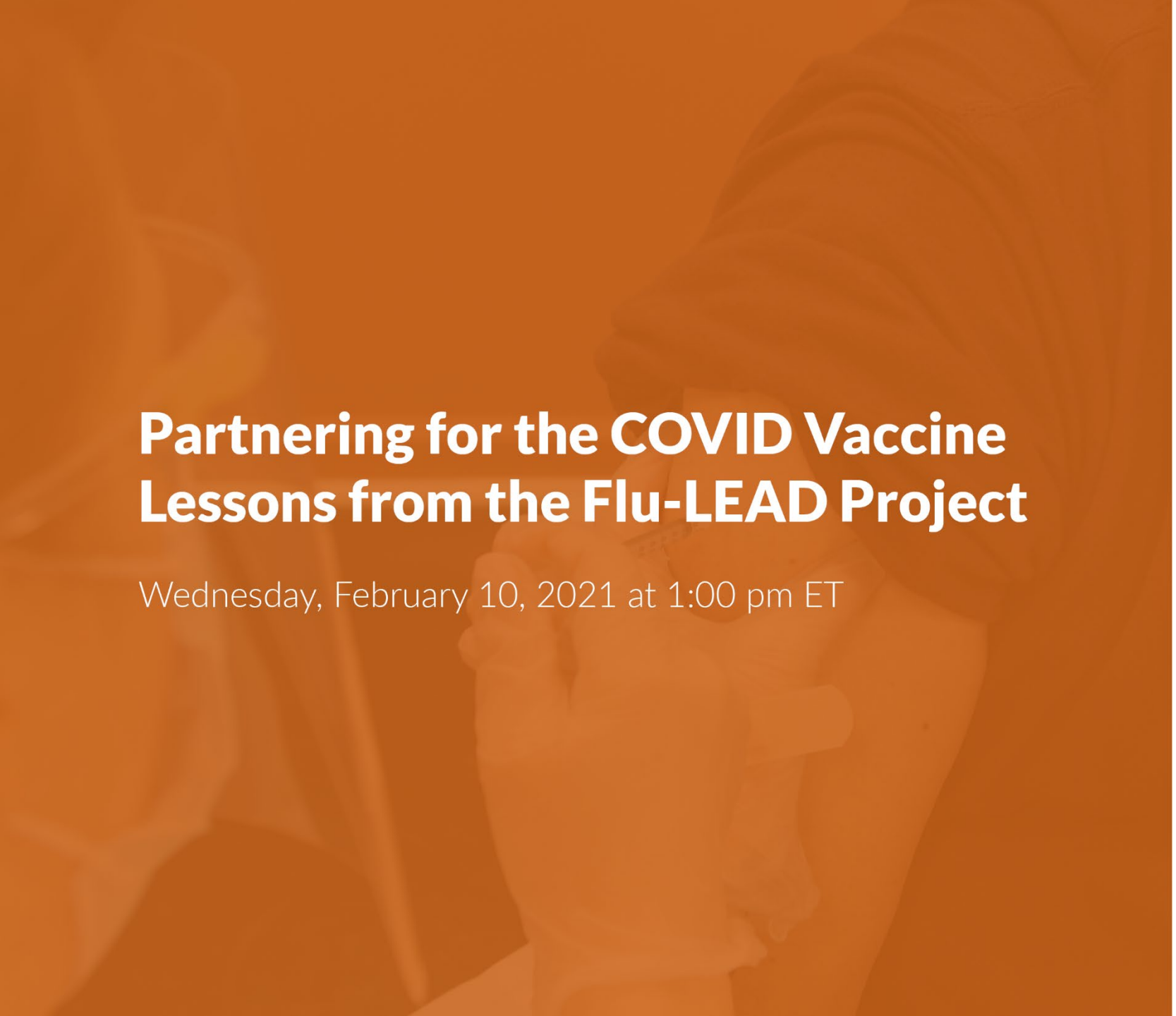


Partnering for the COVID Vaccine Lessons from the Flu-LEAD Project

Wednesday, February 10, 2021 at 1:00 pm ET

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing
a project of North American Management

National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing

The National Center for Health in Public Housing

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing

Agenda

- Introductions
- Health Center and Housing Authority Partnerships
  - Flu-LEAD
  - COVID Vaccine rollout
- Health Center/Housing Authority Panel
- Q&A

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing

Learning Objectives

- Identify key elements of the HUD/HRSA Flu-LEAD project
- Describe strategies to partner across sectors to deliver the COVID-19 vaccine to health center patients
- Identify promising practices in partnership cultivation, development, and sustainability

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing

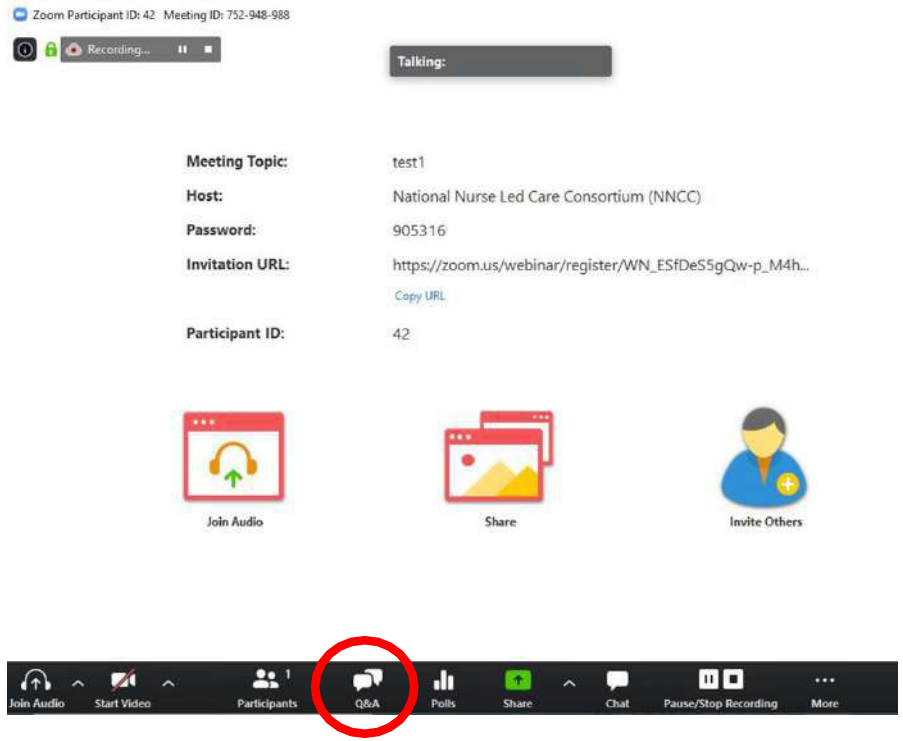
Housekeeping

Question & Answer

- Click Q&A and type your questions into the open field.
- The Moderator will either send a typed response or answer your questions live at the end of the presentation.

Continuing Education Credits

- Please take the SurveyMonkey evaluation at the end of this webinar to receive CME/CNE
- You must complete survey to receive credit.
- Certificate will arrive within 1 week of completing the survey.



NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

NCHPH
National Center for Health in Public Housing

Speakers

Bob Burns, MPA
Project Director
National Center for Health in Public Housing

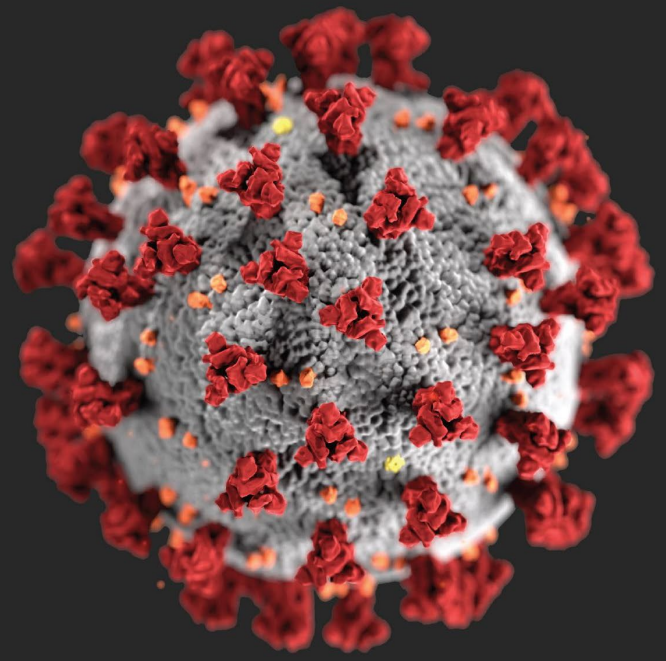
Jason Amirhadji, JD
Neighborhood & Community Investment Specialist
U.S. Department of Housing and Urban Development

