ILLINOIS PRIMARY HEALTH CARE ASSOCIATION

HEALTH SOURCE™

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IPHCA

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The Illinois Primary Health Care Association is a nonprofit trade association that serves as the voice of and champion for Illinois' community health centers. Our members include health centers from across the state, businesses, non-profits and an array of allied organizations. These members form vital connections, working together to provide cutting-edge care for all our communities.

IPHCA Health Source™ is an e-newsletter dedicated to showcasing Illinois' community health centers and the 1.4 million patients they serve.

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Hot Topics in Public Policy: What to Expect from Springfield in 2021

Amber Kirchhoff, IPHCA Director of State Public Policy + Governmental Affairs

The past year has truly been unparalleled. From the COVID-19 pandemic to historic social unrest and political turmoil, none of us could have predicted what 2020 and the start of 2021 had in store for us. The events over the past year have been indelibly imprinted on the American psyche and are not to be forgotten anytime soon. And they have set the stage for what we can expect to see during this spring's state legislative session.

Health equity and racial justice have risen to mainstream consciousness as we face stark racial disparities in coronavirus infection and mortality rates, as well as testing and vaccination rates. Conversations centering around systemic inequality and structural racism as the root causes behind social determinants of health and gaps in health care access and outcomes are not new concepts in the community health center movement. However, they are being uplifted and highlighted in the public square in a way we have not seen previously. In response, the Governor's Administration has launched an equity-focused health care transformation plan, including competitive grants to support partnerships between hospitals and community-based providers. Legislation to implement key portions of this proposal, aimed at addressing the health care needs of our most underserved communities, was passed by the General Assembly during the lame duck session.

Also during the lame duck session, the Illinois Legislative Black Caucus introduced its policy agenda that includes landmark legislation enacting historic criminal justice reforms and the introduction of a comprehensive health care and human services package. While they ran short of time to pass the health and human services legislation, the bill has been reintroduced into the current 102nd legislature and IPHCA is working with the Black Caucus on it. Key provisions include expanding access to doulas, home visiting, and community health workers; incentivizing collaboration and coordination between hospitals and community health centers; and establishing implicit bias training requirements for health care professionals among other important provisions.

Governor Pritzker delivered his annual budget address virtually on February 17. His FY22 budget called for $1.8 billion less in appropriations than FY21 including $400 million worth of spending reductions. Preliminary analysis indicates that health and human services were not recommended for cuts. Absent the passage of the Fair Tax, a proposal to replace Illinois' regressive flat tax with a graduated income tax, he has few tools at his disposal for substantially growing revenues to increase program funding and tackle the state's structural deficit. Fortunately, recent debt projections are down significantly from those predicted earlier in the public health emergency with Illinois' economy performing better than expected.

> **Health care and human services, particularly in underserved areas, are notoriously underfunded.**

Building on our success garnering a rate increase last session, IPHCA has joined with more than 20 statewide organizations to advocate for strengthened investment in critical health care and human services. Not only are these services inextricably intertwined for the individuals receiving them, but they are the backbone of safe, healthy, and thriving communities. **Health care and human services, particularly in underserved areas, are notoriously underfunded** and, in difficult budget years, they are often the first to be considered for cuts or flat funding, which translates to reduced funding because of rising costs associated with inflation. This is short sighted. Not only do health and human services providers offer immediate assistance to individuals and families in need in the short-term, but they deliver tremendous return on investment in

Hot Topics in Public Policy: What to Expect from Springfield in 2021 (continued from page 6)

Demand for services has risen sharply during the pandemic.

Moreover, **demand for services has risen sharply during the pandemic** as people struggle with unemployment, grief, loss, illness, and housing and food insecurity among other challenges. Lastly, adequately investing in health and human services is a must if policymakers are going to make a meaningful difference with lasting impacts in underserved areas. Here are links to the coalition's guiding principles and a recording of its recent bipartisan virtual advocacy event with state legislators.

