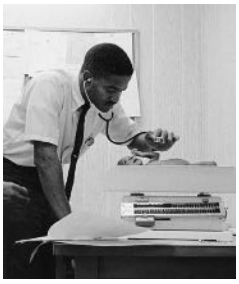
rchn community health foundation

chronicles The Community Health Center Story

THE CHRONICLES BEAT

SELECTED STORIES



Welcome to the CHroniCles Beat

Dear Colleagues,

CHroniCles, a signature project of the RCHN Community Health Foundation, is an interactive, multimedia website dedicated to the living history of the rich, diverse and vibrant community health center movement.

The core of the CHroniCles site is an extensive collection of contributed narratives, photos, founding documents and other materials documenting the founding and decades-long work of health centers across America. Complementing this archive is the site's CHroniCles Beat feature, which spotlights current health center programs, challenges, and triumphs. The fight for health care access and justice, fought community by community, is reflected in these stories showcasing the extraordinary role of our health centers on the frontlines of the opioid epidemic, the Zika crisis in Puerto Rico, care for our veterans, and more. While the stories are intentionally local and unique, the themes are universal, highlighting the depth of the health center commitment to elevating health care and the health of our communities, and the breadth of their vision and leadership.

We are inspired by and grateful to the health centers and primary care associations that have generously shared these stories with us, and to our community health center colleagues everywhere whose work on the ground has been central to our mission.

A small selection of our CHroniCles Beat stories, written from 2012 to 2021, are featured here. The complete set, along with our videos and other features, can be found on the CHroniCles site, and we hope you will visit the site and be similarly inspired by the health centers working to bring health care quality and health equity to every community.

Feygele Jacobs, DrPH
President and CEO
RCHN Community Health Foundation, Inc.

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Designed by Nela Abey
Cover photos in upper row center and bottom row by Daniel Bernstein

A People's Movement: Massachusetts Community Health Centers' Historic Fight for Access

Part 1

Today, there are 37 federally qualified community health centers throughout Massachusetts, a large number relative to the state's population and geographic size. This is no accident, and reflects the long-standing history of health care activism in the state. Significantly, Massachusetts has the unique distinction of being the home of the first urban federally-funded community health center in the country, founded by Drs. H. Jack Geiger and Count Gibson in the Columbia Point housing development located on an isolated peninsula in Boston's Dorchester neighborhood. On a recent visit to the state, I met with Ellen Hafer, the executive vice president and COO of the Massachusetts League of Community Health Centers, to discuss the history of community health centers in Massachusetts.

While Boston is renowned for being home to three of the best teaching hospitals in the country, and to outsiders seemed an unlikely place for the birth of the first community health center, the city's neighborhoods had strong, independent identities and were segregated by culture, race, and ethnicity. Significant pockets of poverty existed amidst these prestigious teaching hospitals. Residents in geographically isolated and racially divided sections of the city, in particular the South End, Roxbury, Dorchester, Jamaica Plain, and East Boston neighborhoods, lacked access to basic medical services. Columbia Point was one of the poorest sections of Boston prior to the opening of the health center in 1965; residents of the Columbia Point Development housing projects had no access to health care services.

Drs. Geiger and Gibson partnered with Tufts University Medical School

to develop the concept and plan for the health center, and sought support from the federal Office of Economic Opportunity (OEO), the government entity charged with developing and implementing the War on Poverty programs that were created as part of President Lyndon Johnson's Great Society initiative. The Johnson Administration advocated community participation to create jobs and training and to foster economic development. The War on Poverty aimed to reduce poverty by expanding the government's role in education and health care, and the OEO was created as a cornerstone of this strategy. Another significant element of the War on Poverty was the creation of the Model Cities program, which aimed to foster urban renewal in marginalized communities through the creation of affordable housing alternatives, workforce development, social service programs, job training, and community organizing. Citizen participation was emphasized as a key strategy in the effort to rebuild and rehabilitate blighted urban areas and form a social service infrastructure. Under the Model Cities initiatives, community activists began to rally poor residents to demand and plan for better social services and access to primary and preventive health care emerged as a key issue. In cooperation with city agencies and in response to pressure from local community leaders, Boston hospitals aligned themselves with their home neighborhoods and supported the formation of community clinics.

The opening of the Columbia Point Health Center initiated a grassroots movement in the city that led to the opening of 18 additional health centers in Boston by 1971. Major teaching hospitals took a larger role in community-based health issues and worked with local activists in the Jamaica Plain and Roxbury neighborhoods. The Harvard School of Public Health worked with residents of Bromley Heath housing

"Columbia Point was one of the poorest sections of Boston prior to the opening of the health center in 1965; residents of the Columbia Point Development housing projects had no access to health care services."

project to open Martha May Eliot Health Center in Jamaica Plain, and Boston University Hospital was involved in the initial formation of Roxbury Comprehensive Community Health Center. Like Columbia Point and the Delta Health Center in Mound Bayou, Mississippi, also established by Dr. Geiger together with Dr. John Hatch as the nation's first rural health center, these centers were funded through the Office of Economic Opportunity. Boston's Health and Hospitals Commissioner further stimulated growth by pushing a city-wide "redistricting plan," which offered financial incentives for local hospitals to develop community-based health centers and to provide primary care in certain Boston neighborhoods. This policy helped to decentralize access to health services and created a neighborhood-based health center model.

Part 2

By the 1990s, the Columbia Point housing project had been converted into a mixed-income development and a majority of the apartments were converted to market-rate housing with a percentage of subsidized units remaining for lower-income residents. As the demographics of the neighborhood

Dan Driscoll, Jack Cradock, Jim Hunt, Sen. Edward Kennedy. NACHC Policy and Issues Forum (1982).

changed, Columbia Point Health Center experienced financial trouble, due in part to a declining patient base. In order to avoid closure, Columbia Point merged with nearby Neponset Health Center, which had historically served a largely Irish Catholic working-class population. This unlikely partnership was led by Dan Driscoll, CEO of Harbor Health Services, the parent organization of the merged and expanded health centers. Driscoll explained that the cooperation between these two centers and their community boards was motivated by a mutual commitment to the survival and growth of their respective centers and by a larger commitment to the mission of community health centers to create access to care for underserved populations. The original Columbia Point Health Center changed its name to the Geiger Gibson Community Health Center in honor of the founders of the community health center movement.

Over time, Boston experienced significant change with waves of immigration and the gentrification of formerly segregated communities. As Boston has been transformed by gentrification, housing prices have increased, and poor and lower-income people have been forced to settle farther outside of Boston proper. These Boston bedroom communities are also experiencing a transformation and health centers have identified a strong need for affordable health services in these areas. Driscoll explained that pockets of poverty exist in suburban communities where the needs are less visible than in dense and segregated urban communities like Dorchester. The health centers have evolved to meet the changing needs of their communities. Because the population is spread across a larger area with a less centralized community, residents are more difficult to reach and have less access to comprehensive care services. Harbor Health Services took on this challenge with the opening of a health center in Hyannis and a dental clinic in Harwich in the early 2000s. They have plans to expand to a brand-new site in Plymouth in 2014. Meanwhile, the original centers have adapted to a new population. Neponset has seen an influx of Vietnamese immigrants, and the center has expanded onsite translation and interpreter services. In addition, the center's social work staff has mentored a cadre of Vietnamese men and women to provide outreach in the community, identify particular health needs, and encourage Vietnamese patients to seek services at the health center.

"The opening of the Columbia Point Health Center initiated a grass-roots movement in the city that led to the opening of 18 additional health centers in Boston by 1971."

Forty-five miles outside of Boston, in Worcester, Great Brook Valley Health Center, now known as the Edward M. Kennedy Community Health Center, opened in 1986 in one of the largest public housing developments in the city. The center was first founded in the early 1970s by a group of mothers who lived in the Great Brook Valley apartments, who together with several board members from UMass hospital worked to secure funding to open a clinic. Similar to the Columbia Point center, the housing project was geographically isolated from the rest of the city and had no public transportation. Current CEO Toni McGuire recalled the isolation residents experienced: "There was one road in and one road out of Great Brook." In a city notorious for gang-related violence and crime, residents had difficulty accessing basic medical care and ambulances were too often slow to respond or refused to enter the valley.

Renamed in 2010 to honor the late Senator Edward M. Kennedy, the center has responded to local needs and over the years has evolved to serve the changing demographics of the community. Worcester has experienced an influx of immigration from Latin America, Southeast Asia, West and East Africa and the Middle East, and has become a settlement site for large numbers of Somali, Liberian, Iraqi, Irani, Burmese, and Bhutanese refugees. These patients have changed the face of the health center, where translation services are provided in over 30 languages and more than 75% of health center staff is bilingual (primarily in Spanish and Portuguese, which remain the languages most commonly spoken by patients). Health center staff receives onsite training to address the specific health disparities and cultural needs of these patients. A special task force focuses on outreach strategies and challenges in meeting the needs of these residents, many of whom are unfamiliar with the Western medical system. Today, the center provides primary and specialty care services including one of the first health-center run HIV/AIDS prevention and treatment programs and operates 13 sites that serve the communities of Worcester, Clinton, and Framingham, Massachusetts.

The East Boston Neighborhood Health Center (EBNHC) opened its doors in 1970. East Boston was originally a series of islands off the coast of Boston proper that were connected into a single landmass with landfill. Separated by Boston Harbor, East Boston suffered from a lack of access to ambulatory and primary care in large part due to its geographic isolation from the nearby city. It has always been a city of immigrants. The Center's windows face a large outdoor mural that paints a visual history of immigrants in East Boston beginning in the 19th century with Irish, Canadian, Italian, and Russian Jewish settlers who were attracted by a booming shipbuilding industry. Also depicted are the more recent waves of immigration from the Caribbean, Central and South America, and Southeast Asia. Because East Boston has always had a low crime rate and is relatively affordable, it has attracted a largely working-class immigrant population who seek a home to raise their families.

EBNHC is one of the only centers with an ambulatory care unit that is open 24 hours, 7 days a week. Because the closest hospital is not easily accessible, the ambulatory care unit is a literal lifesaver for many patients in need of emergency treatment. The facility is equipped with top-of-the-line ER equipment including x-ray equipment, an onsite pharmacy, and laboratory. Medical staff is trained in acute care and have streamlined the intake process to ensure patient walk-ins are able to see a physician in far less time than a typical hospital

Manny Lopes, CEO gives tour of health center's pharmacy (2013). East Boston Neighborhood Health Center (East Boston, MA).

emergency room visit.

Another unique program at EBNHC is the Education and Training Institute. With more than half of staff members residing in the communities they serve, the center has taken steps to increase this number and to further the education and training of current staff who seek to advance their health center careers. Manny Lopes, the current CEO, personifies the health center's commitment to training and development. A native of East Boston and a first-generation American child of Cape Verdean immigrants, he began his career at EBNHC as an 18-year-old researcher and worked his way up to the leadership role he serves in today. Passionate about the growth of the center and with a deep connection to the community it serves, Lopes explained how EBNHC was an important economic engine and source of jobs in the community and has worked to foster ties with local businesses.

Reflecting on the progress that has been made since the founding of Columbia Point, Massachusetts League of Community Health Centers staff with ties to the early health center movement cited a genuine spirit of engagement and active community governance in Boston that made community health center growth uniquely successful. Boston's neighborhoods, in collaboration with outside leaders like Dr. Jack Geiger and Dr. John Hatch, broadened the centers' influence to expand and secure funding. The city government was integral to initiating these programs through OEO. Today one out of every two Boston residents receives care at a community health center, and while a large number of Boston health centers are not federally funded, they follow traditional health center model tenets. Massachusetts has led the charge in reforming the health care system and expanding health access. The passage in 2006 of Massachusetts' landmark health reform law, Chapter 58, which expanded eligibility for the state's Medicaid program and created subsidized insurance coverage for low- to medium-income residents, was the culmination of a decades-long political struggle that began under Governor Michael Dukakis who first made universal health care an important part of his 1988 Presidential campaign.

The strength of Boston's health center movement can be attributed to its unique formula: the initial and sustained support of local government officials who pushed local hospitals to support community health centers within Boston's tightly–knit neighborhoods, the creative vision of leaders like Drs. Geiger and Gibson, and later the political vision and influence of Senator Ted Kennedy, who devoted his career to fighting for healthcare access. Despite Boston's history of racial segregation and cultural and socio-economic division, the Massachusetts League of Community Health Centers successfully mobilized individual neighborhood-led health centers in Boston under a shared commitment to the fight for healthcare access, ultimately expanding that vision and knowledge to other parts of Massachusetts. With this backdrop, community health access has become a cultural expectation and a force to be reckoned with across Massachusetts as health leaders work to implement the broad range of state and federal health reform initiatives aimed at increasing quality, controlling costs and ensuring statewide access to primary care.

Still, the challenge for today's health centers is to continue to evolve to provide relevant and culturally appropriate care to the people they serve. Long-standing health centers like Harbor Health Services and Edward M. Kennedy Community Health Center have adapted to respond to the specific needs and illnesses that affect newer populations in their communities through important partnerships with health center allies, aggressive outreach and creative strategies to providing care. East Boston Neighborhood Health Center, which also serves a multi-ethnic and multilingual patient population, has begun to address the socioeconomic factors that affect its patients' health by expanding its efforts to include economic development and educational training programs. These innovative strategies, and development of the next generation of committed leadership, will ensure community health centers' relevance and future long-term success in strengthening the communities they serve.