CAPT Darin D. Daly, MS, MT (ASCP)
Senior Public Health Analyst
Health Resource Service Administration

Panel

Akron Metropolitan Housing Authority +
Axess Pointe CHC

Housing Authority of San Joaquin County +
Community Medical Centers



COVID-19 RESPONSE

Partnership Lessons from Flu LEAD

National Center for Health in Public Housing
a project of North American Management

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

February 10, 2021

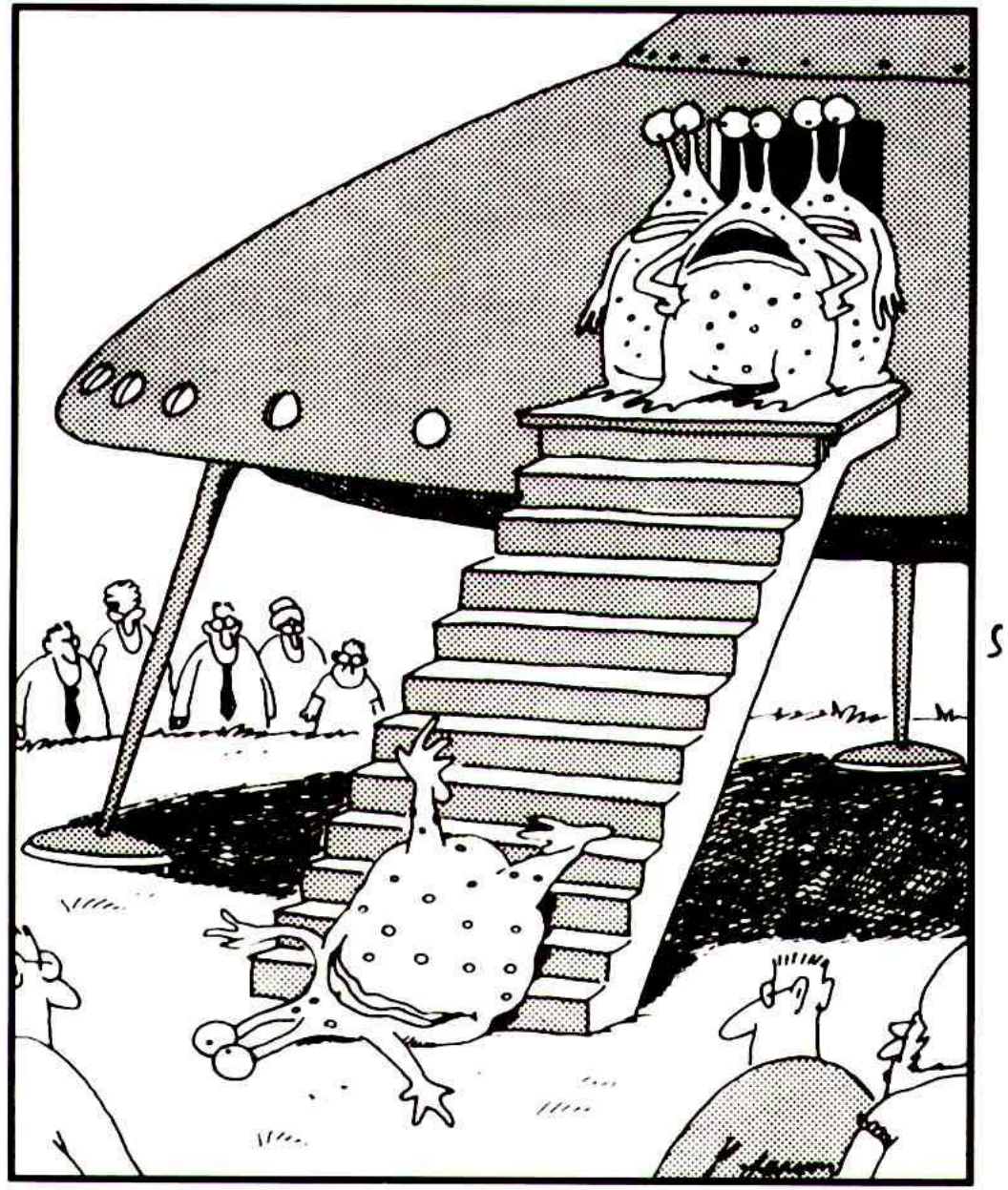
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

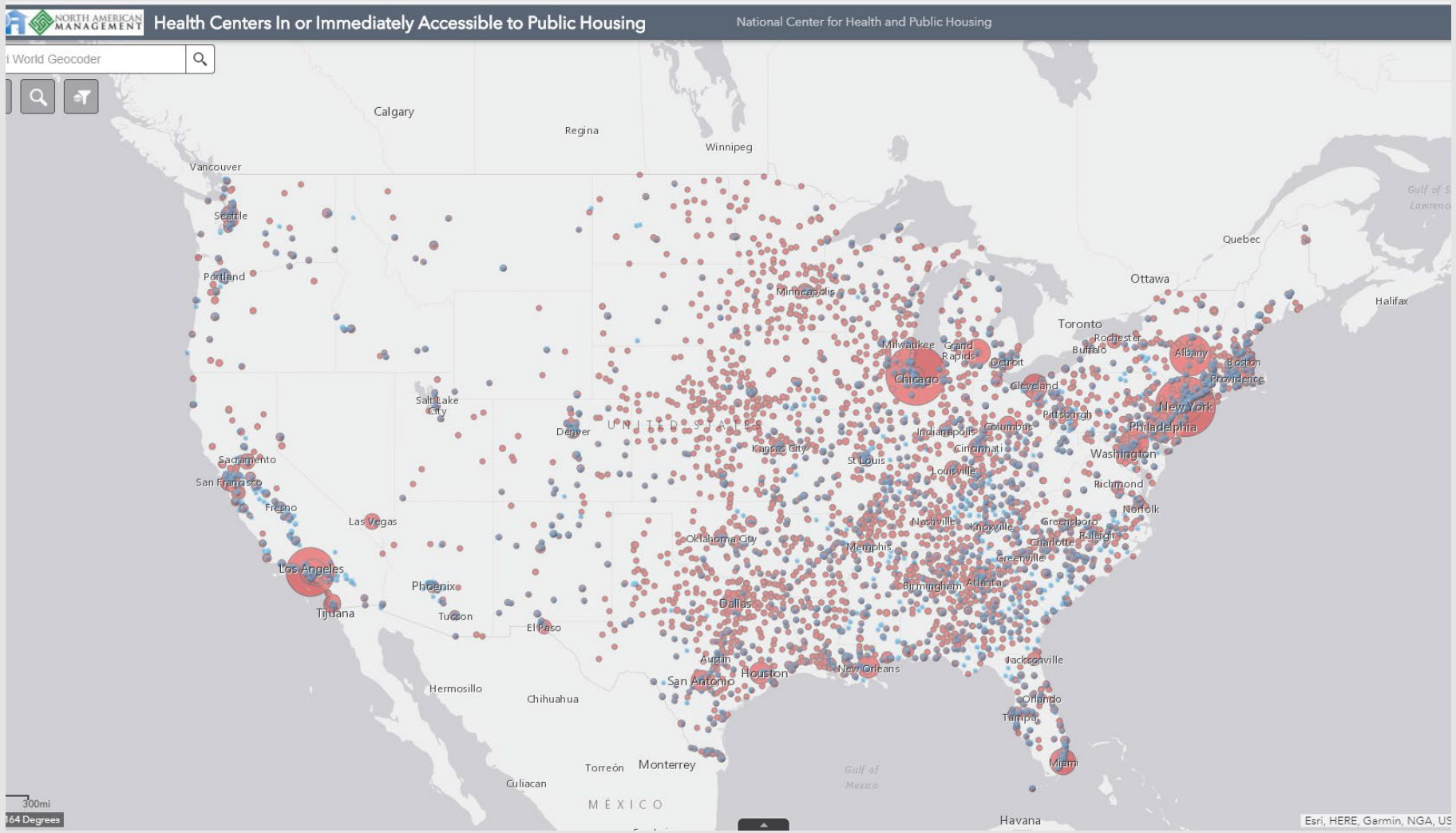
“I’ve never met a problem a good webinar couldn’t solve.”

Sleeves up…

- **Why are we here, where did we come from, what does it all mean??**
  - Bob Burns (National Center for Health in Public Housing)
- **Flu-LEAD and transition to COVID**
  - Jason Amirhadji (HUD) and Darin Daly (ASPR/HRSA)
- **Health center and Housing Authority partnerships**
  - Akron, OH
    - Kellie Morehouse (Akron HA)
    - Jennifer Hayes (Axess Pointe CHC)
  - Stockton, CA
    - Christine Noguera (Community Medical Center)
    - Peter W. Ragsdale (San Joaquin Housing Authority)
- **Multitasking break (are you still with us?) – Q&A / ask us anything**



"Wonderful! Just wonderful! ... So much for instilling them with a sense of awe."