Additionally, IPHCA has made significant progress in advancing a value-based payment methodology proposal. We worked with a leading national consultant and our members to develop a model that emphasizes quality and outcomes over volume; and offers the flexibility to enable CHCs to maximize the time and talent of the full care team in ways that are more responsive to the needs of patients. We will continue to engage the Illinois Department of Healthcare and Family Services and the Illinois Association of Medicaid Health Plans as **we work towards making an alternative payment methodology a reality.**

Adopting updated policies and payment mechanisms will shape the future of telehealth...

Lastly, **adopting updated policies and payment mechanisms that shape the future of telehealth** will be a top priority, not only for IPHCA, but for fellow provider groups, payors, and consumer advocates. We are working with other trade associations to preserve the flexibilities that have been put in place to allow for expanded access to telehealth during the pandemic. Many of these reforms, such as telehealth payment parity, audio-only telehealth, and remote access for patients, have long been backed by CHC leaders because of the potential to better enable access to care by offering convenient options that alleviate burdens associated with social determinants of health. Challenges related to the digital divide remain very real and we look forward to continuing to work with Governor Pritzker's Administration and the Partnership for a Connected Illinois to improve broadband availability and access to reliable, affordable Wi-Fi and devices in underserved areas.

Thank you to all of our members and supporters for your continued advocacy and engagement in these areas. While the pandemic has been incredibly trying on all of us, there has come with it opportunities to effectuate meaningful change that will root out racial inequities, reduce barriers to access, elevate the importance of social determinants of health; and, most importantly, improve the health and well-being of underserved communities.

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IPHCA: Integrating SUD Treatment in HIV Primary Care

Nicky Mehtani, MD MPH, Street Medicine & Shelter Health, National Clinician Consultation Center - 12.08.2020

Advances in antiretroviral therapy (ART) over the past two decades have transformed the experience of HIV disease for millions of patients—particularly among those living in the United States. HIV is now considered to be an easily treatable chronic disease with near-normal life expectancy. Yet, despite remarkable advances in pharmacotherapy, improved outcomes among people living with HIV (PLWH) have not been universal. In particular, people who use drugs are not only at increased risk of acquiring HIV, but also carry greater risks of developing AIDS-defining illnesses and death.[1] This is because substance use can accelerate HIV disease progression, may affect a patient's ability to adhere to daily medications, and is associated with marginalization and increased stigma.[2] It is becoming apparent that clinical treatment of substance use disorders (SUDs) is critically important in providing patient-centered and effective treatment for HIV among these populations.

In 2019, Illinois had a record of 2,233 opioid-associated overdose deaths[3]—a statistic that is expected to be even greater in 2020 in the midst of COVID-19 related public health challenges. Many patients with HIV are at greater risk of developing opioid use disorder (OUD) compared to the general population due in part to increased prescribing of opioids in this population, particularly in the pre-ART era.[4] Though under-utilized, there are highly effective evidence-based medications to treat OUD, including buprenorphine and methadone. Numerous studies have demonstrated improvement in HIV-related outcomes when HIV clinicians integrate the prescribing of antiretrovirals (ART) with medications for OUD. [5-10] This can occur through directly observed therapy of ART in opioid treatment programs (colloquially referred to as "methadone programs") or through the co-location of buprenorphine and ART prescribing in office-based settings by HIV practitioners who are DATA 2000 (or "X") waivered. Best practices for co-prescribing buprenorphine and ART include frequent patient visits (often weekly during initiation of therapy) to assess drug cravings and adherence to medications, the coupling of treatment with regular urine drug screens as a tool to help monitor stability, connection to psychosocial therapy for interested patients, and, when indicated, the ability to refer patients to higher levels of care, including intensive outpatient or residential treatment programs.