- Nicole Rodriguez-Robbins (2014)

Header photo: Dr. H. Jack Geiger celebrates the 25th anniversary of Harbor Health Services (1990). Courtesy of Harbor Health Services (Dorchester MA).

Amidst a Pandemic, Agricultural Workers Toil and Community Health Centers Adapt and Innovate.

Summer usually signals the beginning of beach trips, long warmer days, and visits to the local farmer's market, often brimming with fresh summer produce. Yet, by the time summer rolled around this year, the COVID-19 pandemic had already caused major disruptions to schools, employment, transportation, entertainment, and other industries. Agriculture, the mainstay of our food system, wasn't spared.

When COVID-19 hit the United States, New York soon became the epicenter of the virus. Starting with a single confirmed case on March 1, the virus spread rapidly, to 408,181 confirmed cases and more than 25,000 confirmed deaths statewide at the time of this writing [on July 21, 2020].[1]

While COVID-19 has already put an end to many summer activities, it may be less apparent that it is also directly impacting our food supply and the workers who provide it. Our food supply is dependent on farm laborers—an essential workforce—who often risk their own safety and lives to provide the food we eat. Hired seasonally, agricultural workers are crucial during peak production periods. Working in fields, orchards, farms and canneries, they plant, cultivate, and process the crops.[2] In contrast to states like California where the growing season is year-round, New York relies on the spring and summer season, when most crops are harvested.

The Workforce and Immediate Challenges

An estimated 2.4 million farmworkers fuel our agriculture industry. While some farmworkers have their permanent residence in the U.S., moving from one location to another during the season, other workers enter the United States through the H-2A program, which was created to allow foreign workers to work legally, on a temporary basis, for farmers who meet certain regulatory requirements. In 2019, approximately 258,000 visas were issued to H-2A guest workers.[3] Still, more than half of all farmworkers in the United States are undocumented, and many live in mixed-status families and communities.[4] While the characteristics of farmworkers vary by region, approximately 78% of farmworkers are Hispanic, and about 95% are of Mexican descent.[5] The outbreak of the COVID-19 pandemic at the onset of the growing season, and in a shifting regulatory environment, exacerbated the challenges already faced by farmworkers.

Although agricultural workers have been deemed "essential workers" and "necessary infrastructure," their living and working conditions make them uniquely vulnerable to illness, and compound longstanding language, cultural, financial and mobility barriers. During the season, many farmworkers live in dwellings with shared facilities, and may sleep in one room.[6] Workers frequently travel to work in groups, and work side-by-side, and worksites may lack access to accessible hand-washing facilities with soap and water.

For farmworkers, the pandemic has added another level of fear and uncertainty; with no paid time off, workers simply can't afford to get sick. And because few workers have health insurance, access and affordability remain a continuing challenge.[7] While there remains no comprehensive testing or systematic reporting of positive COVID-19 cases among agricultural workers, clusters have been reported in Arizona, California, Colorado, Florida, Georgia, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Tennessee, Texas and Washington – nearly everywhere that agricultural workers work and live.[8]

To learn more about the impact of COVID-19 on agricultural communities in our home state and around the country, we reached out to our colleagues at Finger Lakes Community Health (Penn Yan, NY) and Oak Orchard Health (Brockport, NY) and to the National Center for Farmworker Health (NCFH).Finger Lakes Community Health, in west-central New York State, was founded in 1989 as a free-standing migrant health center serving the region's farmworkers. The health center was awarded a New Access Point grant in 2009 and became a federally qualified health center. In 2019, the health center operated nine locations and served approximately 29,000 people, around 30% of whom were farmworkers.

1 "Persons Tested Positive by County," NYS-COVID19-Tracker, New York State, Department of Health, Published July 21, 2020, Accessed July 21, 2020, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes.
2 "Farmworkers in the United States," MHP Salud, Accessed July 7, 2020, https://mhpsalud.org/who-we-serve/farmworkers-in-the-united-states.
3 Marcello Castillo and Skyler Simnitt, "Farm Labor," United States Department of Agriculture Economic Research Service, Accessed July 8, 2020, https://www.ers.usda.gov/topics/farm-economy/farm-labor.
4 "Statement on COVID-19 and the Risks to Farmworkers," Resources on Novel Coronavirus COVID-19, National Center for Farmworker Health, Published 2020, Accessed July 8, 2020, http://www.ncfh.org/.
5 "Farmworkers in the United States," MHP Salud, Accessed July 7, 2020, https://mhpsalud.org/who-we-serve/farmworkers-in-the-united-states.
6 "Statement on COVID-19 and the Risks to Farmworkers," Resources on Novel Coronavirus COVID-19, National Center for Farmworker Health, Published 2020, Accessed July 8, 2020, http://www.ncfh.org/.
7 "COVID-19 in Rural America: Impact on Farms & Agricultural Workers," National Center for Farmworker Health, Accessed July 13, 2020, http://www.ncfh.org/msaws-and-covid-19.html.
8 IBID.

Cleaning and hygiene supplies provided to farmworkers (2020). Courtesy of Oak Orchard Health (Brockport, NY).

> **"The local public health departments had to come to us because no one else was testing. That is what we are here for, we are a community health center, tell us what you need and we are happy to do it."**

Testing, Education and Virtual Visits to Navigate a Crisis

Mary Zelazny, Chief Executive Officer at Finger Lakes Community Health, recalled that in one county, just west of Syracuse, nineteen farmworkers at five different farms tested positive for COVID-19 and one died. Health center leadership recognized the pressing need for education about the pandemic, to curb the spread of misinformation and protect workers. Mary explained, "Farmworkers are at a huge disadvantage because they don't have access to the news every day, they are working to feed their families, the news they get tends to not be local, because local news is in English."

She went on to note that "At first we struggled with educating [farmworkers] and teaching them about social distancing and masks, but then some farmworkers got COVID-19." The health center conducted multiple educational Zoom tele-halls in English and Spanish for farmers and farmworkers. The center's medical director outlined safety practices and guidelines, available services, and answered questions. In addition to the tele-halls, Finger Lake's team of community health workers continued their direct outreach to the farms. With farmers concerned that outreach and clinical teams might spread COVID-19 to their farms, the Finger Lakes team began making socially-distant visits to local farms, dropping off masks and hand sanitizer, as well as food and health and safety information, including how to properly wash masks.

The health center also initiated drive-up COVID-19 testing. Mary explained that, "The local public health departments had to come to us because no one else was testing. That is what we are here for, we are a community health center, tell us what you need and we are happy to do it." An early adopter and leader in the field of telehealth, which it has offered since 2008, the health center has continued to offer virtual patient visits for routine health concerns. Finger Lakes was recently awarded grant funds through the Federal Communications Commission (FCC) COVID-19 Telehealth Program to add laptop computers, tablets, telehealth video equipment, remote monitoring equipment, and network upgrades to assist in screening, testing, and treatment for COVID-19 patients in eight counties. However, Mary cautioned that telehealth was a challenge for the more rural patients who don't have consistent access to smartphones or broadband internet, and the health center has maintained some in-person medical and emergency dental visits throughout the pandemic.

Collaborations, and Mutual Trust

Situated in the northwestern most part of the state, Oak Orchard Health started as a migrant health project in 1966, and has since grown into a health network offering comprehensive, integrated health services at six locations including a mobile dental unit, and serving Monroe, Orleans, Wyoming, Steuben, Genesee, and surrounding counties. Commenting on the impact of the pandemic, Karen Watt, Vice Chair of the Oak Orchard Health Board of Directors and co-owner of Watt Farms in Albion, described a different atmosphere from years past, "There's a little apprehension and trepidation for farmworkers coming into this area from other countries on the H2A program."

Still, long-standing relationships across the community and the use of technology have helped ease some of the challenges. Navigators and enrollers work by phone to help patients get health coverage, with the bilingual team providing services in Spanish when required. Through a partnership with a local food distributor, the health center's outreach team has arranged pick-up of food boxes for incoming farmworkers who were going to be quarantined. Sandra Rivera and Estella Sanchez Cacique, part of the outreach team, have provided drive-by drop-offs of masks, hand sanitizer, and disinfectant, along with health and safety information, at worker housing sites. The distancing restrictions required have been difficult for farmworkers. Sandra said, "I've known them for so long that they're family. They want to tell me how their wife, kids, and mama are, and they're not able to do that, it is so difficult for them. We have such a good relationship with the guys that I trust they will call us and let us know if they are feeling unwell and ask us what to do."

Like Finger Lakes, Oak Orchard has also pivoted to telehealth, and has received COVID-19 FCC telehealth grant funds to help workers overcome barriers to care. Karen Watt mused, "What if the pandemic had happened before cellphones? Many of our farmworkers have cellphones –

Community health center staff, masked and ready (2020). Courtesy of Finger Lakes Community Health (Penn Yan, NY).

everyone is connected – it enables us to give so much more than would have been possible twenty years ago."

A National Perspective and a Look ahead

Sylvia Partida, CEO of the National Center for Farmworker Health, explained that the challenges in New York were mirrored across the country. A key challenge for health centers was that many had to transition to telehealth becoming a primary way of delivering services, explaining that this occurred in the context of limited information about the types of technology and connectivity that agricultural workers might have access to. "I don't think that the shift to telehealth is going to go away. We need to leverage technology and we have to help the farmworker community to fully engage in that type of service, for now and in the future. It's critical." NCFH itself, long a champion of farmworkers through the training and technical assistance it provides to community and migrant health centers nationwide, has also sharpened its focus on the immediate challenges of COVID-19.

Together with other advocacy groups, NCFH issued a Statement on COVID-19 and the Risks to Farmworkers. NCFH also prepares a weekly summary, based on HRSA data, about Migrant Health Centers and COVID-19 tracking visits, site closures and testing capacity, and highlighting key health center issues. Resources for agricultural workers, employers and health centers are available in English and Spanish.

And in a unique collaboration with Justice for Migrant Women, the Hispanic Heritage Foundation and fashion designer Mario De La Torre, NCFH launched the Facemasks for Farmworkers campaign, which makes, procures and distributes face masks to agricultural workers, who like, other essential workers, have lacked adequate PPE. To date, the Campaign has distributed 9,000 masks made by volunteers, 7,000 made by designer Marco de la Torre, and is currently distributing 600,000 provided by an anonymous donor. The Campaign also secured 70,000 N95 Masks, 200,000 surgical mask and 1,000,000 nitrile gloves for distribution to community health center staff.

The Ag Worker Access Campaign, developed by NCFH in partnership with the National Association of Community Health Centers, has called on every health center grantee to increase by 15% each year, over the next five years, the number of agricultural workers served. With the pandemic underscoring the importance of care for the agricultural worker community, access remains a priority issue.

The campaign, through the Ag Worker Campaign Task Force, is now focusing on building stronger partnerships with the agricultural industry and American Farm Bureau Federation, determining the types of resources needed by health centers in order to reach and provide more information about COVID-19 to farmworker communities, and developing broad distribution channels to make this information available.
Crisis situations often heighten access challenges, especially for vulnerable populations, and require both adaptability and innovation. Over the past few months, the COVID-19 pandemic has heightened the risks and challenges faced by our nation's farmworkers. Fighting on the frontlines of this pandemic, community health centers continue to adjust and innovate to ensure the health and safety of the essential agriculture workers who keep food on our tables.

- Irene Bruce, Nela Abey (2020)

Header photo: Agricultural workers in upstate NY (2020). Courtesy of Oak Orchard Health (Brockport, NY).

Caring for Veterans, Caring for Our Communities

Community Health Centers are the backbone of America's safety net, and provide essential care to underserved, low-income communities in urban and rural areas throughout the 50 states, the District of Columbia, and the U.S. territories. In 2017, more than 1,400 community health centers (CHCs) provided health care to nearly 28 million people. By mission and mandate, health centers focus on expanding access to care for marginalized communities and populations.

One such significant population served by health centers are America's veterans. The Veterans Choice Program (VCP), authorized by Congress in 2014, permits veterans to access care through eligible providers and facilities that are not a part of the veteran's health care system. Prior to Veterans Choice, veterans were only covered for healthcare by the United States Department of Veterans Affairs (VA) treatment facilities and a limited number of providers who had contracts with a VA facility. Community health centers were one of just a few provider types, along with Indian Health Service facilities, specifically named in the statute as eligible to care for qualified participating veterans, indicating that Congress intended that health centers would play a central role in assisting the VA to successfully implement the VCP.[1] The National Association of Community Health Centers (NACHC) has been at the forefront of developing strategies and establishing relationships to help increase participation in the VCP, and allow veterans to access care in their own communities. About one-third of veterans in the VA system now see outside doctors through the Veteran's Choice Program.[2] In 2017, CHCs served 355,648 veterans, an increase of 15 percent in the number served since 2015.

We reached out to Dick Bohrer, Network Relations Consultant at NACHC, and to a few of our CHC colleagues, to learn more about how they are serving veterans and why CHCs are an important and necessary resource for this population.