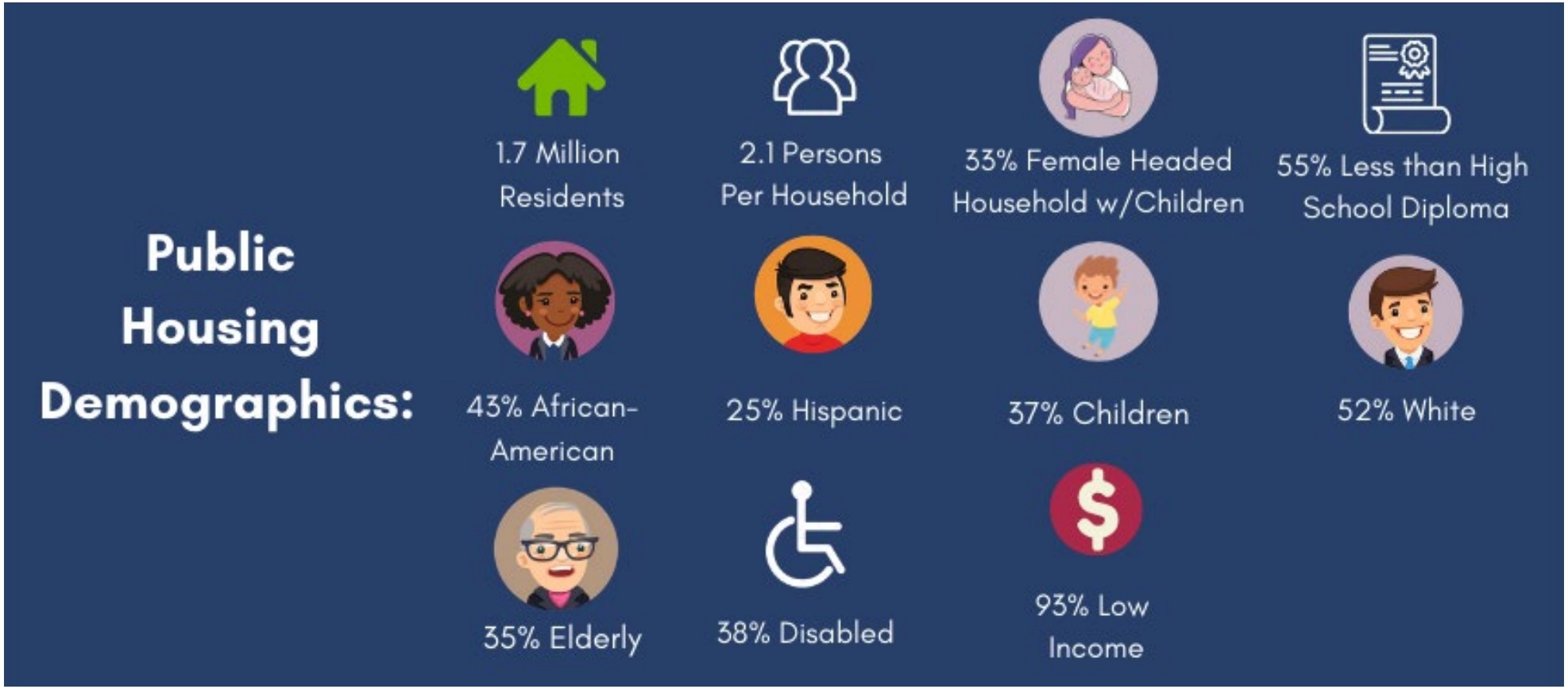


1,400 Federally Qualified Health Centers (FQHC)=30 million

433 FQHCs near Public Housing= 5.2 million patients

108 Public Housing Primary Care (PHPC) = 856,191 patients

In 2020, there were roughly 1.7 million residents of public housing. Approximately 93% were living below poverty, 33% were headed by a single female, 37% of the households had children, and 38% had a member that was disabled. (Source: HUD)



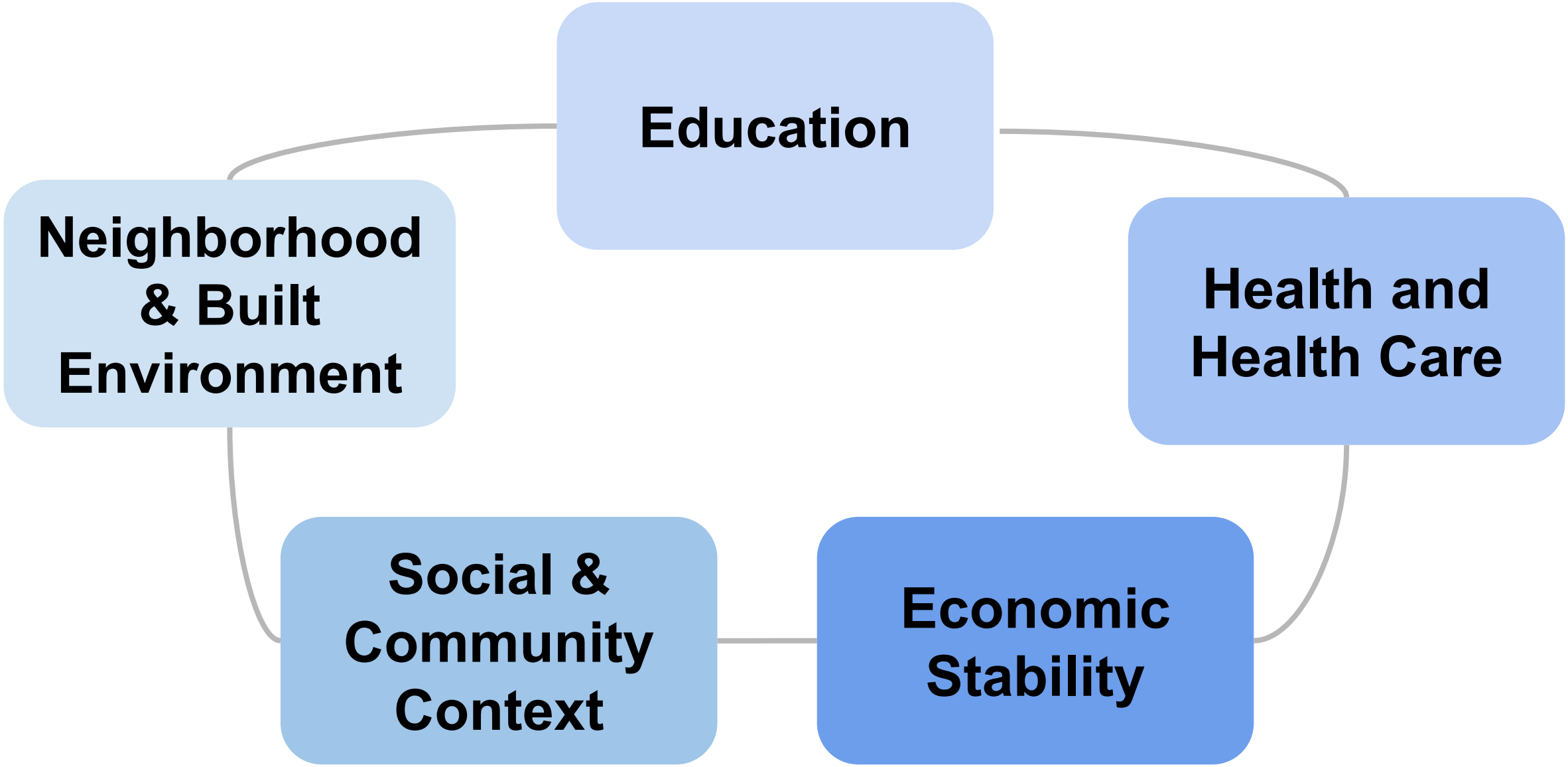
Source: HUD Resident Characteristics 2020

A Health Picture of HUD-Assisted Adults, 2006-2012

Adults in HUD-assisted housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.