While it has received less media attention than the epidemic of opioid-associated overdose, alcohol continues to be the most commonly abused drug in the general population and, in one meta-analysis, over 25% of PLWH screened positive for unhealthy alcohol use.[11] Alcohol negatively impacts PLWH in many ways, including dose-response effects on ART adherence, cardiovascular disease, liver disease, depression, cognitive function, and sexual risk behaviors. Despite the existence of medications for the treatment of alcohol use disorder (AUD), exceedingly few people with unhealthy alcohol use are prescribed pharmacotherapy, and initiation is lower among PLWH than the general population.[12] In particular, daily oral and monthly long-acting injectable formulations of naltrexone, both of which can be prescribed in office-based settings, have been found to promote reduced alcohol use and improve viral suppression in PLWH.[13,14]

In contrast to OUD and AUD, there are currently no FDA-approved medications for the treatment of stimulant use disorders—including addiction to cocaine and methamphetamine. In particular, methamphetamine-related overdoses have increased greater than 18-fold since 2000,[15] and rates of use are on the rise in Illinois.[16] One recent article in the Journal of Acquired Immune Deficiency Syndromes called the persistent use of methamphetamine the "single biggest risk factor" for HIV seroconversion among gay and bisexual men in the United States.[17] This is due to the propensity for methamphetamine to increase sexual risk behaviors, particularly among men who have sex with men.

While not FDA approved, there have been recent studies demonstrating efficacy for the use of mirtazapine in reducing methamphetamine cravings in some populations[18,19] and more robust evidence in support of behavioral therapies, including contingency management.[20]

IPHCA: Integrating SUD Treatment in HIV Primary Care (continued from page 9)

Whether through the integration of pharmacotherapy, behavioral therapy, or increased referrals to dedicated addiction treatment programs, the promotion of substance use treatment in HIV primary care settings is critical to our global mission of "getting to zero."

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Considerations for Diabetes Management Amid COVID-19

Naila Al Hasni, MPH, PCMH CCE, IPHCA – Clinical Quality Improvement Manager

The most recent data from the Illinois Department of Public Health (IDPH) reveals that diabetes is the seventh leading cause of death nationally and in Illinois. More than 30.3 million adults have diabetes (nearly 10% of the population) with 23.1 million diagnosed and about 7.2 million undiagnosed (nearly 24% of people with diabetes are undiagnosed). In Illinois, about 1.3 million adults (12.5% of the population) have diabetes, but about 341,000 are not aware that they do. It is estimated that 3.1 million have pre-diabetes in the state of Illinois. According to the most recent 2019 UDS data, the percent of patients with diabetes in Illinois health centers increased to 14.65% while the percent of patients with uncontrolled HbA1c remains at 32.89%.

In the midst of the pandemic, the Centers for Disease Control and Prevention (CDC) has also found that those with type 2 diabetes are at an increased risk of severe illness from COVID-19. Additionally, based on CDC reporting at this time, those with type 1 diabetes or gestational diabetes may be at increased risk of severe illness from COVID-19 as well. The CDC reports that those who have diabetes-related health problems are likely to have worse outcomes than those with diabetes who are otherwise healthy.

In light of this greater risk posed to people with diabetes and the already growing population with the disease, it is imperative to continue screening, provide outreach and deliver resources to these targeted groups in order to avoid poor control of diabetes. The American Medical Association (AMA) recommends reconnecting to patients with chronic diseases by leveraging telehealth resources. Ensuring that patients are able to touch base with their healthcare providers through telephone or video calls can help patients receive any assistance in managing their condition, which can include encouragement for leading healthier lifestyle changes while at home. One means of conducting this outreach is utilizing Community Health Workers (CHWs) to connect to those with pre-diabetes or those living with diabetes.

CHWs may play a key role in not only educating and supporting patient efforts to control diabetes, but also in identifying and addressing barriers to social determinants of health. This can again be adjusted to the COVID-19 era through phone and video calls as well as classes via group calls. One specific CHW-led program known as Juntos Podemos, which served 2,241 participants across communities in 2020 and found about half of participants reported an increase in health knowledge, fruit and vegetable intake, and physical activity. In addition, CHWs can help identify the social barriers and challenges patients face in adhering to care.