Mr. Bohrer explained that health centers are essential because they can provide resources that supplement those of the VA, commenting: "We are not competing to serve people, we are working together to get people the services that they need." While the VA has an expansive system, there are areas where the VA has limited service capacity and this is where health centers can fill the gaps. For example, more than a quarter of all veterans live in rural areas, some distance from VA services, and with 44% of all health center sites in rural locations, they are well positioned to meet the needs of veterans with limited access to VA resources.[3] Bohrer emphasized that CHCs can also be important in addressing specific needs, such as behavioral health, saying, "The veteran providers hit it out of the park– they have had so much experience dealing with PTSD, and they have some tremendous resources in that area; however, the demand and need for behavioral health exceeds [beyond] the capacity of the VA."

Zufall Health (Dover, NJ)

Zufall Health serves a primarily urban population in Northern New Jersey. Zufall started as a once-a-week clinic in 1990 and today provides services at eight different locations and operates two clinical vans. In 2017, Zufall served 36,603 patients from six different counties in New Jersey. Health center staff realized several years ago that there was almost no dental care available for the community's veterans. This gap exists because most veterans only qualify for VA dental benefits if their dental condition is service-related. Zufall's President and CEO Eva Turbiner explained that initially, Zufall set up a medical van that they took to the local VA Community-Based Outpatient Clinic (CBOC). Veterans could receive some limited dental treatment from the van and go to the health center's brick and mortar clinic if they needed additional care. As the need for services grew, the health center obtained a fully-equipped dental van that could provide more comprehensive services. Today, the Zufall dental van goes to many locations, including soup kitchens and shelters, Stand Down, and The American Legion, where they can reach low-income veterans.

Most recently, Zufall partnered with generous corporate sponsors to bring a weekend of free dental care to almost 200 veterans and their families. Dentists from all over New Jersey generously donated their time and labor. In addition to oral health services, Zufall also provided free breakfast and lunch as well as other medical services over the two days. Volunteers from across New Jersey

1 "Veterans Health," National Association of Community Health Centers, accessed August 9, 2021, https://www.nachc.org/focus-areas/policy-matters/emerging-issues/veterans-health/

2 Richard E. Rieselbach, Ted Epperly, Greg Nycz, and Peter Shin, "Community Health Centers Could Provide Better Outsourced Primary Care for Veterans," Journal of General Internal Medicine, 2018, https://doi.org/10.1007/s11606-018-4691-4

3 IBID.

Mobile dental van at Zufall Health Center (Dover, NJ).

assisted with providing services. Zufall currently has a permanent part-time veterans' outreach position, to help reach veterans who don't realize that they might qualify for services at Zufall. As Turbiner explained, "The difference with having a community health center being the sponsor is that if something goes wrong with the denture, if the cavity comes loose, if they develop a second cavity, they can come back to the health center. This is not a one-time charity event. The next day we are still here and that is critical to the ongoing health and wellness of these veterans." Another benefit to providing outreach and care is that veterans are also able to bring their families to the health center.

Turbiner acknowledged that there have been challenges. For example, she remarked, "Where we run into difficulty is that many of these folks come in not just for cleaning and cavities, but with a huge need for dentures. These are people who have not had dental care for a number of years and providing free dentures is difficult. We try to make them as affordable as possible." Many veterans are also older, which increases the need for dentures. The health center has been successful in identifying some foundation support to help make these services accessible.

Commenting on future opportunities, Turbiner said, "We are aware that certain women's health services are also lacking and there is a gap at the VA. We are examining where the gaps are in women's health. We are currently focusing on oral health, but woman's health is probably the next thing we're going to look at." Overall, Turbiner says that, "One of the things that we have found is that there is tremendous community support for veterans."

Family Health Center of Marshfield, Inc. (Marshfield, Wisconsin)

Family Health Center (FHC) of Marshfield, Inc. is located in rural Wisconsin and first opened its doors on March 1, 1974. It was the product of a unique partnership with Marshfield Clinic, a multispecialty group practice, and the Greater Marshfield Community Health Plan, an HMO.[4] FHC serves patients at 32 clinic sites in 13 northwestern Wisconsin counties.[5] In 2017, FHC served 89,686 patients; about 60% of the services that year were for dental care. Family Health Center opened its first dental clinic in 2002, after realizing that rural Wisconsin had a significant need for oral healthcare. In 2005, as they were opening their second dental center, FHC learned from the County Veterans Service Officers (CVSOs) that access to oral health care was one of the most challenging health issues that veterans, particularly those of low income, faced.[6] Today, FHC operates 10 dental centers throughout northwestern Wisconsin and works with the community to provide both dental and medical care to veterans.

Nicole Larson, Family Health Center's director of Business Development said: "They served our country and we want to take care of them, and we also want to take care of our community." At the invitation of the CVSOs, health center staff attended the county veterans' office annual conference in 2017 and were invited back in 2018. According to Larson, attending the yearly conference opened many doors. Staff were able to meet directly with veterans' officers, who in turn relayed comprehensive information to the veteran community. She explained that "oftentimes when we speak specifically to veterans there is not a full understanding of what benefits are available to them, or a misunderstanding of what's available to them. Through the partnership with the CVSOs and other agencies, we are able to break down that barrier a bit. We want to see what we can do to meet their needs." FHC has also collaborated directly with the VA to assist veterans, take referrals and fill gaps in care.

Today, Family Health Center is primarily focused on growing relationships within the community. Larson attributes the success of their program to the "deep roots in the community that we serve. We don't build locations just to build; we build based on the needs of the community."

Yakima Neighborhood Health Services (Yakima, Washington)

Yakima Neighborhood Health Services' (YNHS) first clinic opened in downtown Yakima in May 1975 and today, YNHS has medical and dental clinics in Yakima, Sunnyside, and Granger, serving both urban and rural communities. In 2017, YNHS served 22,784 patients. Rhonda Hauff is the health center's Chief

4 Kelly Engstrom, "Serving the Oral Health Needs of Our Nation's Military Heroes," Community Health Forum, National Association of Community Health Centers, Community Health Forum®, Winter 2018, accessed October 20, 2018, https://www.nachc.org/wp-content/uploads/2018/02/Serving-the-Oral-Health-Needs-of-Our-Nations-Military-Heroes.pdf
5 IBID.
6 IBID.

Operating Officer; she explained how the health center has engaged with veterans over many years. YNHS participates in Stand Down, a national grassroots community-based intervention program designed to help the nation's homeless veterans by offering a variety of free and low-cost resources. While Yakima provides a wide variety of general medical services, Hauff noted that they try to highlight their behavioral health services to veterans, "In our CHC setting, our number-one behavioral issue is PTSD and that hurts veterans and other clients alike. Services for PTSD are so well integrated into our primary care program that patients don't have to worry about being stereotyped." Hauff mentioned that it's essential that health center staff are familiar with what's available in the community so that they can both refer veterans for care, and identify gaps and needs.

YNHS has worked with the Yakima Housing Authority (YHA) for many years and has recently embarked on an exciting new venture that it hopes will provide outreach and more services to veterans. The YHA has acquired armory property specifically to provide 41 units of supportive housing for homeless veterans and their families. An additional 12,000 square feet will be dedicated for social services that target homeless veterans. Through this partnership, YNHS will be able to provide medical, dental, and behavioral services onsite at the armory, providing care for both veterans that live there, as well as other veterans in the community who need medical services.

Zufall Health, Family Health Center of Marshfield and Yakima Neighborhood Health Services each serve a diverse and local population, and they share a commitment to serving those who have served. All have found unique ways to engage with and provide the resources that the veterans in their area need.

The new VA Maintaining Systems and Strengthening Integrated Outside Networks Act, or "VA Mission Act" signed into law on June 6, 2018, is intended to expand on the Veteran's Choice program, and establishes the Veteran's Community Care Program to provide community-based services. What exactly that will look like in practice remains uncertain – especially because of the possibility of funding shortfalls – but Bohrer commented that, "Given the Mission Act and the direction that the VA is headed in, health centers are going to need to be in direct communication with the veteran treatment facility that is closest to them. At a minimum, people need to find out where that office is in that VA facility and who the people are, and what they need to begin that journey." Health centers that want to get more involved in serving veterans can reach out to the VA, dedicated service organizations in their area, and access the resources that are available online including resources from the VA and those available through NACHC. An informal Veterans Health interest group convened by NACHC meets periodically.

- Irene Bruce (2018)

Header Photo: Courtesy of Zufall Health (Dover, NJ).

Community Healh Centers Respond to the Zika Crisis in Puerto Rico

In August 2016, the U.S. Department of Health and Human Services (HHS) declared the Zika outbreak in Puerto Rico a public health emergency. There is much that experts don't yet understand about Zika, but scientists do know that it is transmitted primarily through the bite of infected mosquitoes and can also be sexually transmitted. While most infected individuals are asymptomatic or exhibit only mild symptoms such as fever, rash or joint pain, the virus can have dire consequences and poses a particular risk for unborn children of infected mothers. Zika infection during pregnancy has been linked to birth defects including congenital brain abnormalities and severe microcephaly. The emergency declaration recognizes that Zika has found a stronghold in Puerto Rico, where the tropical climate presents ideal conditions for mosquitoes to spread the virus. As of September 23rd, there were 22,348 laboratory-confirmed Zika cases in Puerto Rico,[1] and the Puerto Rico Department of Health had reported 1,871 cases in pregnant women by late September.[2] The CDC estimates the actual number of people infected is much higher and CDC Director Dr. Thomas Frieden has estimated that 25% of the island's population could be infected in the first year.[3]

Occurring in the midst of Puerto Rico's unprecedented economic crisis, Zika has put further strain on an already overburdened healthcare system, creating a perfect storm for an explosive healthcare emergency.

1 "Informe Semanal de Enfermedades Arbovirales (ArboV)," Departmento De Salud Gobierno de Puerto Rico, September 23, 2016, goo.gl/djmDkS.
2 IBID.
3 Lena Sun, "Zika Is Spreading Explosively in Puerto Rico, Report Says," The Washington Post, July 29, 2016, https://www.washingtonpost.com/news/to-your-health/wp/2016/07/29/zika-is-spreading-explosively-in-puerto-rico-report-says/?variant=116ae929826d1fd3.

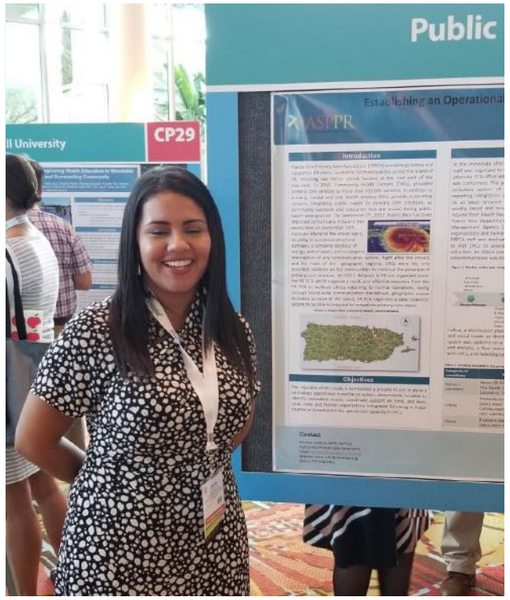
Puerto Rico's community health centers, which together operate more than 80 sites and served nearly 350,000 people in 2015, have been squarely on the front lines of responding to the Zika outbreak. Like their mainland counterparts, Puerto' Rico's health centers provide a medical home for the island's vulnerable populations. Yet they face extraordinary challenges resulting from the island's extreme poverty, high need and a general deterioration of the economy. A recent report from the Geiger Gibson /RCHN Community Health Foundation Research Collaborative found that nearly 1 person in 10 in PR depends on community health centers for their care. More than 75 percent of those served by Puerto Rico's health centers are covered through public health benefits such as Medicare and Medicaid, but at reimbursement rates far lower than those stateside, and 12 percent remain uninsured; furthermore, there are no tax subsidies for private coverage.[4] In addition, a mass exodus of health professionals over the last several years has resulted in severe shortages and put a growing strain on hospitals, health centers and other providers.

Already recognized as high-performing primary care providers for all underserved people generally, Puerto Rico's CHC's serve many uniquely vulnerable populations including agricultural workers, public housing residents and homeless individuals most at risk for Zika infection and its serious complications. Social determinants of health such as poverty, educational opportunity, and substandard housing have a significant impact on overall population health. Those who live in substandard housing typically don't have air-conditioning or even window screens. Poorer neighborhoods and the island's many rural communities lack adequate trash collection, and mosquitoes flourish in the tropical climate. In addition, a recent article in the Washington Post indicates that an estimated 65 percent of pregnancies are unplanned.[5]

CHCs have stepped up as the first responders in the fight against Zika. Health centers are working in coordination with other agencies to prevent the spread of Zika through direct outreach to educate the public about the dangers of Zika and to connect people with testing, screening, family planning services, contraception and treatment. Asociación de Salud Primaria de Puerto Rico (ASPPR), the Primary Care Association representing the Island's health centers, is working with the Puerto Rico Health Department to develop a strategic plan that is responsive to the continuing threat. Moreover, ASPPR is coordinating with CHCs to help track infection rates in each of the municipalities and disseminate information and resources. The association has developed training programs to help outreach workers and clinicians effectively inform community members about the dangers of the virus and the importance of precautionary measures. Their strategy will include a school-based campaign to educate children about Zika and how to prevent infection. One creative program is a traveling puppet show, where children learn about Zika in a fun and engaging way and can then go home and teach their family members about the virus. Further grassroots campaigns will be initiated and are intended to reach those who may be otherwise resistant to information or difficult to access through traditional networks. ASPPR has also facilitated donations of condoms, mosquito repellent, mosquito nets and larvicides for community-wide distribution.