	HUD-Assisted	Low-income renters	All Adults
Fair/Poor Health	35.8%	24%	13.8%
Overweight/ Obese	71%	60%	64%
Disability	61%	42.8%	35.4%
Diabetes	17.6%	8.8%	9.5%
COPD	13.6%	8.4%	6.3%
Asthma	16.3%	13.5%	8.7%

Source: Helms VE, 2017



Housing as a Social Determinant of Health: *Healthy People 2020*

Partnerships

- Community Partners:
  - Public Housing Agency (PHA)
  - HUD EnVision Centers
  - Faith-based organizations
  - Departments of Public Health (DPH)
- Clarify service area and population needs
  - Consult Residents Groups
  - Survey Patients
- Explore the type of services the Health Center and Partners can provide:
  - On-site clinics, mobile units, or shuttles
  - Outreach, Enabling Services & Case Management
  - Short-Term and Long-Term Care

- Establish Goals and Priorities
  - Initial Handshake
  - Partnership Agreement
  - MOUs
- Put it into action!
  - Reciprocal membership on each others' boards or advisory groups
  - Cross-referrals, for example, PHA refers residents to Health Center
  - Community Health Workers: a critical connection!

Flu LEAD A–Z

FLU FIGHTERS

BREVIS

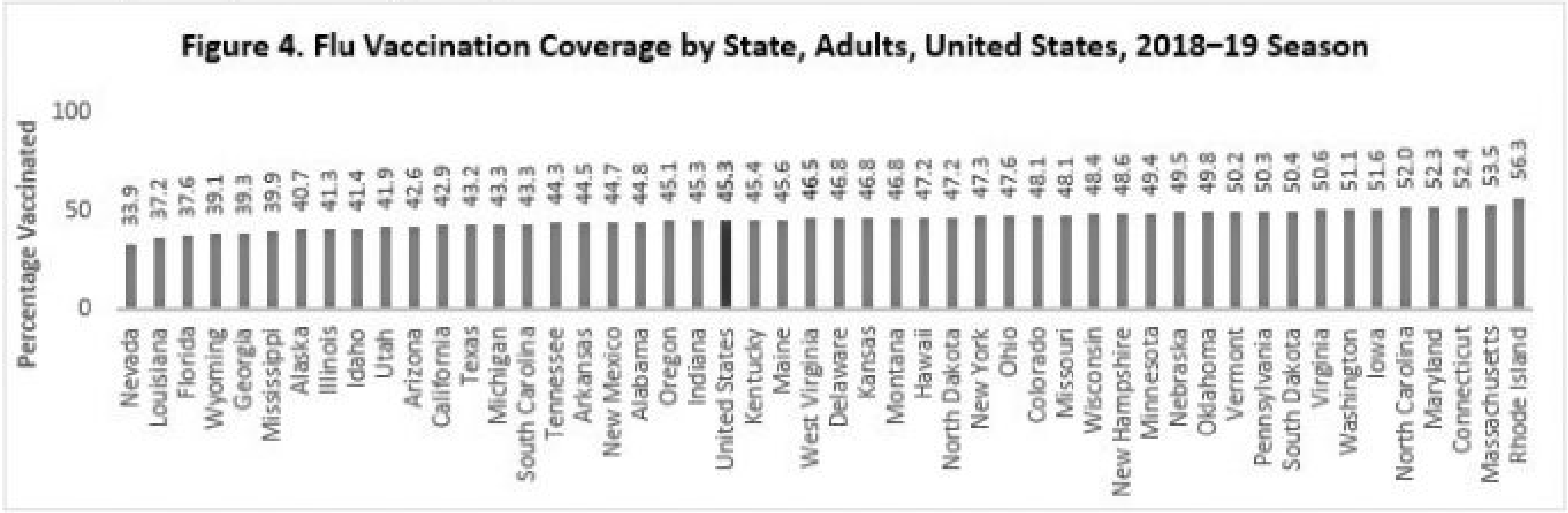
CDC estimates* that, from **October 1, 2019**, through **April 4, 2020**, there have been:

39,000,000 – 56,000,000
flu **illnesses**

18,000,000 – 26,000,000
flu **medical visits**

410,000 – 740,000
flu **hospitalizations**

24,000 – 62,000
flu **deaths**



CDC recommends **annual influenza vaccination** for **everyone 6 months and older** with **any licensed, age-appropriate influenza vaccine** with no preference expressed for any one vaccine over another

Factors associated with low influenza vaccination coverage[1]

- **Lower Level of Education**
- **Lower Household Income**
- **Urbanicity**
- **Lack of Health Insurance**

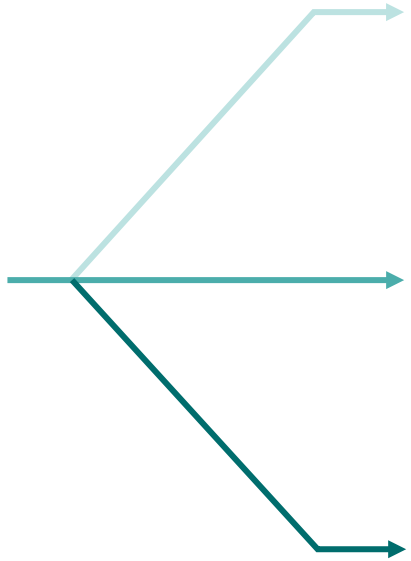
Healthcare Resilience Working Group (HRWG)

- One of five work groups supporting the Unified Command, the national COVID-19 response led by the U.S. Department of Health and Human Services
- HRWG Mission: optimize healthcare delivery for COVID and non COVID patients in all health settings
- Work group broken into five teams, each with a focus on different aspect of health care system: hospitals, long-term care facilities, emergency medical services, health care workforce, and outpatient settings/ambulatory settings
- Flu LEAD is a priority pilot project of the Ambulatory Team of the HRWG

Flu LEAD

GOAL

Increase site-wide flu vaccine coverage during the 2020-2021 influenza season.



OBJECTIVES

Increase influenza vaccination coverage among HUD-assisted residents beginning in Fall 2020.

Enhance health and health resiliency of residents of HUD-assisted communities.

Foster partnerships between HUD-assisted communities and local HRSA-funded health centers.

Flu LEAD

HUD-assisted Communities:

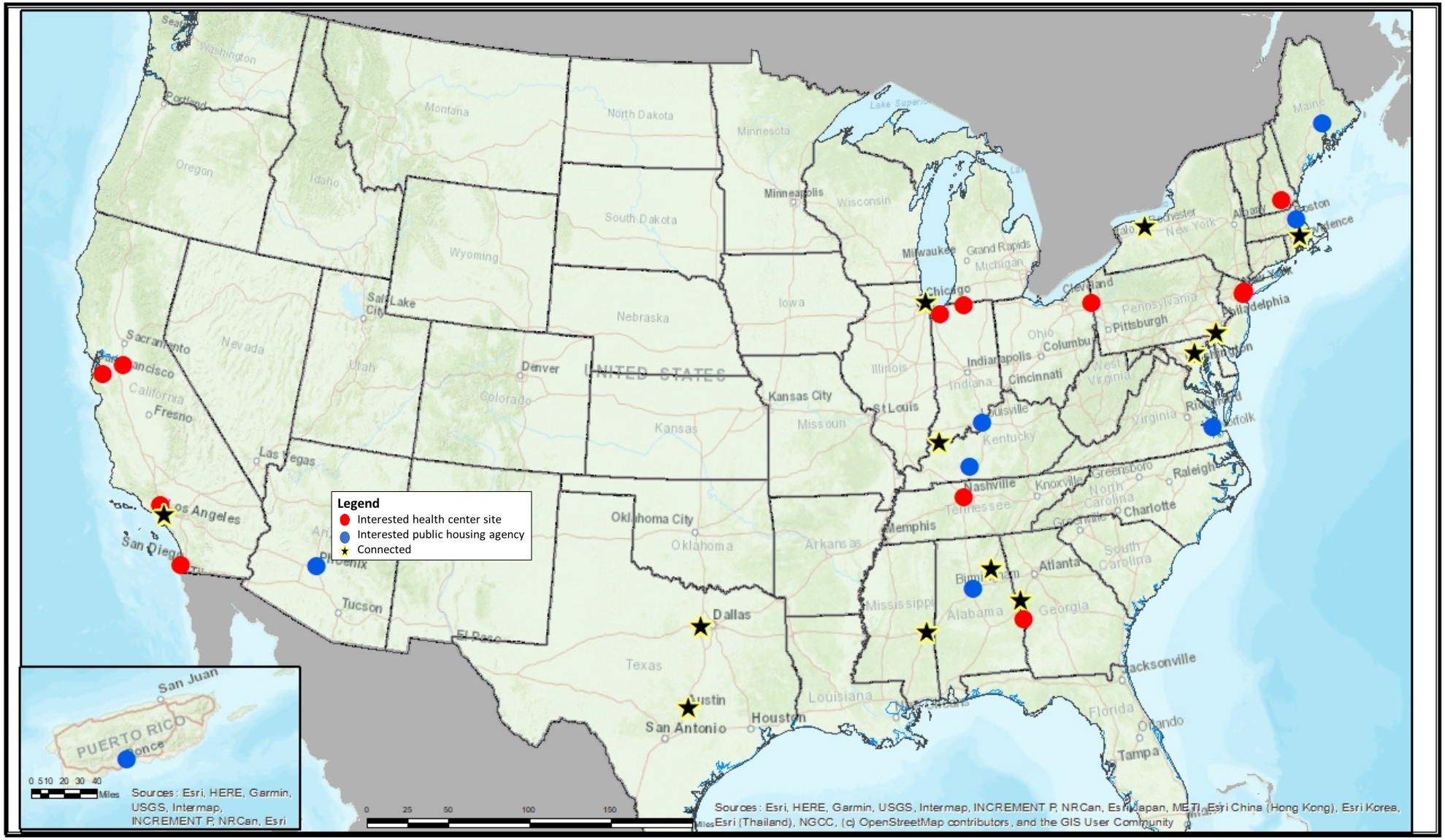
- Managed by hundreds of PHAs and multifamily owners across the country.
- Served by 433 FQHCs located in or immediately near public housing, of which 108 are HRSA-funded Public Housing Primary Care awardees.
- **Successful sites will leverage aspects of HUD's place-based programs:**