The CDC also recognizes that running evidence-based programs such as the Diabetes Prevention Program (DPP) and diabetes self-management education and support (DSMES) through telehealth poses an opportunity to hold virtual classes to reach patients at home. However, the CDC has found that there are numerous barriers to participating in DPP and DSMES. Barriers include limited health literacy, transportation, disabilities, and time-based barriers among others. These barriers can be mitigated through an increased focus on telehealth services. As such, the CDC has released a guide for implementing telehealth technologies, such as texting, smartphone apps, phone calls, and virtual-based programs to help reach more participants for DPP and DSMES services. The full guide for using telehealth technologies in DPP and DSMES can be downloaded by clicking here: https://bit.ly/3qWGZQk

Considerations for Diabetes Management Amid COVID-19 (continued from page 11)

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Additional Resources:

Covid-19 Community Health Worker Resources: https://professional.diabetes.org/content-page/covid-19-community-health-worker-resources

A Guide for Using Telehealth Technologies in Diabetes Self-Management Education and Support and in the National Diabetes Prevention Program Lifestyle Change Program: https://www.cdc.gov/diabetes/pdfs/programs/E_Telehealth_translation_product_508.pdf

ECHO-Diabetes in the Time of COVID-19: https://med.stanford.edu/cme/diabetescovid.html

Diabetes in Special and Vulnerable Populations: https://chcdiabetes.org/home/#resources

What is Medication Therapy Management?

Megan Williams, MS, Public Health Initiatives Manager

According to the American Pharmacist Association (APhA) medication-related problems and medication mismanagement are a massive public health problem in the United States. It is estimated that 1.5 million preventable medication related events happen each year that result in $177 billion in injury and death. (APhA, 2020)

Medication therapy management (MTM) is an extremely effective way for patients to gain a better understanding of their medications, take control over their own health and prevent medication related problems and mismanagement. MTM has been proven to be effective for patients with multiple chronic conditions and/or complex medication therapies. (CDC, 2020) But what exactly is MTM?

MTM is a term used to describe a broad range of health care services provided by pharmacists. It allows direct communication between pharmacists and patients. Patients are given the opportunity to meet one-on-one with their pharmacist to learn about and understand the medications they are prescribed. Pharmacists help their patients get the most from their medications by actively managing drug therapy and identifying, preventing and resolving medication-related problems. (APhA, 2020)

The MTM model has five core elements. The elements are important to the overall structure, the order in which they are done is up to the pharmacist.

Medication therapy review (MTR)
During the MTR process the pharmacist and patient will meet and discuss all medications the patient is taking, this includes all prescribed medications as well as over the counter, dietary and herbal supplements. The pharmacist will provide guidance on how to best utilize these medicines.

Personal medication record (PMR)
The PMR is a list of the patients medications with their directions, strengths, interactions and any other information that is important to the overall health and wellness of the patient.

Medication Action Plan (MAP)
The MAP gives the patients strategies on how to receive the most benefit and best utilize their medications.

Intervention and/or Referral
This step gives the pharmacist the opportunity to address any problems with the medications or interactions that may occur. If deemed necessary they can refer the patient to other health care services.

Documentation and Follow Up
Documentation allows the pharmacist to remember the important conversations with the patient and the follow-up ensures the patient continues to follow their personal action plan and receive the most benefit from their medications.

It has been shown that MTM can greatly improve the pharmacist–patient relationship. The one-on-one meetings help build trust with open conversation and education. This allows the patient to understand and take control of their own health to hopefully lead to overall better health outcomes, which is the goal of MTM.