In recognition of the significant threat posed by the virus, and the essential role of the island's CHCs, HHS in April 2016 allocated 5 million dollars to the Commonwealth's 20 community health centers to fight the spread of Zika. The emergency declaration issued in August underscores the public health threat and will allow the government to direct additional resources to combatting the disease. Still, a bill providing $1.1 billion in Zika funding nationally was deadlocked in Congress for months; while approved in late September, the delays had a cost for both services and research. And CHCs on the ground report that they have encountered substantial challenges in their efforts to provide information and stop spread of the virus.

One such challenge is the rural nature of the island, making it difficult to effectively reach some communities. In addition, many people are dealing with other immediate concerns. The economy is bad, the crime rate is high, wages are low and unemployment rates are rising; these problems all weigh heavily on public morale. Furthermore, Puerto Rico had already suffered through outbreaks of Dengue fever and Chikungunya, both mosquito-borne illnesses, before Zika emerged. Because these diseases are so widespread, some view new viruses as merely an unavoidable consequence of life on a tropical island and misjudge the severity of the Zika threat. To combat these challenges, the first order of business is finding ways to provide meaningful information and education, and Puerto Rico's network of CHCs is launching a creative and aggressive public education campaign, focused on convincing people to take special precautions such as spraying mosquito repellent, wearing protective clothing, and taking measures to prevent pregnancy.



Darielys Cordero, Director of Special Programs, Asociación de Salud Primaria de Puerto Rico (ASPPR).

Puerto Rico will not know Zika's true impact for years to come. As the numbers of infected people continue to rise, Puerto Rico is struggling to track and respond to the growing epidemic. Meanwhile, community health centers continue to provide essential public health outreach and serve as the backbone for the delivery of high-quality, comprehensive primary care and preventive services. Yet they are underfunded and operate in an environment of extraordinary fiscal uncertainty and scarcity. To combat Zika, and avert future public health threats, the special role of health centers must be not merely recognized, but continuously supported through appropriate funding and reimbursement.

- Nicole Rodriguez-Robbins (2016)

Header photo: ASPPR Executive Director Alicia Suárez and HealthProMed Medical Director Dr. Héctor Villanueva are interviewed for ¡Viva la tarde! WAPA-TV. Courtesy of ASPPR (San Juan, PR).

4 Peter Shin et al., "Puerto Rico's Community Health Centers in a Time of Crisis," The Geiger Gibson/RCHN Community Health Foundation Research Collaborative, December 2015, https://www.rchnfoundation.org/wp-content/uploads/2015/12/Geiger-Gibson-Brief-43.pdf
5 Kristyn Brandi, "We Know How to Fight Zika in Puerto Rico, But We Aren't Giving Women the Tools to do It," The Washington Post, August 22, 2016, https://www.washingtonpost.com/posteverything/wp/2016/08/22/we-know-how-to-fight-zika-in-puerto-rico-but-we-arent-giving-women-the-tools-to-do-it/.

Community Health Centers and the COVID-19 Vaccination Roll-out: A Close Look at Two Health Centers on the Front Lines

This time last year, sirens were a constant sound in New York City and elsewhere in the U.S. as the COVID-19 pandemic surged. While those who could stayed inside and worked from home, community health centers (CHCs) throughout the country did everything they could to keep their doors open and provide essential healthcare, in person or by pivoting rapidly to telehealth, and to add essential COVID-19 testing capacity. In January 2021 the news broke that vaccinations would soon be distributed, offering a way forward from a year marked with uncertainty. The promise of vaccinations led to new questions. How would the vaccine roll-out proceed? How could the vaccines be distributed equitably and who would ensure that underserved communities were reached? In March 2021, the Biden Administration announced that it was investing $10 billion to expand access to COVID-19 vaccines and build vaccine confidence in the hardest-hit and highest-risk communities. This investment included $6 billion to community health centers. To understand what the vaccine roll-out looked like on the ground and how community health centers were navigating this new pandemic-related challenge, I reached out to our colleagues at Callen-Lorde Community Health Center in New York City and Community Health Center, Inc. in Connecticut.

Callen-Lorde Community Health Center, NY

Callen-Lorde Community Health Center was created specifically to serve LGBTQ+ communities and traces its roots to the Stonewall era in the late 1960s. The health center has since grown into a network of primary care centers across New York City, with locations in Manhattan, Brooklyn and the South Bronx. Each site offers a wide variety of services, including comprehensive primary care, on-site pharmacies, behavioral health services, women's health, transgender health and medical case management support, and access to dental care.

I spoke with Dr. Peter Meacher, Callen-Lorde's Chief Medical Officer, who underscored the importance of the health center's relationship with its community in the vaccine effort. Callen-Lorde is focusing on vaccinating those patients who are less likely to find vaccination appointments on their own and who might otherwise fall through the cracks. The health center is administering vaccinations at all three of its sites and has focused its efforts on those patients who are most likely to get very sick if they get COVID-19, those who are at risk because of age, race and ethnicity, and transgender/ non-binary persons. "We have connections to the communities we serve that are unique and very often are the only connection individuals have with the health system," said Dr. Meacher. "Trust around the vaccine is a huge issue and trust is something that is often unique between the patient and the federally qualified health center in a way that the patient might not trust so many other aspects of the health system."

Dr. Meacher explained the health center's strategy as carefully nuanced to prioritize medical issues, but also address social determinants of health, noting, "We went from thinking we would vaccinate every patient to realizing that actually our job is to focus on the people who are not going to go to mass vaccination sites. Those are the people where FQHCs have an advantage with and a responsibility (to) because of the trust and relationship that exists between these patients and medical staff at FQHCs." Dr. Meacher emphasized that some of Callen-Lorde's patients might feel uncomfortable going to a mass vaccination site for a variety of reasons, "whether it's the technological divide—TurboVax and Dr. B require a tech competency and access to tech that is beyond the reach of many people—or because they are transgender and have had terrible past experiences in our health system, we want to make sure we are reaching out to and getting them vaccinated at Callen-Lorde." TurboVax, a free tool developed by N.Y.C.-based software engineer Huge Ma as a public service, compiles the available vaccine appointments from the three main city and state vaccine systems and provides near real-time availability on Twitter. Dr. B, founded by former ZocDoc CEO Cyrus Massoumi, alerts people who are willing and able to travel within the city on short notice to available stand-by vaccine appointments.

Dr. Meacher explained that while the health center no longer experiences significant supply challenges, the uncertainly around vaccine supply can make planning difficult. Callen-Lorde was selected to participate in the Health Center COVID-19 Vaccine Program, which has since been extended to invite all funded and look-alike community health centers. The health center has offered the Moderna vaccine. The two-dose vaccinations are an extra challenge for some patients, whose life circumstances and other health conditions may make it hard for them to return for a second dose. When we spoke, Dr. Meacher was waiting to find out if Callen-Lorde had been approved to distribute the single-dose Johnson & Johnson vaccine. Earlier this month, administration of the Johnson & Johnson vaccine was temporarily paused by the Food and Drug Administration (FDA) and the CDC because of a potential link between the vaccine and serious blood clots. The CDC and FDA have since lifted the pause, allowing use of the Johnson & Johnson

vaccine to resume without restrictions, noting that "women younger than 50 years old should be aware" that there is a rare but increased risk of this adverse event.[1] It is still unclear how this temporary pause will affect the supply and future distribution of the Johnson & Johnson vaccine. However, if available, the single-dose Johnson & Johnson vaccine could be especially important for the health center's patients, removing the obstacle of requiring that patients return for a second appointment.

The health center is pressing on, trying to get doses to as many people as possible. He stressed that it's important to help people understand that feeling unwell after being vaccinated is a normal response and just means the vaccination is working like it's supposed to. One positive Dr. Meacher noticed was that over the past few months, patients who had initially rejected the vaccine were changing their mind. "Some people just need a little time and as people see their friends, families and colleagues get vaccinated and not get sick, they are becoming more open to it."

Community Health Center, Inc., CT

Community Health Center, Inc. (CHC, Inc.), started by activists in a Middletown, CT apartment in 1972, now provides medical, dental, and behavioral health services at 16 fixed sites to meet the needs of the entire community, including the uninsured, underinsured and vulnerable populations.

Mark Masselli, the health center's founder and Chief Executive Officer, spoke with me about Community Health Center Inc.'s vaccine roll-out, and the challenges and successes of its testing and vaccine campaign amidst an unprecedented public health crisis.

Mr. Masselli has worked closely with the state of Connecticut, including the Governor's office and Department of Public Health, from the earliest days of the pandemic. Prior to the vaccine roll-out, CHC, Inc. was already the largest tester in its state and has tested more than 600,000 residents for COVID-19. CHC, Inc. is currently running four mass vaccination sites in East Hartford, Danbury, Middletown and Stamford, in addition to providing vaccinations at its health center locations. These mass vaccination sites were opened at the request of the Governor's office. CHC, Inc. was one of the first health centers tapped as part of the Biden administration's Health Center COVID-19 Vaccine Program, and the health center has had good access to vaccine supplies.

On the grounds of a former airfield in East Hartford, the health center runs the state's largest mass vaccination site, with the capacity to administer up to 5,000 vaccinations a day: "Everyone is doing what they can; someone who is 25 remarked that they had just vaccinated someone who was 105 years old, forging a connection between generations that I think is very important."

CHC, Inc. also provides vaccinations in congregate settings like homeless and domestic violence shelters and Masselli spoke of the importance of providing care to farmworkers who are in smaller isolated areas that make them more difficult to reach. Mobile clinics are utilized daily to reach those living in underserved communities. To date, the health center has provided approximately 400,000 vaccines across the state of Connecticut.

Adding the many resources needed for testing and vaccinations has brought challenges along with rewards. CHC, Inc. has continued to provide primary care for its community members to meet their ongoing health care needs. With vaccinations and COVID-19 tests come more patients seeking care. In less than a year, CHC, Inc. has seen more than 300,000 individuals new to the Health Center for COVID-19 testing. Masselli remarked, "Welcome to the world of community health centers, with the smallest amount you need to do the most. That's true of CHCs around the country, with small resources prior to the pandemic, during the pandemic, and after the pandemic we don't really have the resources to accomplish everything we want to. We have to really think about how we can do as much as our population needs us to do." Masselli was thoughtful about the health center's responsibility to not only add service capacity, but to reach those most vulnerable to infection and illness, and to "make sure that the population we care for is included in the strategies of our state and other states across the nation. Black and Brown and Indigenous populations need to be prioritized. The rates of hospitalizations and death have been higher for Black and Hispanic populations and a strategy needs to be determined to prioritize them."

Masselli also noted that it was important to acknowledge the responsibility to patients who are hesitant about taking the vaccine, and whose concerns may reflect a lack of trust and confidence in the medical system. "We need influencers from the communities that we care for who will talk with someone who might be hesitant." Worries about the new variants persist, but Masselli ended on a hopeful note, remarking that, "There is a joy and excitement in both those who are giving it and those that are receiving and that is a whole different experience than the testing site. This is about getting a cure. We've lost the joy in healthcare and we need to find it again. Giving vaccines can bring joy back to healthcare."

As of May 3, 2021, the death toll from COVID-19 has exceeded 51,800 people in New York state, including more than 32,600 in New York City, and 8,097 have died in Connecticut. COVID-19 has disproportionately affected Black and Hispanic communities. These inequities are mirrored in New York City's COVID-19 vaccination rates, with recent data indicating that 44 percent of white adults have received at least one dose of the vaccine while only 26 percent of Black adults and 31 percent of Latino adults have received their first dose. Similar discrepancies exist in Connecticut where as of March 22, 2021, 37 percent of white residents had received at least one dose, in comparison to 20 percent of Black residents and just under 17 percent of Hispanic residents. As much as vaccinations offer hope and a glimpse of a pandemic-free future, it's important that we continue to invest in community health centers to ensure that vaccines and essential services are accessible to the hardest-hit communities.

- Irene Bruce (2021)

Header photo: Mass COVID-19 vaccination site, East Hartford, CT (2021). Courtesy of Community Health Center, Inc. (Middletown, CT).

1 "CDC recommends use of Johnson & Johnson's Janssen Covid-19 Vaccine Resume," CDC, April 25, 2021, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/JJUpdate.html.

Community Health Workers in the Community Health Center Setting

This is the second essay in a two-part series. Part 1, 'Profiles – Community Health Workers in the Community Health Center Setting' can be accessed here.