Partnership facilitators, such as program managers and service coordinators

Resident advocates, such as Community Coaches and community health workers

Meeting space, such as community centers and service sites

Flu LEAD Pilot Sites



Flu LEAD MythBusters

Source: NPR

MythBuster #1:

"All Housing Authorities and Health Centers already work together."

- ~~**Handshake**~~ **Elbow-bump philosophy:** Get to know partners within your community. Use easy wins like vaccination to develop lasting relationships.

MythBuster #2:

Housing authority residents are patients of their Health Centers.

- Data collected from our Flu LEAD pilot program (15 voluntary FQs and HUD partners) identified that most patients didn't know where their local Health Center was located.
- Residents were less informed about affordability for theirs and family's health care. Health Center sliding fee scales are tiered based of Federal Poverty Guidelines (FPG).
- Of the residents who participated in Flu Clinics conducted, ***30%*** of them became patients of the Health Center, as their Patient Centered Medical Home (PCMH).

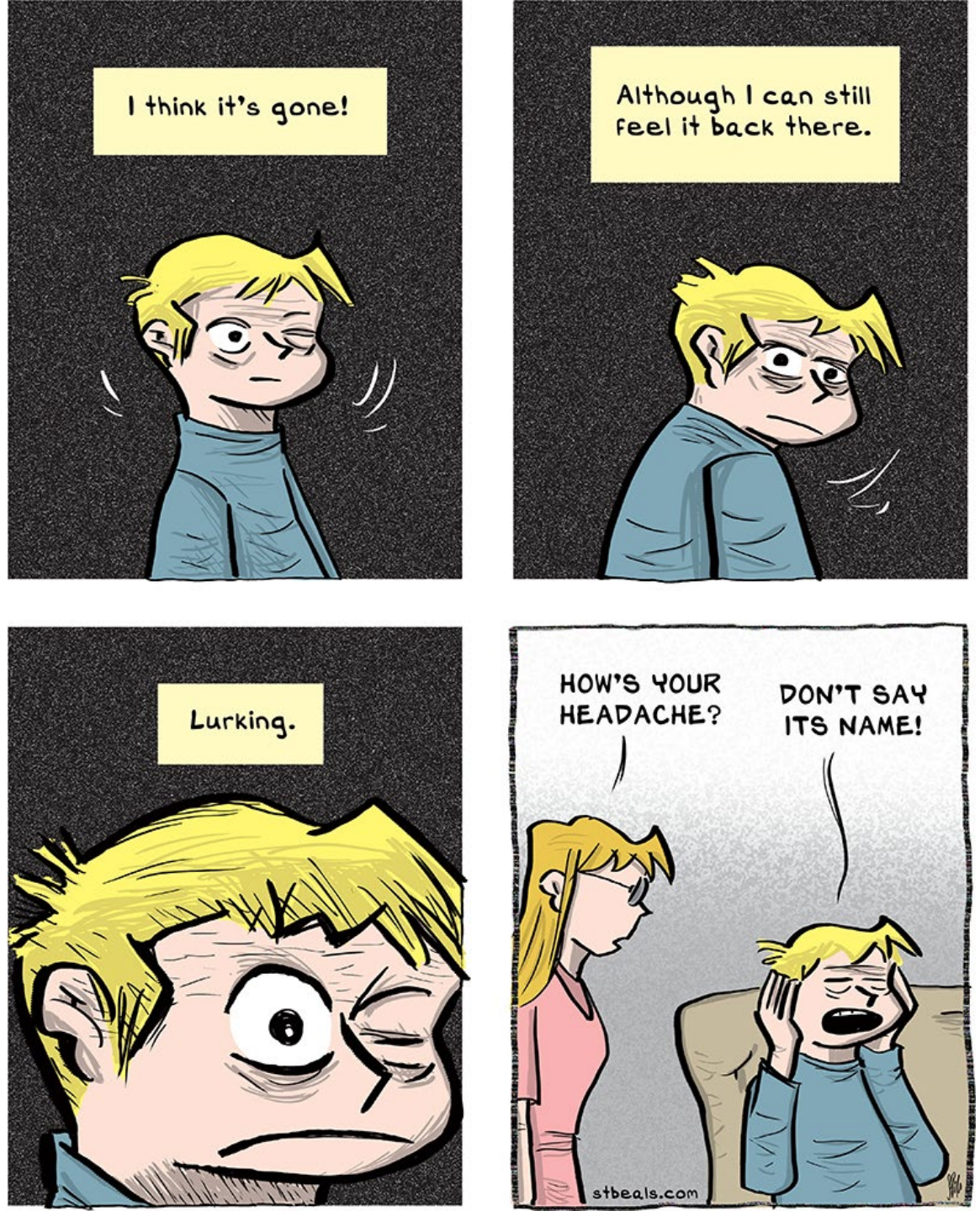
MythBuster #3:

Government Agencies don't work well with each other towards a common goal.

- Flu LEAD is bridged HRSA/BPHC and HUD to come together for our common customers.
- We broke down agency silos and effectively communicated in a common language.
- This cross-pollination of agencies should be the normal and not the exception.

- **Better relationships lead to better wellness**
  - FQHC-PHA partnerships can be a model for delivery of health care, particularly to low-income and minority patient populations
  - 30% of our customers became new patients with a primary care medical home (PCMH) which has a drastic long-term effect within our Communities

- **Greater cross-federal & federal-state-local coordination is needed**
  - A slowdown or lag found during the Flu LEAD pilot is that vaccines (seasonal influenza or COVID-19) are allocated by CDC through states
  - COVID allocations to Health Centers will be direct from federal to the local level

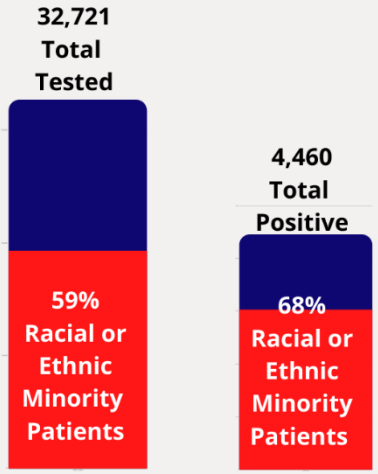

I think it's gone!
Although I can still feel it back there.
Lurking.
HOW'S YOUR HEADACHE?
DON'T SAY ITS NAME!
stbeals.com

PUBLIC HOUSING PRIMARY CARE (PHPC) COVID-19 BY THE NUMBERS

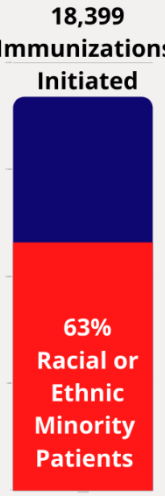
FEBRUARY 8, 2021
NUMBERS AS OF JANUARY 22, 2021
NUMBER OF PHPC HEALTH CENTER RESPONDENTS= 68(63% OF ALL PHPC HEALTH CENTERS)

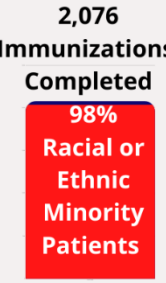
IN 2019, THERE WERE 108 PHPC HEALTH CENTERS SERVING 856,191 PATIENTS LIVING IN OR IMMEDIATELY ACCESSIBLE TO PUBLIC HOUSING.