While there is no one certification/training that must be taken to become an MTM provider, it is definitely recommended to become certified in order to provide the best care for your participants. There are a multitude of trainings and certifications for providers to learn best practices and specific MTM skills. If an organization would like to be reimbursed for their MTM services they must apply and meet specific requirements. To learn more about the requirements for reimbursement, visit: go.cms.gov/3pRSur5

What is Medication Therapy Management? (continued from page 13)

Below is a successful MTM program implementation at a health department in Ohio. The story is included on the CDC website for MTM best practices strategies.

Stories from the Field - Medication Therapy Management
MTM at Ohio Department of Health

In 2014, the Ohio Department of Health (ODH) teamed up with three Federally Qualified Health Centers (FQHC) sites to assess the effect of MTM counseling sessions on patients with hypertension. This effort involved collaboration among the Ohio State University College of Pharmacy, Ohio Pharmacists Association, Ohio Association of Community Health Centers, and the Health Services Advisory Group. These partners helped plan and develop the assessment. Pharmacists administered MTM to 5,000 patients with hypertension who were receiving care at one of the three FQHC sites. After six months, assessments found that hypertension control had increased to 68.6% among these patients. There were key components related to the project's achievement, which included maintaining relevant partnerships, implementing the pilot in one type of pharmacy setting, allowing FQHC sites to develop their own protocols for patient enrollment, using effective dissemination processes, and selecting data points that align with current pharmacy practices. Challenges included finding champions for the MTM model.

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Citations

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Mass Vaccination Plan Development and Implementation

Madison Boente, Pandemic Health Navigator
Regional Lead Coordinator

The Illinois Department of Public Health (IDPH), Office of Health Protection (OHP) Immunization Section and IDPH Office of Preparedness and Response (OPR) Medical Countermeasures Program have steered the concerted efforts of the COVID-19 Vaccination Section in the development of the State of Illinois COVID-19 Vaccination Plan.[2]

Although this is a state-level plan, the Chicago Department of Public Health (CDPH) will receive direct allocation of vaccine from the federal government.[2] IDPH has worked alongside CDPH to "ensure both the state and city-level plans are in sync and complementary".[2]

IDPH is implementing the National Academies of Science, Engineering, and Medicine's (NASEM): A Framework for Equitable Allocation of COVID-19 Vaccine.[2] This framework focuses on "reducing severe morbidity, mortality and negative societal impact due to the transmission of SARS-CoV-2."[4] The emphasis of the framework is "to vaccinate all those who choose to be vaccinated and who do not have medical contraindications to the vaccine."[4]

The state is adopting a phased approach, per the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) guidance.[2] In Phase 1, "limited and/or scarce supply of COVID-19 vaccine doses are available."[2] Initial efforts focus on reaching critical populations.[2] Vaccine administration strategies in Phase 1 are divided into three sub-phases (1A, 1B, 1C), which define the critical populations. Critical populations in Phase 1A include healthcare personnel and long-term care facility residents and staff.[2] Critical populations in Phase 1B include frontline essential workers, inmates, and persons aged 65 or above.[2] Additionally, effective February 25, Phase 1B will be expanding to include individuals with comorbidities or underlying conditions, as defined by the CDC, as well as prioritizing individuals with disabilities.[5] This expansion is possible due to the nearly 30% increase in vaccination supply seen under the new federal administration.[5] Critical populations in Phase 1C currently include other essential workers and persons aged 16-64 with high-risk medical conditions.[2] In Phase 2, an increasing number of vaccines will be available.[2] The focus will be on "ensuring access to vaccine for members of Phase 1 critical populations not yet vaccinated and extend efforts to reach Phase 2 critical populations."[2] Phase 2 critical populations have not yet been defined. As the state moves through each phase of the vaccination plan, the IDPH Immunization Section intends to define the critical populations accordingly.[2]