Community health workers (CHWs) are an integral part of the health care landscape. CHWs vary broadly in title, role and scope of work. Known by various names – Promotoras, Community Lay Worker, Community Health Liaison, and many more – the American Public Health Association defines CHWs as "frontline public health workers who are trusted members of, and/or have an unusually close understanding of, the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[1]

Whether strengthening ties through community outreach, providing clinical support as members of the primary care team, or serving one of many roles within or outside their organizations, CHWs are an invaluable bridge between communities and local health infrastructure. Embedded in the very communities they serve, CHWs have a lived understanding of their communities, and their unique cultural and social characteristics. Such insights into the specific issues and needs of the local populace are crucial to the success of community healthcare teams.

CHWs may serve in any number of different roles, including as counselors, helping low-income and underserved patients overcome the barriers that prevent them from seeking vital healthcare; as health educators, providing vital education about preventive health as well as available healthcare options; and as health monitors, supporting the care and treatment of patients living with chronic illness so that they can live healthier and longer lives.[2]

Though CHWs and CHW programs are well established as essential workforce in some organizations and health centers, the role of CHWs in health centers is still not widely understood or accepted, and uncertainty persists. "There's still a profound misunderstanding of who CHWs are inside of community health centers (CHCs)." explained Seth Doyle, Director of Strategic Initiatives at the Northwest Regional Primary Care Association (NWRPCA). "I think what really needs to happen is an understanding of how the services that CHWs can provide or do provide is complementary to all of the different services that health centers are providing… they are not meant to take the place of any existing workforce, they're really meant to enhance what the full workforce of community health centers are intending to do."

Mr. Doyle contends that it really comes down to trust and, "the ability that CHWs have to gain access to communities who may not have a lot of trust in the health care system who, for whatever reason, are alienated from that system. So a CHW who is able to be that bridge, is really vital."

Community health workers provide the community with greater access to the health care system, assisting in mitigating and overcoming barriers to care, especially in hard-to-reach populations. Mr. Doyle, whose organization provides services to CHCs in Region X, encompassing the states of Alaska, Idaho, Oregon, and Washington explained, "I think it would be important to note – specifically around Region X, but also likely true for other grantees around the country – that we tend to see a stronger representation of CHWs in the special populations health centers, among migrant health grantees and health care for the homeless grantees in particular." The community health center model has long recognized the needs of special populations within their communities, Mr. Doyle went onto say that "health centers overall, and [with] some of the special populations health centers - in particular, migrant health and health care for the homeless - have for decades really engaged CHWs as an essential workforce for them to be able to carry out their missions." For example, CHWs working with homeless populations may recognize the complex needs of people experiencing homelessness and provide trauma-informed care and outreach. They build trust through their own lived experience, community ties, and engagement, forging a bridge to care and services.

The bridging is also essential to address the particular needs of immigrant communities, where cultural perspectives on health and health care, language, and even policy create complex dynamics. For example, the public charge rule, whose implementation has been blocked by temporary injunctions, has created a lot of fear, anxiety and confusion in immigrant communities. CHWs may be a trusted source of information and guidance. Mr. Doyle emphasized that CHWs are often part of an immigrant community themselves or may be impacted in a way

1 "Community Health Workers," American Public Health Association, accessed September 1, 2019, https://www.apha.org/apha-communities/member-sections/community-health-workers.

2 "Who Are Community Health Workers and What Do They Do?," Unite for Site, accessed September 1, 2019, http://www.uniteforsight.org/health-workers-course/module1.

other health center staff are not. “The combination of the lived experience, I think, adds to the trust community members have in CHWs. I think that’s an important issue and with regard to immigration, having CHWs, outreach workers, or promotoras in the community helping separate myth from fact and educate community members is key.”

Deeply invested in serving their diverse urban, rural, special and at-risk populations, CHWs are embedded in many health centers, and play a pivotal role, yet more work is needed to highlight their value. Mr. Doyle further suggests, it is necessary to “understand[ing] the range of roles that CHWs can play and how to best leverage that to enhance the organization overall.” By investing in CHWs, health centers can overcome barriers to care and help improve the health of those they serve.

- Nela Abey (2019)

Header photo: Participants of Mariposa CHC’s ‘Comer Bien’ (Eat Well) program take part in an exercise demonstration. Courtesy of Mariposa Community Health Center (Nogales, AZ).

(Above and below) SJWCFC Community Health Worker Silvia (R) conducting home visits (Los Angeles, CA).

Mariposa Community Health Center and RCHN CHF staff alongside FVRx program collaborators from Villas Market, (Nogales, AZ).

Cutting-Edge Technology and Good, Old Fashioned Caring in Rural Upstate New York

Finger Lakes Community Health serves over 17,000 patients in upstate New York. Established in 1989 as a Migrant Health Clinic, it became designated as a Federally Qualified Health Center (FQHC) in 2009 and has experienced tremendous growth as an organization in a few short years. Finger Lakes currently operates sites in Penn Yan, Port Byron, Bath, Dundee, Keuka, Sodus and Geneva, N.Y. and is in the process of opening three new locations in King Ferry, Ovid, and Newark. As Finger Lakes has grown as an organization, it has learned how to adapt to the unique challenges associated with treating a diverse patient population in a rural setting.

On a snowy February day, I visited the Center’s Geneva site. The road to the Geneva clinic is dominated by a flat, open landscape and crosses the Montezuma Wildlife Refuge before passing a collection of small farms, many of them run by the Mennonite and Amish communities. The clinic is located in a non-descript strip mall building that is easily overlooked. The facility is small and somewhat cramped but manages to incorporate primary care, dental health and behavioral health services under one roof. For the population surrounding Geneva, a mix of migrant seasonal workers, Amish and Mennonite families, and others who earn their living primarily from farming, Finger Lakes is their only access point to health care. Mary Zelazny, CEO at Finger Lakes, explained that while several private providers practice in the area, most are unwilling to accept patients who are covered by Medicaid or Medicare, or are uninsured. These providers are also often both unwilling and unequipped to treat migrant patients, who have specific linguistic and cultural needs.

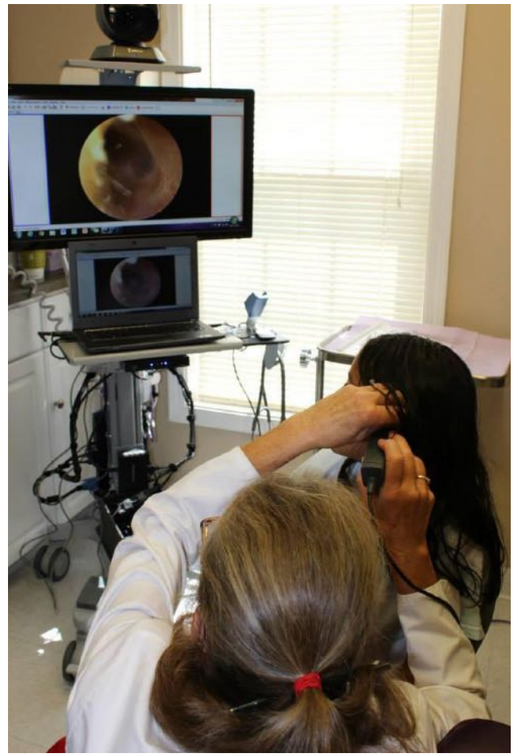
Finger Lakes opened the Geneva site

after the local Planned Parenthood clinic closed its doors several years ago. Since opening, the Center's patient numbers have doubled. They are currently in the process of expanding into the next-door offices, where they plan to open a pharmacy and add additional examination rooms to accommodate more patients. During my tour of the clinic, Zelazny showed me their state of the art "Telehealth" program, which is used for communicating remotely with providers at different sites and to specialists in other parts of the state. There is very limited public transportation in the Finger Lakes region and driving long distances between sites can be particularly challenging during the winter months. An invaluable piece of equipment at Finger Lakes is "Ruby," a robot equipped with video monitoring capabilities and a joystick so it can be moved remotely throughout the clinic as needed. Ruby allows providers to treat patients at different sites and can also be used for language interpretation when a bilingual staff person is not available at a certain location. With this technology, providers can connect those patients who often live in isolated rural areas with off-site specialists, without making them travel prohibitive distances. Patients can receive retinopathy screenings as part of management of diabetes, as well as dental consults and behavioral health treatment. Zelazny explained that the trauma and isolation of immigration and the effects of separation from their families and communities put migrant patients at high risk for depression and other mental illness. There is a large need for behavioral health clinicians who are often hard to come by in rural areas. The telehealth technology has given clinicians and social workers the ability to connect patients to mental health providers through online video conferencing. Case workers and clinicians who have the linguistic and cultural competency to diagnose behavioral health-related conditions are then able to make a direct connection between a patient and mental health provider. This technology also affords patients a sense of anonymity by giving them access to providers who are outside of their tight-knit community where cultural taboos around mental health treatment might prevent them from seeking treatment.

Despite a surrounding community and political climate that is overwhelmingly anti-immigrant and largely hostile, and the legal limitations of caring for an undocumented population, Finger Lakes is dedicated to serving the migrant community with the best possible care. The center has built trusting relationships with the migrant population over the years through concerted outreach efforts and linguistically and culturally appropriate care. The staff has a clear understanding of the health hazards associated with agricultural work and the daily risk migrants face. They have employed creative solutions to meet the unique challenges of treating an uninsured, transient and unstable population. Through use of cutting-edge technology as part of their telehealth program, and concerted outreach to the migrant camps, they are able to provide patients the necessary health care services and ensure they receive proper follow-up treatment.

The Affordable Care Act's principal aims are to achieve equity in the health care system, improve health outcomes, and lower health care costs. While the ACA doesn't expand coverage to undocumented immigrants, the state does have some degree of flexibility in determining eligibility for certain legal immigration statuses through the Health Benefit Exchanges. According to a new report from the New York Immigration Coalition and Empire Justice Center,[1] 2.1 million non-citizen immigrants currently reside in New York State. This includes 625,000 persons who are undocumented and as such, are barred under the ACA from any types of public benefits and ineligible to purchase directly coverage through the health insurance exchanges. This still leaves 1.4 million lawfully-residing immigrants in New York, and N.Y. State, which has historically offered a broad scope of benefits, has the opportunity to maximize coverage for these residents under the Exchange. Presently, New York provides Medicaid coverage to those immigrants classified as PRUCOL (Persons Residing Under Color of Law, or those in process of applying for asylum, status adjustment, or who have been granted a deferred action). The definition of PROCUL is more expansive than the ACA definition of "lawfully present" immigrants and continuing to extend coverage under the PRUCOL definition will ensure access for additional immigrants. Further, although DREAM Act youth are not eligible for coverage under the ACA, New York State also has opportunity to include this group by extending the PRUCOL definition. The New York Immigration Coalition recommends that the state review options for an insurance product for undocumented immigrants.

1 New York Immigration Coalition, "Maximizing Health Care Reform for New York's Immigrants," NYS Health Foundation, February 5, 2013, https://nyshealthfoundation.org/resource/maximizing-health-care-reform-for-new-yorks-immigrants/.



Telehealth ear exam at Finger Lakes Community Health (Penn Yan, NY).

"Through use of cutting-edge technology as part of their telehealth program, and concerted outreach to the migrant camps, they are able to provide patients the necessary health care services and ensure they receive proper follow-up treatment."

It is up to the state to form health care exchanges which can broaden the participation of immigrant populations. It is logical that giving all immigrants access to care, including preventive services, is for the public good and generates an overall cost savings for individuals and the state. While universal health care coverage and access is not yet a reality, community-based providers like Finger Lakes will continue serve the needs of disenfranchised immigrant patient populations in an effort to close the gap in health disparities.

- Nicole Rodriguez-Robbins (2013)

Header photo: Ovid Community Health Open House with Finger Lakes CEO Mary Zelazny (Penn Yan, NY)

Identifying and Responding to Human Trafficking – A Public Health and Health Center Challenge

Human trafficking is a global issue, as well a local one. Trafficking is, simply stated, a form of slavery, and it is a crime. Trafficking is complex; it entails "the exploitation of someone for the purpose of compelled labor or a commercial sex act through the use of force, fraud, or coercion."[1] Sex trafficking of youth under the age 18 is a crime regardless of whether there is any force, fraud, or coercion.[2] While there is no shared profile of victims, human trafficking most effects marginalized individuals in society - the poor, immigrants, and refugees, and those with unstable living situations.[3] Within the United States, victims of trafficking are disproportionately girls and women of color[4], and those who have been in contact with the child welfare system, have run away from home or foster homes or have aged out of the foster care system, and people who are experiencing homelessness.[5] Many victims are foreign nationals, who face unique challenges and language barriers. It is estimated that in the U.S. alone, the total number of human trafficking victims, including adults and minors, reaches into the hundreds of thousands.[6] From 2007-2017, 40,987 cases were reported to the National Human Trafficking Hotline, with 8,759 cases reported in 2017.[7]

Increasingly, trafficking is becoming a public health concern. As victims experience health problems, they may make their way to local providers. Community health centers, which by mission provide essential care to the uninsured, underserved, and to marginalized communities, are likely

1 "Human Trafficking," National Human Trafficking Hotline, Polaris, accessed September 10, 2018, https://humantraffickinghotline.org/type-trafficking/human-trafficking.
2 IBID.
3 "Building the Capacity of Community Health Centers to Address Human Trafficking," AAPCHO Policy Brief 2015, accessed September 10, 2018, http://www.aapcho.org/wp/wp-content/uploads/2015/10/AAPCHO-Human-Trafficking-Policy-Brief_103015.pdf.
4 Michelle Lillie, "Human Trafficking: Not All Black or White," Human Trafficking Search, accessed September 10, 2018, http://humantraffickingsearch.org/human-trafficking-not-all-black-or-white/
5 Liza Kane-Hartnett, "The Foster Care-Human Trafficking Nexus," Human Trafficking Search, January 16, 2018, accessed September 10, 2018, http://humantraffickingsearch.org/foster-care-and-human-trafficking-nexus/
6 "The Facts," Polaris, accessed September 10, 2018, https://polarisproject.org/human-trafficking/facts.
7 "Growing Awareness. Growing Impact:2017 Statistics from the National Human Trafficking Hotline and BeFree Textline.," Polaris, accessed September 10, 2018, https://polarisproject.org/wp-content/uploads/2019/09/2017NHTHStats-1.pdf

encountering trafficking victims daily, and are uniquely situated to identify, help and support them. As Dr. Kimberly Chang, family physician at Asian Health Services in Oakland, California, and a nationally-recognized clinician advocate, explained, it's not a question of if health centers are treating trafficked victims: "We are seeing these patients, period. We are taking care of these patients, period." To bring visibility to the issue, Dr. Chang helped found HEAL, Inc. a multidisciplinary group of professionals dedicated to ending human trafficking and supporting its survivors from a public health perspective.