PHPC PATIENTS TESTED



PHPC PATIENTS VACCINATED





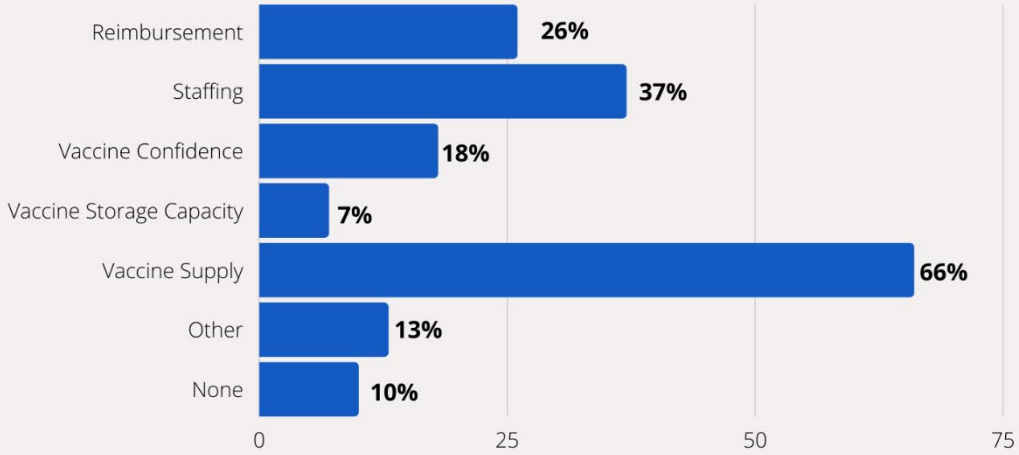
PHPC STAFF VACCINATED:

STAFF IMMUNIZATIONS INITIATED
4,106

STAFF IMMUNIZATIONS COMPLETED
4,337

Disclaimer: This publication is supported by the Health Resources and Services Administration (HRSA)of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,824,000 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit hrsa.gov.

PHPC CHALLENGES IN OBTAINING COVID VACCINE:



OPERATIONS AND STAFF:

89.3% HEALTH CENTER WEEKLY VISITS (VS. PRE COVID-19 WEEKLY VISITS)