A network of informed and accessible vaccine providers is crucial to ensuring success in the COVID-19 vaccination campaign for Illinois. Local public health departments and hospitals have been relied upon heavily to distribute initial vaccines.[2] In an effort to address rural areas with limited access to vaccines, IDPH will focus on enrolling FQHC's and pharmacies as vaccine providers.[2] Local public health entities should plan to work in partnership with the potential vaccine providers in their jurisdiction.[2] This collaboration will ensure that the defined critical populations have equitable access to the initial vaccine supply.[2] The ultimate aim of the COVID-19 Vaccination Plan is to achieve herd immunity for the state of Illinois.[2]

Illinois is now in Phase 1B of the Vaccination Rollout. See current Illinois resources COVID-19 Vaccine Administration Data and Frequently Asked Questions for more details.[1,3]

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Date/Time Coming Soon

MAY

WORKFORCE DEVELOPMENT LEARNING COLLABORATIVE- ADDRESSING IMPLICIT BIAS, TRAUMA AND RACISM IN SERVICE DELIVERY
Location: Webinar
Date/Time Coming Soon

INTRODUCTION TO SOCIAL DETERMINANTS OF HEALTH TOOLKIT
Location: Webinar
Date/Time Coming Soon

MIDWEST DIABETES VIRTUAL LEARNING - 6 PART SERIES
MAY-JUNE
Location: Webinar
Date/Time Coming Soon

JUNE

MIDWEST DIABETES VIRTUAL LEARNING - 6 PART SERIES
MAY-JUNE
Location: Webinar
Date/Time Coming Soon

BEST PRACTICES FOR ADMINISTERING PREP
Location: Webinar
Date/Time Coming Soon

Illinois Community Health Centers Are Critical to Equitable Vaccine Distribution

Amber Kirchhoff, IPHCA Director of State Public Policy + Governmental Affairs

Equity has been declared a focal point of governmentmental COVID-19 response efforts, including the President's COVID-19 Vaccination Plan, Illinois' Vaccination Plan, and Chicago's Vaccine Equity Plan. Officials at the federal, state, and local level also recognize the unique nature of community health centers (CHCs) and their potential as partners in ensuring equitable vaccination, as evidenced by the President's newly established Community Health Center Vaccine Program, the Governor's FQHC distribution announcement, and Chicago's Mayor Lightfoot naming federally qualified health centers specifically in the city's plan and hosting multiple vaccine-related press conferences and events at CHCs.

CHCs are Illinois' largest network of primary care providers and have deep roots in communities hard hit by the pandemic, including communities of color, immigrant communities, and low-income communities. By definition, CHCs are located in medically underserved areas, making them especially well-positioned to play a key role in vaccinating priority populations and reducing racial disparities.

Health centers have been frontline providers for decades. In fact, CHCs can trace their roots back to the Civil Rights Era when some of the first health centers were established to provide care to public housing residents in Chicago. During the COVID-19 pandemic, they have stepped up to meet the needs of the communities they call home during the pandemic by adopting telehealth, transforming operations to allow for social distancing, and setting up walk-up, drive-thru, and mobile testing sites.

Illinois health centers have begun offering vaccinations as well. While vaccine remains in short supply, it has increased roughly 30% in recent weeks. Unfortunately, given the modest supply, CHCs are limited in their ability to administer vaccine. In the meantime, they have launched robust community engagement efforts to strengthen vaccine confidence and provide accurate, up-to-date information to better equip their patients to make informed decisions about their care. Fortunately, new vaccines are expected to be approved and on the market in the coming weeks and months. Additionally, increased federal coordination inspires hope that allocations to states and CHCs will continue to increase.

The new federal Health Center COVID-19 Vaccine Program will supplement allocations to CHCs from state and local government and enable CHCs that meet certain criteria to receive vaccine directly. According to the U.S. Health Resources & Services Administration, "The program will ramp up incrementally at select HRSA-funded health centers that specialize in caring for particularly hard-to-reach and disproportionately affected populations" such as individuals experiencing homelessness; public housing residents; migrant/seasonal agricultural workers; and patients with limited English proficiency.