"It's not a question of if health centers are treating trafficked victims: "We are seeing these patients, period. We are taking care of these patients, period."

Dr. Chang has worked in multiple capacities to heighten awareness of trafficking among healthcare providers. Together with Dr. A. Seiji Hayashi, she has co-authored "The Role of Community Health Centers in Addressing Human Trafficking" in Springer's volume, Human Trafficking Is a Public Health Issue [2017] We reached out to Dr. Chang and a few of our CHC colleagues to learn more about this difficult problem and how our colleagues are tackling it.

La Maestra Community Health Centers (San Diego, CA)

La Maestra Community Health Centers (La Maestra) is a nonprofit, 501(c) 3 Federally Qualified Health Center (FQHC).

Photo courtesy of La Maestra Community Health Center (San Diego, CA).

The organization is headquartered in City Heights, San Diego, just 16 miles from the U.S.-Mexico border. City Heights is a large resettlement area, therefore, the health center serves immigrants, refugees and people at heightened risk, including people who may have been misled by the promise of work and a visa in the U.S., and coerced into forced labor, sex work, smuggling or related activities.

Originating as an Amnesty Center, the organization began providing legal advocacy services in 1986 to underserved immigrants and refugees, including human trafficking survivors. In response to the needs of the community, in 1990, additional social services were offered at La Maestra's clinic. In 2006, La Maestra's CEO, Zara Marselian, was a member of a bilateral human trafficking taskforce comprised of the FBI, CIA, local law enforcement, and local community-based nonprofit organizations. As the only representative from the healthcare field, Mrs. Marselian recognized that human trafficking victims in the community needed subsidies to obtain healthcare services. Mrs. Marselian established and sponsored the "Maddalena Fund" to enable human trafficking survivors to obtain health care, counseling and additional social services free of

charge until their cases were processed by Homeland Security.

In 2011, La Maestra officially merged its legal advocacy and social services programs to form the Legal Advocacy and Social Services Department (LMLASS) specifically to provide education, assistance, and support to people who face rights violations and are survivors of crimes,[8] including trafficking. Carmen Kcomt is a legal advocate and the director of La Maestra's human trafficking program. Many of her clients are immigrants; they lack identifying documents and are often not eligible for benefits.

In an interview, Ms. Kcomt described La Maestra's Circle of Care TM services. She likes to call it a "flower of care" - where each department is a different petal of the flower. When a trafficked individual accesses services at La Maestra, they are connected to all of the services provided by La Maestra's Circle of CareTM. Services include medical, dental and behavioral health, public program application assistance, nutritious food and basic necessities assistance, and financial, social, legal, and wellbeing programs.[9]

La Maestra's staff members, many of whom are refugees or immigrants themselves, collectively speak more than 28 different languages and dialects and know first-hand the barriers that must be overcome in order to access health care, and the unique risks that their patients face. La Maestra's Medically Trained Cultural Liaisons provide translation services in-house to ensure that translations are both accurate and trustworthy. Translation is not left to a casual source or to the person accompanying the patient, because that individual may be the very one victimizing the person presenting for care. Recently, La Maestra has seen more transgender patients accessing services. Ms. Kcomt has noted that many current clients have been referred by friends or family who accessed services themselves, reflecting their comfort with and trust in the health center. The availability of culturally and linguistically appropriate services helps patients feel safe and empowers them to seek services. Ms. Kcomt advocates for people who face rights violations, and states, "Our main goal is to help."

Colorado Community Healthcare Network (Denver, CO)

In Denver CO, staff at the Colorado Community Health Network (CCHN) recognized the prevalence of trafficking in their community and have started to work on helping member health centers respond to this issue. CCHN has partnered with the Colorado Department of Public Health and Environment, the Department of Justice, and the Colorado Human Trafficking Council. CCHN was surprised to learn that these organizations were largely unfamiliar with community health centers and the valuable services and resources they might offer for trafficked victims and as community partners.

This past May, CCHN hosted a training program for CHC behavioral health, dental, medical, and operations directors. The purpose of the training was to provide an overview of trafficking, create awareness, and provide members with connections to community partners for broader and more intensive training. Dr. Kimberly Chang provided a keynote, highlighting the resources available to CHCs, and survivors of human trafficking also spoke about their experiences and shared resources,

8 Kimberly S.G. Chang and A. Seiji Hayashi, "The Role of Community Health Centers in Addressing Human Trafficking," in Human Trafficking Is a Public Health Issue, eds. Makini Chisolm-Straker and Hanni Stoklosa (Cham: Springer International Publishing AG, 2017), 356.
9 IBID, 357.

including an anonymous hotline that can be utilized by both victims and other concerned parties to report incidents.

Jessica Sanchez, the Vice President of Quality and Operations at Colorado Community Healthcare Network, told us that "Dr. Chang brought it to our attention that people come in for very regular visits... providers need to think more about why a patient is coming in multiple times for the same reason." For example, a patient coming in once with a STD isn't necessarily suspicious, but if they come in several times for the same STD that could be a sign that there is something going on. Dr. Chang explained that she wants providers to focus less on identifying victims with screening tools, and more on asking their patients basic questions. Creating a rapport with a patient is much more likely to lead to successful support. Here, a few extra questions can make a difference in a person's life. The training crystallized for the participants that many encountered and treated far more trafficking victims than they realized. Going forward, CCHN wants to help health centers make more connections with law enforcement, public health departments, and other partners. To that end, CCHN plans to maintain its partnership with the Human Trafficking taskforce and promote their trainings with Colorado CHCs.

"Dr. Chang brought it to our attention that people come in for very regular visits...providers need to think more about why a patient is coming in multiple times for the same reason."

Kokua Kalihi Valley Comprehensive Services (Honolulu, HI)

Kokua Kalihi Valley Comprehensive Services (KKV) has provided healthcare and social services to predominantly low-income Asian and Pacific Islander immigrant populations since 1972. Dr. Nicole Littenberg, a physician at KKV as well as a co-founder of HEAL Trafficking, told us that "Our patients face significant challenges, including Hawai'i's extremely high cost of housing and food and relatively low wages, which mean that many of our clients face overwhelming financial hurdles in establishing themselves. For the sex trafficked population, these financial pressures, combined with lack of stable social support, extensive histories of trauma, and drug dependency compound their recovery." At KKV, staff help patients receive the medical care that they need, and connect them with the Pacific Survivor Center (PSC), co-founded in 2007 by Dr. Littenberg. PSC was established to address the need for trauma-informed healthcare for victims of human rights abuses. Through a unique partnership with KKV, trafficked persons can receive primary care at KKV and additional subspecialty and ancillary services through PSC's extensive community-based Human Rights provider network (HRPN).

Dr. Littenberg recommended that health centers "identify champions within the health center who can connect with trafficking-specific-community-based resources." These champions can then create and forge partnerships with both non-governmental and governmental organizations to create a multidisciplinary program that helps victims access the full

> **“When nothing seems to help, I go and look at a stonecutter hammering away at his rock, perhaps a hundred times without as much as a crack showing in it. Yet at the hundred and first blow it will split in two, and I know it was not that last blow that did it, but all that had gone before.”**

can be a point of care and a point of action. At a recent panel at the 2018 NACHC Policy and Issues Forum, Dr. Chang quoted muckraker Jacob A. Riis: “When nothing seems to help, I go and look at a stonecutter hammering away at his rock, perhaps a hundred times without as much as a crack showing in it. Yet at the hundred and first blow it will split in two, and I know it was not that last blow that did it, but all that had gone before.” Working together, and in partnership with other health centers, PCAs, and public agencies, health centers can both elevate the issue and help provide a pathway for victims to become survivors.

- Irene Bruce (2018)

Header Image: RCHN Community Health Foundation (2018).

range of legal, social, and medical services that they need.

La Maestra, KKV and the CCHN’s member health centers serve different communities, but the people they serve have shared experiences, and the organizations themselves are examples of how health centers can be successfully involved in the fight against trafficking.

Collaborations are essential. Ms. Sanchez noted, “There is a hotline in each state - they will share resources to give to CHCs. There are experts in the state who are willing to travel to the CHCs to do staff trainings. NACHC has great resources on their website.” Also essential is the identification of funding to ensure the stability and continuity of effective programs and development of new resources.

Community health centers, which are deeply embedded in their neighborhoods,

Integrating Oral Health in Primary Care: Community Health Centers Take the Lead

While maintaining good oral health is essential to overall health, ensuring access to dental and oral health services has long been challenging in the U.S., especially in medically underserved communities with multiple barriers to care. Health care systems continue to grapple with meeting the gaps in care and integrating oral health care with general health services. Community health centers have heeded the call of the Office of the U.S. Surgeon General, “to change the perception of oral health as separate from medical health,”[1] and have played a key role in developing and implementing models that help integrate oral health and primary care.

In 2017, 81% of the nation’s community health centers offered dental care, and in all, provided 15.7 million dental visits, an increase of 70% since 2010.[2] Don Weaver, M.D., Senior Advisor, Clinical Workforce at the National Association of Community Health Centers (NACHC) explains that “health centers are people-centered health homes, and to care for the whole person, you have to include the integration of oral and behavioral health.” We visited with a few colleagues whose organizations are dedicated to doing just that.

Community Health Center of Franklin County, Inc. (Greenfield, MA)

The Community Health Center of Franklin County (CHCFC) opened in 1997 in Turners Falls, Massachusetts, and today has three sites. CHCFC began offering dental services in 2001. Providing accessible points of care and integrated services in the largely rural community is the foundation of the CHCFC approach. In addition to offering comprehensive

1 “Integration of Oral Health with Primary Care in Health Centers: Profiles of Five Innovative Models,” NACHC, accessed January 31, 2019, http://www.nachc.org/wp-content/uploads/2015/06/Integration-of-Oral-Health-with-Primary-Care-in-Health-Centers.pdf.
2 “Community Health Center Chartbook,” NACHC, accessed January 31, 2019, http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf.

oral health and urgent dental walk-in care at its two main dental clinic sites, the center provides services at its Urgent Dental Clinic located inside the Baystate Franklin Medical Center. Dental Director Dr. Allison van der Velden explained "we're in a rural area and we don't have a lot of public transportation. So transportation really is a big barrier for people." CHCFC recently relocated a medical and separate dental practice to a combined site in downtown Greenfield, located on an accessible bus route; CHCFC expects that this will make it much easier for people to make – and keep – their appointments.

A mobile, school-based dental hygiene program currently serves 19 schools and locations in the surrounding communities. This program offers essential early intervention, including cleaning, sealants, and fluoride applications to the area's children. Recently, through a partnership with the Connecticut River Valley Farmworker Health Program, the health center began offering medical visits to agricultural workers and their families. Dr. Van der Velden hopes that dental visits will follow suit: "We're really excited about that. It's not that people don't want to finish their treatment plans, but often they don't have the resources or time to come back."

Community partnerships, and an emphasis on understanding the needs of each patient, drive the practice. "I can fix the holes in your teeth, but if we don't change something about the environment or find some way to decrease your risk for new cavities, then you'll just be back. I want my patients to be caring for their teeth and I'm here to help them find the best and most effective strategies."

Piedmont Health (Carrboro, NC) and North Carolina Community Health Center Association

Founded in 1970 as the Orange-Chatham Comprehensive Health Services, Piedmont Health was established by the University of North Carolina at Chapel Hill Division of Health Affairs and a local Community Action Plan to provide comprehensive healthcare services and education to all members of the community, and address gaps in access. Today, Piedmont Health operates 8 sites in 14 counties, and dental care is now offered at five sites, including a recently renovated site in Carrboro, and an expanded practice in Burlington. Comprehensive dental care is available to infants, children and adults of all ages. The Baby Oral Health Program (BOHP) serves infants through age 3. Through early detection and treatment including dental sealants, the health center helps children prevent and avoid tooth decay and dental problems later in life.