34.6% PERCENT OF WEEKLY VISITS DONE VIRTUALLY

85 PHPC HEALTH CENTER SITES CLOSED

88 STAFF MEMBERS WITH POSITIVE COVID-19

4% OF STAFF UNABLE TO WORK DUE TO COVID-19

TRENDS IN
TURNAROUND TIME FOR COVID-19 TEST RESULTS

10.29% LESS THAN 1 HOUR

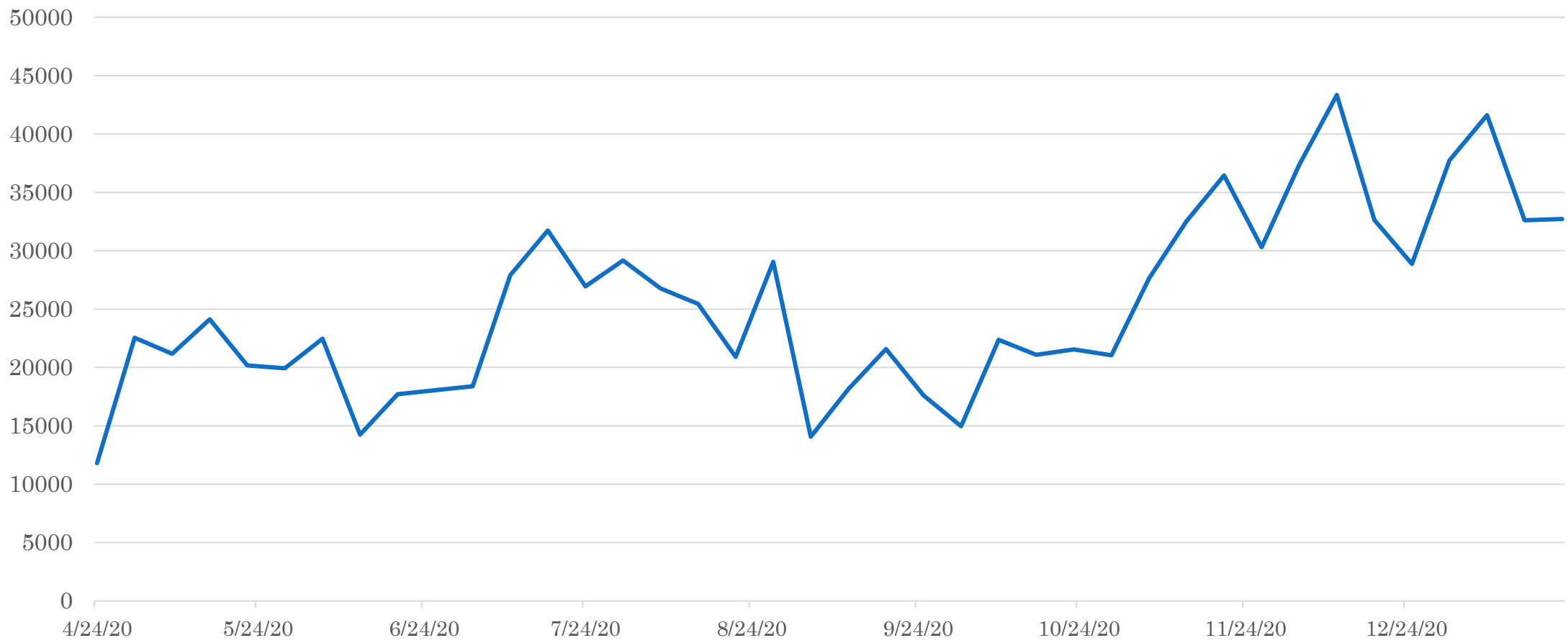
14.71% 24 HOURS

2.94% 12 HOURS OR LESS

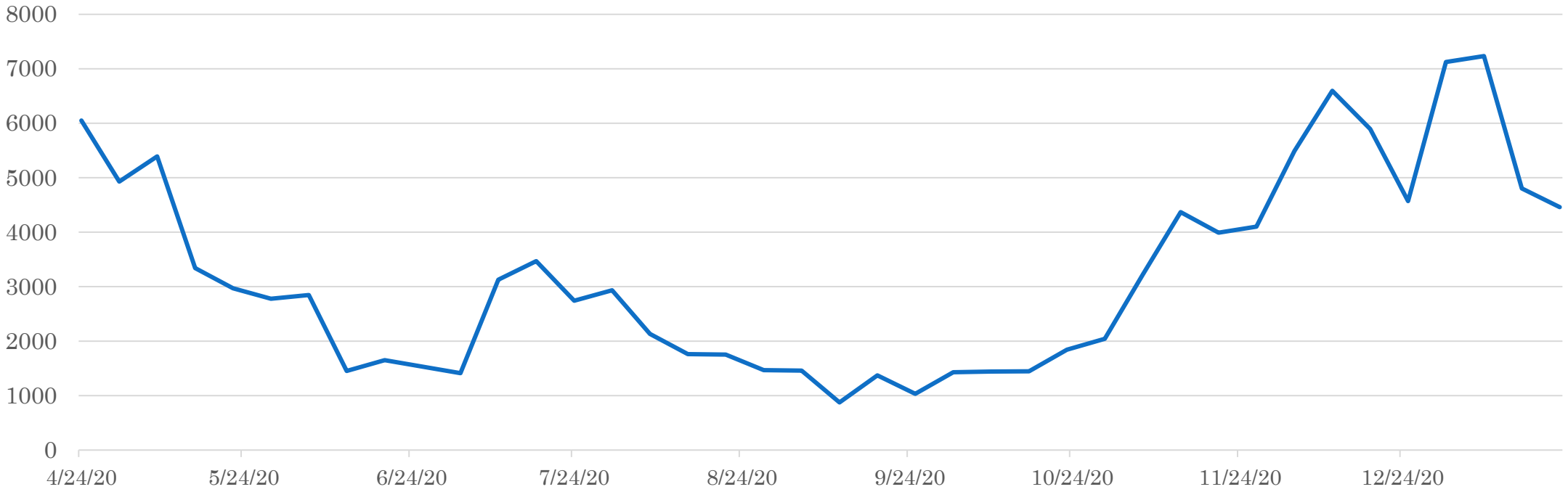
61.76% 2-3 DAYS

4.41% 4-5 DAYS

Number of PHPC Patients Tested for COVID-19



Number of PHPC Patients Positive for COVID-19



Community Health Centers Vaccination Program

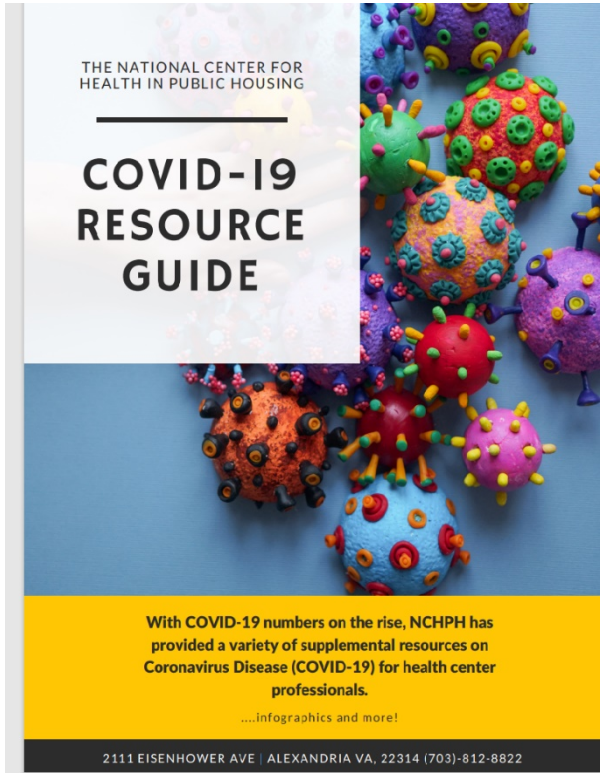
- **Starting February 15 (NEXT WEEK), FQHCs will begin directly receiving vaccine supply!**
- Initial phase will include at least one Community Health Center in each state, expanding to 250 centers in the coming weeks.
- Program will begin incrementally at select HRSA-funded health centers that specialize in caring for particularly hard-to-reach and disproportionately affected populations.
- Initial health centers chosen for this program include those that serve a large volume of special populations, including:
  - Individuals experiencing homelessness
  - Public housing residents
  - Migrant/seasonal agricultural workers
  - Patients with limited English proficiency
- **Vaccine supply will be in addition to jurisdictional supply!**

- More information: www.hrsa.gov/coronavirus/health-center-program

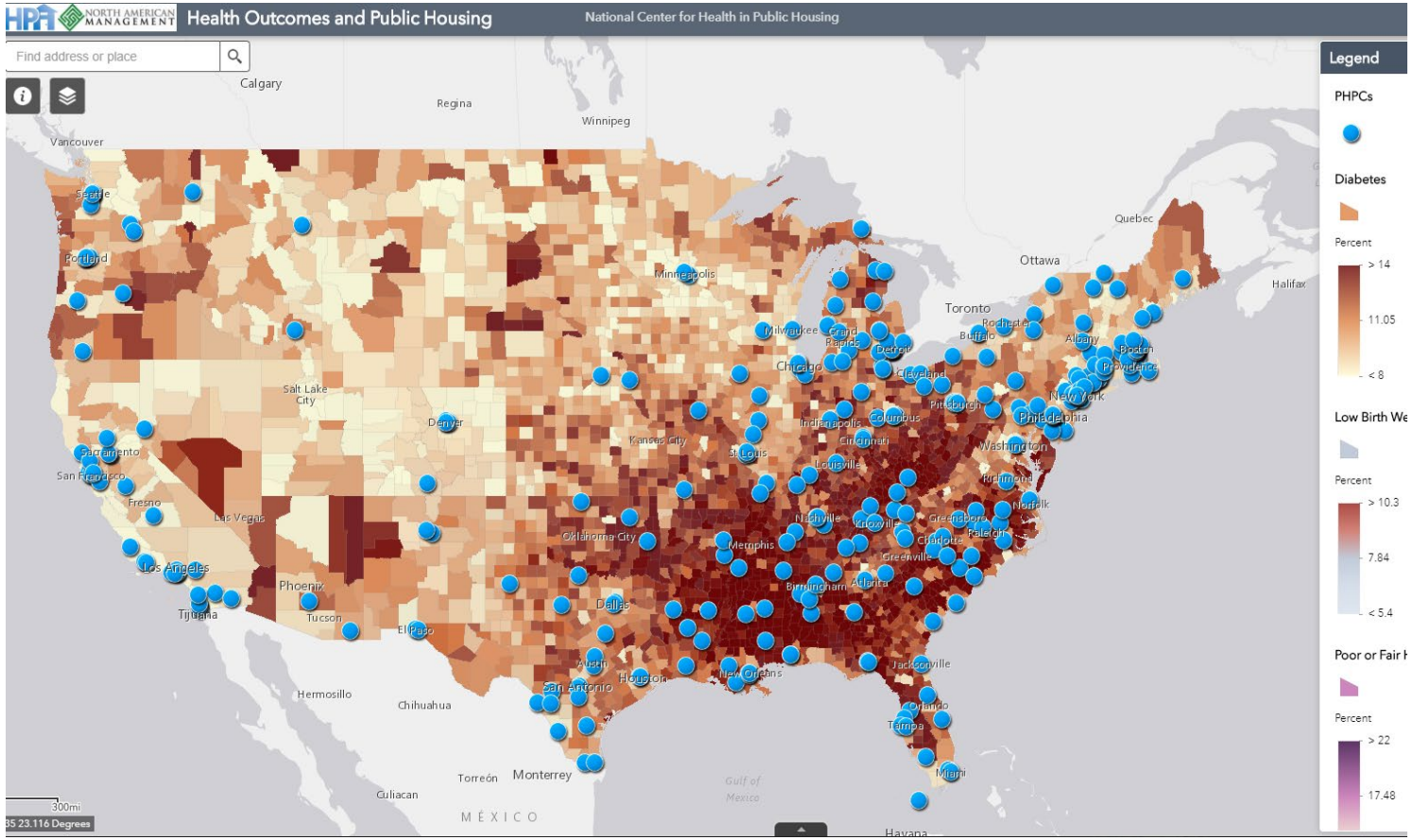

Community Health Workers, the missing link…

- PUBLIC HOUSING PRIMARY CARE (PHPC) BY THE NUMBERS
- NCHPH COVID- 19 DASHBOARD
- COVID- 19 TRAINING AND TECHNICAL ASSISTANCE WEBINARS AND LEARNING COLLABORATIVES
- INFOGRAPHICS

LEARN MORE AT: NCHPH.ORG/DASHBOARD



Visit our Interactive Maps at www.nchph.org/training-and-technical-assistance/maps/



- Diabetes in Public Housing Primary Care
- Health Behaviors and Public Housing
- Health Centers In or Immediately Accessible to Public Housing Map
- Health Center Program Grantees and Public Housing Developments
- Health Outcomes and Public Housing
- Socioeconomic Health Factors and Public Housing
- Other Public Housing Programs, e.g., Jobs Plus, Connect Home, FSS

Akron, OH Partnership


AxessPointe
Community Health Centers
AMHA
Akron Metropolitan Housing Authority

About API

- Established 1995
  - *to provide a quality, affordable, and compassionate health home for every patient, every time…*
- 5 Health Centers serving 2 counties in North East Ohio
- Multiple Service Lines
- Patient Demographics
- Community Partnerships

AMHA
Akron Metropolitan Housing Authority

AccessPointe
Community Health Centers

AMHA and API Partnership

- Vaccine Services
  - Door to Door
    - Annual Flu
    - Back to School
  - Transportation for COVID Vaccine
- Monthly Events
  - Health Education
  - Food Pantry (on site)
  - Mobile Medical and Dental Unit
- Shared Community Health Worker
  - AMHA Resident
  - Trained through API
  - Presence in both the AMHA Community and the Health Center

AMHA
Akron Metropolitan Housing Authority

AxessPointe
Community Health Centers

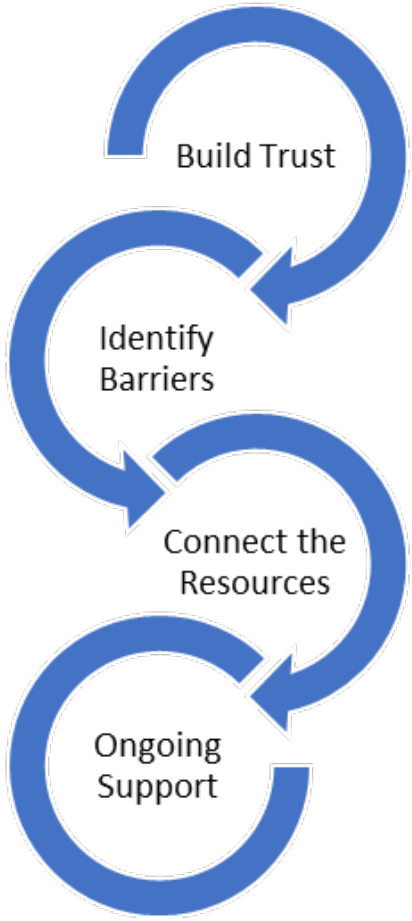
Community Health Worker

- *Our CHW roles are tailored to meet the unique needs of the community they serve.*
  - Serve as a patient advocate with healthcare providers
  - Assist in navigating the social service and healthcare system resources
  - Reduce social isolation
  - Live and work in the community they serve
  - Build trusting relationships so that we can provide crucial feedback to improve social determinants of health

AMHA
Akron Metropolitan Housing Authority

AxessPointe
Community Health Centers

CHW Cycle



Akron Metropolitan Housing Authority

AccessPointe Community Health Centers

Pandemic Transformation

- Get out from “behind the stethoscope”
  - Meet people where they are
    - Delivery
    - Curbside Services
    - Door to door vaccines
- Targeting the Underserved
- Focus on quality not quantity

AMHA
Akron Metropolitan Housing Authority

AccessPointe
Community Health Centers

Community Medical Centers

Mission: Working Together To Improve Health And Well - being In Our Communities.