IPHCA continues working closely with federal, state, and local officials to shore up vaccine allocations to CHCs and, most importantly, to the patients in the highly impacted communities they serve. Illinois health centers have served valiantly throughout the pandemic and we are pleased to share the following feature highlighting the incredible work they are doing to vaccinate their staff, patients, and community members!

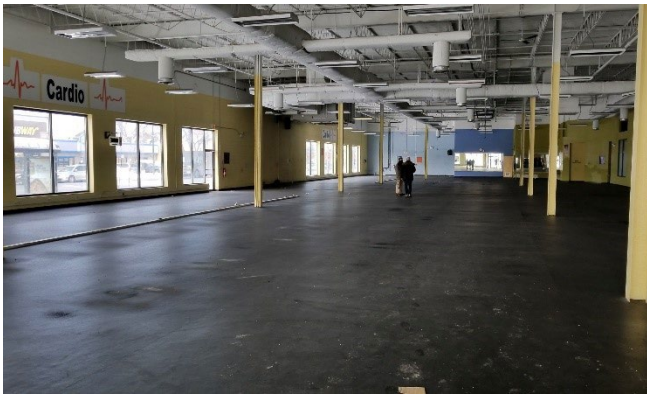
Illinois Community Health Centers Are Critical to Equitable Vaccine Distribution (continued from page 16)

COMMUNITY HEALTH CENTERS ARE LEADING THE WAY

"Esperanza began administering COVID-19 vaccinations on December 28 in the community room of our flagship Brighton Park clinic. We received the first doses of the Moderna vaccine in the city, and Chicago Mayor Lori Lightfoot paid us a visit that day as the initial doses went into the arms of our front desk workers. Within a month, as we began vaccinating patients as well as staff from other health centers, we knew we needed a larger space for our vaccination efforts."

-Dan Fulwiler, President + CEO

Esperanza vaccination set up at Mansueto High School in Brighton Park - Chicago



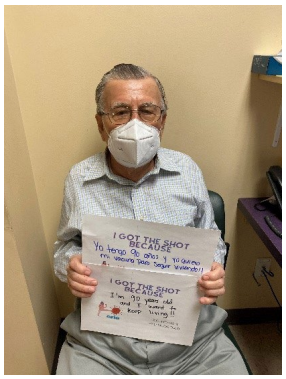
Future Esperanza Health Center Vaccine Site

"We were approached by Mansueto High School, located right next door to our Brighton Park clinic, and they offered us their gymnasium. As we hustled to transform the space into a clinical site, we partnered with the Brighton Park Neighborhood Council to identify local residents we could hire as non-clinical support. In one short week, the site was open and capable of delivering up to 3,000 doses a week.

We then turned our sights to another area of Chicago's Southwest side that has been devastated by COVID-19 – the communities of Gage Park, Chicago Lawn, and West Englewood – and located a large empty storefront that we'll convert to a second mass vaccination site in mid-February."

- Dan Fulwiler, President + CEO

Illinois Community Health Centers Are Critical to Equitable Vaccine Distribution (continued from page 17)



Wilfredo, Erie Patient

Dr. Lee Francis, Erie Patient & CEO

Ligia, Erie Patient

"Getting this shot is the same feeling as that helicopter lifting me out of Vietnam. And I have the same feeling of wanting to take everyone with me."
-Army Veteran & Erie Patient

HEALTH CENTERS ARE VACCINATING STAFF, PHASE 1B

"Erie Family Health Centers' commitment to working towards preventing racial disparities in the uptake of the vaccine began with our own staff. Erie employs many people from the very communities we serve; nearly 60% of our employees are Latino. We put great effort into surveying staff about vaccine hesitancies, educating employees about the safety and efficacy of the vaccine, and were responsive to questions within 24 hours. We are proud that 80% of Erie's patient-facing employees have completed at least their first vaccine dose.