Lauria Davis, the health center's Dental clinic manager and dental hygienist, stressed the relationship between oral health and general health and well-being. Good oral health needs to start early, and is essential at every age. That's why the health center emphasizes close communication between the medical and dental teams, and interdepartmental referrals. "As an organization, we work together and collaborate well together," said Davis. "It makes me happy to be an employee working together with our medical and WIC departments." Through community events like Give Kids a Smile the health center provides free dental screenings, exams and cleanings to children who do not have insurance.

Piedmont Health is committed to filling gaps in care and ensuring that each patient's medical home includes the dental services needed for optimal health. Like other centers in the state, Piedmont's efforts are supported by the work of the state's primary care association, North Carolina Community Health Center Association. Marti Wolf, RN, MPH, the Association's clinical programs director, described their work to support the health centers that want to open or expand dental services. Ms. Wolf explained, "We're trying to show how all these different pieces integrate and the impact of oral health on the body. We want to make sure that people understand that you're not going to have good diabetes control if your patients have rampant oral health issues." A quarterly dental directors' work group provides opportunities for colleagues to meet with dental directors' and learn from existing programs.

Providing comprehensive care takes trained, competent, dedicated professionals. Across the country, CHC dental care is provided by nearly 18,000 full-time equivalent staff, including Dental Hygienists (14%), Dentists (27%), and Dental Assistants, Aides, and Techs (59%)[3] – but expanding care will require more trained professionals at every level. NCCHCA works with the University of North Carolina and East Carolina University School of Dental Medicine. By educating North Carolinians to become dentists, these students will return to their communities and health centers, achieving both training and access goals.

Dr. Weaver added that it's really important to "grow our own," explaining that those best suited to serving a community have a deep personal commitment and understand the issues affecting the community through their own experience. "A challenge for us is to have a workforce that represents the population we serve. We all need to work on diversifying our workforce."

To expand care in both urban and rural areas, partnerships are essential. NACHC works with a variety of partners, including the National Network for Oral Health Access, National Oral Health Innovation and Integration Network, Oral Health Progress and Equity Network (OPEN), and the National Health Service Corps to provide assistance and support to health centers in developing and strengthening their dental programs. It also partners with schools, including A. T. Still University's Arizona School of Dental and Oral Health, Missouri School of Dental and Oral Health and NYU Langone.

Clinical Affairs Director of Information Resources and Outreach at NACHC Ellen Robinson put it like this: "It's not just NACHC, it's a lot of partners helping us to reach our urban and rural health centers across the country." Understanding local needs, and forging effective collaborations, is crucial to expanding the availability of high-quality oral health care.

- Irene Bruce (2019)

Header photo: Health center dental staff. Courtesy of Kinston Community Health Center, Inc. (Kinston, NC).

3 IBID.

Making Connections: Community Health Centers go the Extra Mile for Elders

The National Population Projections released by the U.S. Census Bureau project that by 2034, there will be 77.0 million people aged 65 years and older, or one-and-a half times as many as were reported in 2016 (49.2 million).[1] For the first time, adults will outnumber the nation's children under the age of 18. By 2030, 1 in every 5 U.S. residents will be of retirement age.

As the country prepares for this demographic milestone, community health centers will be challenged to care for greater numbers of older adults, with more complex and pressing health care needs. Data from the UDS show that health centers are already responding to this demographic shift. In 2018, older adults accounted for 9.6% of those served by community health centers, or 2.6 million people.[2] Reflecting this shift, Medicare is an increasingly important payer for health centers, with the number of health center Medicare patients doubling from 2005-2014. In 2018, 2.7 million health center patients, or 9.7%, were covered by Medicare and an additional 1 million (3.7%) were Medicare/ Medicaid dual-eligible.[3]

To get a bird's-eye view of how several health centers are meeting new demands for care, we reached out to colleagues in California, Vermont and Illinois known for elder-focused care. While each has unique programs and faces local challenges, each has found a way to forge connections with elders in their communities and to offer older patients high-quality, empathic care. [Ed: With so much going on at health centers as demographics and approaches change, the next article in this series will look specifically at PACE, or Program of All-Inclusive Care for the Elderly.]

1 "Older People Projected to Outnumber Children for First Time in U.S. History." The United States Census Bureau, October 8, 2019. https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html.
2 "National Health Center Data," HRSA, date accessed February 5, 2020, https://data.hrsa.gov/tools/data-reporting/program-data/national
3 IBID.

LifeLong Medical Care (Berkley, CA)

LifeLong Medical Care was focused from the outset on addressing the unmet need for health services in Berkeley's senior community. Dr. Marty Lynch, who joined Lifelong in 1980, is the center's executive director and co-founder of NACHCs Sub-committee on Healthy Aging. He explained that the health center was founded by a group of Gray Panthers, senior advocates who realized that the area's growing low-income aging population did not have access to necessary medical services and decided to develop a place where older adults could receive support and quality health care. The Over 60 Health Center was there for the "folks who weren't always welcome in the normal private practice offices. Folks who were poor maybe they didn't speak English, maybe were African American whatever it might be and they didn't fit in and the doctors didn't want to see them."

From the very beginning, Lifelong had an integrated approach to care, adapting as the needs of the community have changed. Care for older people is available across the health center's network, and includes a range of medical, mental health and case management programs. Lifelong continues to run The Over 60 Health Center, a geriatric-specific program where older patients receive care from a team that includes primary care providers, nurses, social workers and specialists. An Adult Day Center provides social activities along with daytime nursing care and therapeutic activities. Complementing the health-center based programs are street outreach for the homeless and primary care at home for people who are not able to leave their homes. The Senior Network and Activity Program (SNAP), a program funded by the Contra Costa Mental Health Department, provides senior residents of public housing in West Contra Costa County with social and recreational activities.

> **"We all believe that housing is health care. It's very hard to accomplish good primary care if a person is on the streets or in a shelter."**

Increasingly, Lifelong has been faced with meeting the needs of those who are homeless. With the cost of housing on the rise, the area's homeless population has expanded, and an increasing number of those facing homelessness in the inner Oakland Bay and San Francisco are over age 55. But age aside, says Lynch, "There's a firm amount of research that shows that a 55-plus-year-old homeless person has the same health and chronic issues as a 75-year-old person who lives in a house. There's at least a 20-year pick-up on the

types of problems people have." The health center cares for many homeless individuals who may not yet qualify for Medicare, but have complex needs similar to those of much older adults.

Together with community partners, LifeLong has a Supportive Housing Program (SHP) that helps improve the quality of life for adults experiencing homelessness. "We all believe that housing is health care. It's very hard to accomplish good primary care if a person is on the streets or in a shelter," he said. The health center brings health and social services to subsidized affordable housing so that tenants who have a history of homelessness can attain housing stability and improve their quality of life. Services are provided to approximately 600 tenants, at 13 different housing sites, as well to those residing in scattered housing elsewhere in Alameda County.

Dr. Lynch remarked that "the elder work that we started with transitioned to homelessness, supportive housing, severe mental health and behavioral health work. It made it a lot less scary because we were already dealing with people who had serious functional problems as well as medical problems, so it felt like the most natural thing in the world to deal with other populations who also had complex problems." This commitment to meeting people where they are ensures that older adults, and all patients of the health center, receive high-quality attention and care.

Howard Brown Health (Chicago, IL)

The seeds for Howard Brown Health were planted in 1974, when four medical students who were members of the Chicago Gay Medical Students Association began an informal, volunteer clinic to provide safe, confidential care to Chicago's gay men and lesbians. The first clinic board took shape in 1976, and the clinic was named the Howard Brown Memorial Clinic, in tribute to Dr. Howard J. Brown. A trailblazing gay rights activist, Brown was the founder of the National Gay Task Force (now the National Gay and Lesbian Task Force) and had served as New York City Commissioner of Health and the city's first Health Services Administrator.

I reached out to Kelly Rice, the Program Manager for Intensive Community Care Services, to learn about the health center's signature programs for LGBTQ and vulnerable older adults. She explained, "The most recent data I've heard is that is 80% of folks go back in the closet when they need aging-related services. Members of the community may not know we exist, and we want them to know about us so that even if you don't feel comfortable being open about who you are where you live, you know that you can at least come to us and we are here." To help address head-on the discrimination and disparities known to many LGBTQ elders, Howard Brown Health developed Nurse's Health Education About LGBT Elders, or HEALE, a cultural competency curriculum for nurses and other health care professionals. HEALE, funded by HRSA and developed in partnership with Rush University's Geriatric Workforce Enhancement Program of Illinois (GWEP-I) addresses topics such as An Introduction to LGBTQ Elders, Health Disparities and Barriers to Care, Sex and Sexuality in for LGBTQ Older Adults, Transgender and Gender Non-conforming Elders HIV and Aging, and Financial and Legal Barriers to Care.

Educating providers is complemented by evaluating needs. To be sure that the health center remains responsive to the needs of the diverse LGBTQ community, Howard Brown conducted an LGBTQ aging needs assessment in 2017 to get an in-depth, insider view of the needs of older adults, and the challenges and gaps they identified. The comprehensive assessment included focus groups, interviews, and more than 300 surveys, which identified the need for more chronic disease support and management, and mental health care services. In addition, the survey revealed a need for more research focused specifically on older LGBTQ adults. Not surprisingly, in a community where many older gay men had lost partners and friends to HIV/ AIDS, was the desire for more social interaction to combat isolation and loneliness.

To increase outreach and encourage community connections, Howard Brown has worked hard to build networking relationships with aging service programs in the area. Howard Brown also provides frequent evidence-based health workshops at churches and other community-based locations.

Finally, Howard Brown is attentive to the physical aspects of care and adjustments that may be needed to serve all people. Ms. Rice added, "When providing care to the elderly it's important for health centers to make sure that their buildings are accessible, that people can read the forms. Are all your forms in a ten-point font? You know, a lot of older adults have issues with small fonts, bright screens or bright paper, so do you have different ways to accommodate different needs? Consider your marketing and outreach, too. Are you only presenting youth in the images that you are sharing in your marketing materials?" People need to see themselves in the marketing materials and be able to access the physical facilities for care to be effective.

While clearly a leader in the field, Howard Brown continues to grow and innovate. Ms. Rice is excited about the upcoming launch of the health center's aging service advisory board, which will be comprised equally of Howard Brown staff and patients. This will serve to both engage patients, and help ensure that the health center is best equipped to meet the needs of its older LGBTQ adults.

Community Health Centers of Burlington (Burlington, VT)

The People's Free Clinic opened in 1971, a tiny storefront in Burlington's Old North End. Announcing "a new kind of health care," the People's Free Clinic founders envisioned a mission that would make a resonating statement: every person – regardless of age, race, class, or gender – deserves good medical care regardless of their ability to pay.

Staffed entirely by volunteers, including two local physicians, the small clinic saw 50 people per week by the end of the following year. Soon, the clinic would strengthen its commitment to care in the local community, and become the Community Health Centers of Burlington (CHCB). CHCB was officially awarded the status of a Healthcare for the Homeless Program grantee in 1989, ensuring completely free access to health care for individuals and families experiencing homelessness, and today remains the only organization in Vermont with this designation. It subsequently was designated Vermont's second Federally Qualified Health Center.

Today, the health center strives to make services accessible to all, including the area's seniors. Kim Anderson, the health center's Director of Development and Communications said, "Societally, I think elders are often a forgotten population, not necessarily ignored, just forgotten. I think our role at CHCB is to find the people falling through the cracks – it is our job as a health center to make that connection and have people feel heard; as much as they might not be loud, our older Vermonters are an entire population worthy of extra care."

Through a partnership with a community physician, CHCB offers a Doctor-At-Home Program, to visit elderly patients in their home or place of residence. This serves two purposes: it provides care to those who may not otherwise be able to get to the health center; and it allows the physician to connect with patients when they are feeling less vulnerable. Last year, CHCB piloted a unique home-visit psychiatry program. While the funding has run out, an unexpected benefit developed. Anderson explained, "For a lot of these folks there was a physical barrier to getting out, but there was also a mental barrier. Now, many of the patients come to the health center for their care. Our goal is to provide this quality of care and also help you access it." Additionally, the Community Health Pharmacy offers convenient mail delivery, ensuring access to prescriptions for homebound patients.

The Burlington area is home to many elderly people for whom English is not their primary language. They are part of a larger community of nearly 8,000 refugees from all over the world who have resettled in Vermont over the course of the last 30 years. In the 1990s, the majority of refugees resettled were from Bosnia and Vietnam, while in the last decade, the newcomers have been from Bhutan, the Democratic Republic of Congo and Somalia [USCRI Vermont]. Noted Ms. Anderson, "While CHCB offers many resources, we need to be sure that people are aware of them so that they can then use them. A focus of ours is making sure New Americans are aware of the range of services they can access at CHCB." She highlighted that language and cultural barriers can be especially challenging for elderly patients; health center staff work to identify these particular needs to ensure proper care: "Whether a provider is visiting a patient at home or in the office, they are consistently delivering holistic care."