History of CMC

1965: Community health care volunteers collaborate to provide services to farmworkers

1976: 1st Federal funding, formed 5013c non-profit, Agricultural Workers Health Centers

1980: Merged with Solano Clinics, to add 4 sites

1995: Opened Channel site downtown, added two school-based sites

2001: Health care for the Homeless, 2011 added Gleason House HCH

2013: HER - NextGen

2014 – 2017: Added Integrated BH all sites, Podiatry, Optometry, PT, Chiropractic, SUD, Virtual Dental Home. Preethi Raghu, COO joins CMC.

2018- 2019: SUD Recovery Center (walk in BH Assessments, Sobering), Endocrinology

Needs Assessment: Opportunities and Challenges

- RWJF: County life expectancy data shows Latinos & African Americans live on average 12 years less than the average white resident, Asian Americans live 4 years less
- 87,000 residents in service areas without health coverage year-round
- 27,000 of established CMC patients have not seen any health provider in over 12 months
- 36% of service area population are Medi-Cal eligible
- 9.22% of service area adults have diabetes, compared to 8% statewide
- Primary care and specialty provider shortages

Today:

- 101,100 Patients served in 2019
- 340,700 Patient care visits in 2019
- 3 counties (San Joaquin, Solano, Yolo)
- 26 sites
- 10,000 Patients with a diagnosis of diabetes
- 96% of patients are below 200% of Federal Poverty Level
- $90M budget FY 2020-2021
- Staff: 925

CMC Services

Primary Care

- Adult medicine
- Pediatrics
- Women's Health (OB/GYN)
- Geriatrics

Integrated Behavioral Health/ Psychiatry

- SUD
- Sobering and Recovery Services

Dental

- Virtual Dental Home and Pediatric Preventive services in 110 preschool, head start and K-3 schools

Specialty

- Endocrinology
- Pediatric cardiology, GI,
- Podiatry
- Chiropractic/ Physical Therapy/ Acupuncture

Health Care for the Homeless

- Street outreach
- Adolescent team etc.

Lessons from Flu LEAD/ COVID Testing

- **Communication is Key**
  - Internal with local HA staff
  - Multiple methods of contact are needed (flyers, text messages, day of presence)
- **Residents have competing priorities**
  - Jobs, Childcare, etc.
- **Visibility: be in front or main area**
- **Flexibility**
- **Student Nurses** (need exposure to community health, and injection practice)
- **Mobile Van**: Ready to go, all needed supplies are stored and replenished at end of day

This is my story

This is my story.

When I brought him his medications, he knew the words "thank you so much I really needed this god bless god bless." Bringing the medications made his day which made mine.

And this is my community.

The love that is shown here is amazing … Love over everything. That's what I felt here.
- West Lane Patient

This is my story.

They service people of all needs where other places won't, and they understand and don't judge which takes the stress out of going to the doctor .

And this is my community.

This is my story.

When patients tell me they don't understand what's happening, I love being able to sit down with them and get to what is concerning them.

And this is my community.

COMMUNITY
Medical Centers

CMC Leadership

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Preethi Raghu Chief Operating Officer praghu@cmcenters.org Office: 209-373-2832 Cell: 925-548-4449	Ginger Manss, DNP, RN, HACP, AOCN *Chief Nursing Officer* gmanss@cmcenter.org Office: 209-373-2840 Cell: 209-609-6759	Mical L. Cayton *Chief Information Officer* mcayton@cmcenters.org Office: 209.626.5525 Cell: 209.888.9146
Alyssa Arismendi-Alvarez, MPH, CPHQ *Director of Quality Improvement* aalvarez@cmcenters.org Office: 209-373-2814 Fax: 209-373-2897	Linh DeLuca, DDS Dental Director deluca@cmcenters.org Office: 209-940-5618 Mobile: 508-317-5011	Alfonso Apu Director of Behavioral Health aapu@cmcenters.org Office: (209) 373-2842

HACSJ
HOUSING AUTHORITY
COUNTY OF SAN JOAQUIN

DELTA COMMUNITY DEVELOPERS CORP

- HCVP Voucher Allocation: 5,174
- Public Housing Homes: 1,000 Circa 1950's and 1960's
- Mixed Finance/New Construction Homes: 300
- Average Median income in Stockton, CA: $47,000
- Average Median Income in HACSJ Public Housing: $15,400

FREE FLU CLINICS

- In partnership with Community Medical Centers, Free Flu Shot Clinics were scheduled at the following communities:
  - Public Housing: 1,165 potential families
  - Seasonal Migrant Centers: 285 potential families
  - Year-Round Farm Labor Housing: 31 potential families
- Potential COVID-19 Vaccinations across sites: 1,500

		Hispanic														Non Hispanic													
	Totals	Mixed Race		American Indian or Alaska Native		Asian		Black/ African American		Native Hawaiian/Other Pacific Islander		White		No Race Selected		Total		Mixed Race		American Indian or Alaska Native		Asian		Black/ African American		Native Hawaiian/Other Pacific Islander		White		No Race Selected		Total	
Age 65 and Over	197	0	0.00%	0	0.00%	0	0.00%	1	0.07%	1	0.07%	96	6.54%	0	0.00%	98	6.68%	0	0.00%	0	0.00%	45	2.33%	40	2.07%	1	0.05%	12	0.62%	1	0.05%	99	5.13%
Age 50 to 64	354	3	0.20%	2	0.14%	0	0.00%	0	0.00%	1	0.07%	141	9.62%	0	0.00%	147	10.03%	2	0.10%	4	0.21%	61	3.16%	98	5.08%	3	0.16%	39	2.02%	0	0.00%	207	10.74%
Age 18 to 49	1255	14	0.95%	13	0.89%	3	0.20%	17	1.16%	4	0.27%	487	33.22%	6	1.10%	544	37.11%	50	2.59%	17	0.88%	167	8.66%	355	18.41%	3	0.16%	115	5.96%	4	0.21%	711	36.88%
Under 18	1588	35	2.39%	29	1.98%	9	0.61%	54	3.68%	4	0.27%	523	35.68%	23	3.40%	677	46.18%	95	4.93%	13	0.67%	152	7.88%	503	26.09%	5	0.26%	125	6.48%	18	0.93%	911	47.25%
Totals	3394	52	3.55%	44	3.00%	12	0.82%	72	4.91%	10	0.68%	1247	85.06%	29	1.98%	1466	100.00%	147	7.62%	34	1.76%	425	22.04%	996	51.66%	12	0.62%	291	15.09%	23	1.19%	1928	100.00%

	Totals	Mixed Race		American Indian or Alaska Native		Asian		Black/ African American		Native Hawaiian/Other Pacific Islander		White		No Race Selected	
Age 65 and Over	197	0	0.00%	0	0.00%	45	22.84%	41	20.81%	2	1.02%	0	0.00%	1	0.51%
Age 50 to 64	354	5	1.41%	6	1.69%	61	17.23%	98	27.68%	4	1.13%	180	50.85%	0	0.00%
Age 18 to 49	1255	64	5.10%	30	2.39%	170	13.55%	372	29.64%	7	0.56%	602	47.97%	10	0.80%
Under 18	1588	130	8.19%	42	2.64%	161	10.14%	557	35.08%	9	0.57%	648	40.81%	41	2.58%
Totals	3394	199	5.86%	78	2.30%	437	12.88%	1068	31.47%	22	0.65%	1430	42.13%	52	1.53%

	Totals	Non Hispanic		Hispanic	
Age 65 and Over	197	99	50.25%	98	49.75%
Age 50 to 64	354	207	58.47%	147	41.53%
Age 18 to 49	1255	711	56.65%	544	43.35%
Under 18	1588	911	57.37%	677	42.63%
Totals	3394	1928	56.81%	1466	43.19%

HACSJ COMMUNITY DEMOGRAPHICS

Q&A

- Please type your questions into the Q&A pod!

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