Examples of elder-focused care abound, and challenges remain. One such challenge – and a significant one – is recruiting clinicians and staff who are trained to meet the needs of ever-older patients with complex needs. Still, health centers have the opportunity to build on their local, community-based strengths while learning from colleagues nationally on how to effectively meet new needs as people age. As Dr. Lynch said, "don't make perfect the enemy of the good. There will always be challenges, but community health centers are uniquely positioned to make practical changes that will best serve their elder population."

- Irene Bruce (2020)

Header photo: CHCB At-Home Physician, Dr. Karen Sokol, with one of her patients. Courtesy of Community Health Centers of Burlington (Burlington, VT).

Tackling Access Barriers, In Three Languages

Monmouth Family Medical Center (MFMC) is located in Long Branch, NJ, a small city situated along the Jersey Shore, and a popular summer destination for those from the New York and New Jersey metro area as well as more local communities. The center's main building is located across the street from the town beach in a working-class section of the city, which stands in sharp contrast to Long Branch's more prominent affluent communities. While Monmouth was first designated a federally qualified health center in 2004, it has served the Long Branch community as an outpatient arm of Monmouth Medical Center Hospital for over 30 years. The population served by the health center is one-third Latino, one-third African American, and the balance are Caucasian; 10% of the patients are Portuguese speaking. Since many of its patients have limited English skills, there are a number of employees who are trilingual, and speak English, Spanish and Portuguese. The center has established a strong reputation as a health care provider among the Latino immigrant community, a population that is overwhelmingly uninsured and often lacking the documents required in order to qualify for Medicaid. Over the past several years demand for community health services has grown and Monmouth's patient population has more than doubled, due both to growing migration to the area and an increase, with the economic downturn, in the ranks of uninsured and unemployed.

I recently visited the center and was inspired by the staff's passion and dedication to their patients. CEO Marta Silverberg and Medical Director Dr. Rashka Joshi spoke to me at length about the various programs and strategies MFMC has implemented in order to provide the most successful and cost-effective care possible for their patients. Dr. Joshi emphasized the importance of active patient recruitment, systematic

follow through with patients and effective record-keeping practices. All patients at Monmouth are either covered by the Medicaid program, the government insurance program for the very poor, or are uninsured. A majority of these patients are recent Latino immigrants with limited English skills and many don't have legal immigration status. These linguistic, economic and legal barriers among the patient population, pose unique challenges for the health care system. One of the biggest challenges is ensuring that patients receive the necessary follow-up treatment and education about how to manage their own health. Most patients don't understand how to navigate the complicated and bureaucratic medical system. In addition, many patients, especially those with chronic medical conditions such as diabetes, heart disease and asthma, need information about how lifestyle may impact their health. It is Monmouth's responsibility to respond to these particular social determinants which significantly impact their patients' health outcomes.

Dr. Joshi described how Monmouth has created an emergency diversion program which works closely with the hospital to identify patients who have used the Emergency Room for non-emergency conditions. Intake specialists identify these patients and then immediately link them to Monmouth, to schedule appointments for primary care services. The center has set aside "open access appointment" slots specifically for patients who had visited the ER so that they can quickly obtain general check-ups. The program has been a simple but positive way to recruit and retain patients who are in need of primary care services, while providing care in a cost-effective manner and ensuring that emergency resources are used appropriately.

Medical Director Dr. Rashka Joshi with a health center patient (2012). Monmouth Family Health Center (Long Branch, NJ).

The Center has also made strategic use of pre-natal visits to cover important cancer screenings and comprehensive preventive treatment and screenings. The majority of Monmouth's female patients are not insured and many don't come in for regular check-ups, missing out on essential screenings when they are unable to get to the center for routine care. Under Dr. Joshi's leadership, the medical team has implemented a protocol for providing pregnant patients with as many other required services and screenings as possible during their prenatal visits.

CEO Marta Silverberg and Dr. Rashka Joshi (2012). Monmouth Family Health Center (Long Branch, NJ).

"It is Monmouth's responsibility to respond to these particular social determinants which significantly impact their patients' health outcomes."

The center's medical team has promoted prenatal services by hosting baby showers in the community and holding events and programs at churches and housing projects. As part of an important study addressing ways to reduce and prevent disparities in infant mortality, they also provided post-partum physical exams, information about contraception options and screening for post-partum depression. When needed, a case manager was assigned to the mother during both her pre- and post-natal visits. The case manager was in charge of follow up and reminding the patient about her upcoming appointments. Another part of the case manager's responsibility was ensuring that the infants received their regular check-ups, screenings and immunizations as well as counseling about social and nutritional practices for the parent. Apart from the study, Monmouth has sought to develop creative ways to offer comprehensive care designed to meet the specific needs of the community. This holistic approach recognizes that the economic and social conditions that community health center patients face are in many ways the greatest potential barriers to health and must be taken to account when designing a health care model. Monmouth's example highlights how health centers are truly embedded in their communities, and use their resources to expand not only access and scope of service, but indeed the general definition of what "health" is all about, in many languages.

- Nicole Rodriguez-Robbins (2012)

Header photo: Nurses at the health center (2012). Courtesy of Monmouth Family Health Center (Long Branch, NJ).

"Who's Counting on You to Stay Healthy" – Comprehensive Insurance Outreach and Enrollment in Maine

Maine is a largely rural state where the major industries, fishing and logging are made up of a largely seasonal workforce. Maine was the only New England state to reject Medicaid expansion, and as result, an estimated 38,000 were excluded from Medicaid.[1] Rather than extending coverage, the Governor opted instead to shrink the state's MaineCare program, and implement a federally-facilitated insurance marketplace. Maine had a historically generous Medicaid program but under Governor Paul LePage seniors, the disabled, low-income parents and childless adults were dropped from coverage. In 2014, Maine Primary Care Association (MPCA), the statewide non-profit membership organization for Maine's community health centers, received an Outreach and Enrollment grant from the RCHN Community Health Foundation to develop a comprehensive strategy focused on helping member centers enroll uninsured Maine residents in the ACA healthcare exchanges and MaineCare. The PCA worked closely with 18 member centers to leverage Maine's outreach network, develop highly trained staff and test new strategies and messages to improve health insurance literacy and get people enrolled and in care.

Minnie Elliott is a Certified Application Counselor at Health Access Network (HAN), which provides comprehensive primary medical, dental and behavioral health services to the rural communities of Lincoln, Millinocket, West Enfield, Lee and Medway. The communities were

1 "A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults," Kaiser Family Foundation, 2014, http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/

The Maine PCA's Outreach and Enrollment campaign is targeted at the state's vulnerable uninsured. The campaign slogan, "Who's Counting on You To Stay Healthy" aims to speak to the experiences and concerns of many Mainers."

previously home to a booming paper mill industry. Over the past several years many of these paper mills have closed, leaving a large workforce without jobs. The recent closure of two paper mills, Great Northern Paper Mill and Lincoln Paper Mill in the past year, has dramatically affected the community served by the health center. Each closure means hundreds of layoffs. While it's not unusual for rural resident to drive over 40 miles to a job, the high cost of gas often means work is literally out of reach, since low-wage jobs barely pay enough to justify the commuting costs. Many local residents are among the estimated 24,000 Mainers who fall into the coverage gap,[2] that is, they earn too much to qualify for Medicaid, but below the lower limit for Marketplace premium tax credits. Elliott reported seeing many such families in her work. For them, the desire for insurance must be weighed against the cost of food and heating their homes in the winter. Day-to-day necessities – food, heating, school clothes for the kids – often win out, even with the potential of a tax penalty.

Sue Mahar is a certified application counselor at St. Croix Regional Health Center in Princeton, Maine where she serves communities throughout the Washington County region. Located in the eastern-most section of the U.S., it closely borders New Brunswick, Canada and is one of Maine's poorest counties. Mahar is a native of the area and described her personal passion for her work in the community. She formerly worked at a pharmacy where she witnessed firsthand the unmet needs of customers who came to the pharmacy unable to afford the cost of their medications. Her manager would tell her "do not let anyone leave here with nothing." She learned how to navigate the system to help people apply for financial assistance, get samples from their primary care doctor or a cheaper, generic brand of a medication. She brought this passion and knowledge to her current position as an enrollment assister this past year. A few cases illustrate her work and its many challenges. One woman in her early 60's worked as a beautician and had lived without insurance for the past 40 years. She couldn't afford insurance premiums until she enrolled through the marketplace last year. Ms. Mahar later ran into her in town and the woman recounted how she had been so sick with bronchitis that she was hospitalized. She felt incredibly fortunate to have been insured at

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the time. “I don’t know what I would have done if I didn’t have the health insurance” she told Mahar, and thanked her for her help. It is those individuals who inspire Ms. Mahar’s enrollment work amidst the complications brought on by glitches with the enrollment website, and often difficult driving conditions to the outreach sites in the winter on rural roads. While there were many success stories, there were many more examples of those who couldn’t enroll because they didn’t meet the income level requirement to qualify for the tax credits for marketplace insurance. There are strict guidelines to qualify for Medicaid coverage in the state of Maine, making it especially difficult for those who fall below the Federal Poverty Guidelines and yet do not qualify for coverage or tax relief. Sue shares resources and helps her clients apply for the sliding fee at the health center and free care at local hospitals. She reported that those she helped enroll were incredibly satisfied with their insurance and grateful for her help.

Rita Haskins works at Fish River Rural Health, the northern-most health center in Maine. She works in the St. Johns Valley area, where much of the population is of Acadian descent. Many of the residents are middle-aged and primarily French speaking. Ms. Haskins described their primary language as “Franglais,” a Canadian French dialect with both English and Native American words mixed into the vocabulary. Haskins is a native speaker and the majority of those she enrolled preferred to speak Franglais. While the health center has developed an outreach campaign, in the intimate and informal culture of the town, many enrollment contacts are made through word of mouth. People call Ms. Haskins at St. Croix after another friend or family member has enrolled in the marketplace with her help. In some cases, Haskins makes home visits to the elderly or those who live far away and don’t have transportation to the town center. A lot of handholding is necessary in order to inform people about how the health care coverage system works. Haskins has to explain the difference between premiums, deductibles, and co-pays. She reported that some people feel most comfortable at their kitchen table, sharing one-on-one their questions and concerns and having her walk them through the application process. A good number of older residents are illiterate and Haskins is very sensitive to these applicant’s needs. She shows patients the insignias of each insurance company so that they will be able to identify important insurance forms they receive in the mail. Haskins instructs them to call her when they get one in the mail and she will return to read the forms to them and help them fill out necessary paperwork. The first enrollment step is often only the beginning of her relationship with applicants.

The Maine PCA’s s Outreach and Enrollment campaign is targeted at the state’s vulnerable uninsured. The campaign slogan, “Who’s Counting on You To Stay Healthy” aims to speak to the experiences and concerns of many Mainers. Through research and focus groups, MPCA determined that being uninsured and the potential burden of medical debt was less of a concern for many CHC patients than was the potential immediate loss of income and job security if they got sick and had to miss work. This knowledge inspired a campaign that focuses on the importance for individuals to stay healthy for their families who depend on their financial support. Jeb Murphy, MPCA’s Director of Communications and Data Collection, explained that many Mainers come from tight-knit communities where extended families and aging parents rely on their adult children for their care. Neighbors rely on each other for information and many learned about the ACA through another trusted member of their community before they sought out assistance from a Certified Application Counselor. To best reach these individuals, MPCA took a grassroots approached by posting ads in local newspapers announcing the “Who’s Counting On You to Stay Healthy Campaign” along with a photo of the local Certified Application Counselor with their name and contact information. The posters and brochures they distributed featured photos of workers in the local industry typical of each region. For coastal areas, the outreach image is of a local lobsterman. In central Maine, they used photos of a working logger, carpenter and waitress along with their family. The idea is that Mainers can identify with the campaigns message and that the image will resonate with their own experience.

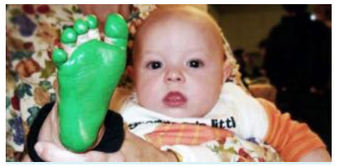
The Application Counselors I interviewed in many ways serve a broader role in their communities beyond enrolling individuals for healthcare coverage. Each of them has strong existing ties to the communities they are working in. They understand firsthand the economic hardship that local Mainers struggle with. They also understand the unique culture of these tight-knit communities where language and education are barriers to accessing insurance and other services. In order to be successful they must establish trust among residents in small rural communities. These application counselors provide an important bridge to services for those individuals whose needs go beyond just filling out an insurance application. They go out of their way to identify resources and services for those who don’t quality and can’t afford the insurance but still need access to care. Their strength lies in their existing connections to the communities they work in. They are from the communities and understand the cultural and economic needs of the individuals they serve. Thus, even in the constrained environment where Medicaid expansion has been thwarted, they are able to provide important support, and get Mainers into coverage and into care.

- Nicole Rodriguez-Robbins (2015)

Header photo: Maine PCA Outreach and Enrollment Team (2014). Courtesy of MPCA.

Outreach and Enrollment staff, Denise Harriman and Sue Mahar. Courtesy of St. Croix Regional Family Health Center (Princeton ME).

Promoting health insurance enrollment assistance in snowy Maine (2014). Courtesy of Harrington Family Health Center (Harrington, ME).



Young patient with painted foot. Photo courtesy of St. Croix Regional Family Health Center (Princeton, ME).