Erie's vaccinated staff are now some of our best Vaccine Ambassadors. We are providing people with tools and resources to go back to their communities, answer questions and share their personal reasons for choosing to be vaccinated. As our patient vaccination efforts ramp up, Erie employees are doing personal phone outreach to patients, posting selfies as part of our #IGotTheShotBecause campaign, and speaking to community partners and on panels."

Kate Birdwell,
Senior Communications Manager

Illinois Community Health Centers Are Critical to Equitable Vaccine Distribution (continued from page 18)

Howard Brown partnered with the National Mexican Art Museum to offer vaccines in Pilsen – Chicago.

"We drew on our expertise in infectious disease epidemiology and crisis HIV response to quickly provide COVID contact tracing services, as well as critical social services and support to keep our patients safe and healthy throughout the pandemic.

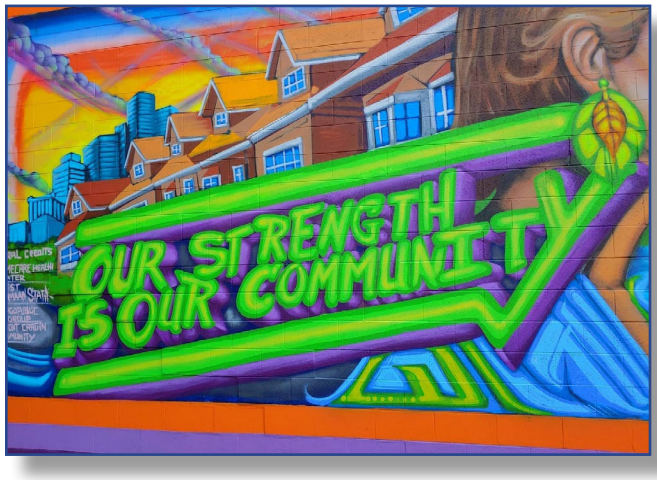
It is our goal to reach as many people with COVID vaccines as we were able to reach with our testing and support efforts, with an emphasis on equitable distribution of the vaccine to underserved and disproportionately impacted communities.

This month we hosted a citywide vaccination event, offering free vaccinations to 2,000 eligible patients and community members in the Phase 1b distribution category. We are also working with community partners on the South and West Sides [of Chicago] to ensure that there were accessible and trusted vaccination sites for folks in those neighborhoods.

As we continue to ramp up our vaccination efforts, Howard Brown remains committed to ensuring that everyone that we serve has access to the care that they need in order to stay healthy and to thrive."

-David Munar, President + CEO

Our Strength is Our Community



Ricardo Rinconeno, Marketing & Communications Manager, PrimeCare Health

We have completed a community mural in our Belmont Cragin neighborhood. In partnership with Chicago Public Arts Group we organized a community engaged mural which aimed to acknowledge the significance of current events and their impact on the community, promote awareness of the importance of community health centers, and highlight the resilience of Belmont Cragin.

As you may be aware, the Belmont Cragin community has been hard hit during the pandemic. Its rates of COVID-19 have been some of the highest in the city. Through all this, the community continued to show resilience in the face of adversity. PrimeCare Health saw this resilience and wanted to highlight the diverse and vibrant people that make up this community.

We were happy to have had the opportunity to commission muralist Rahmaan Statik . Rahmaan creates public murals that fuse the graffiti aesthetic with classical training he received from the American Academy of Art. As co-founder of R.K Design, a graphic arts and mural collective, he has produced over 400 murals. As a core artist with the Chicago Public Art Group, he has created dozens of community engaged murals.

Through focus groups, we asked community members to tell us what makes their community special. All images and text in the mural was inspired by community input. Key components of the mural were the subjects, background, and text. The majority of the individuals in the mural were modeled from actual community members. We have also included power words in English, Spanish, and Polish that were generated in our focus groups. Many of the words are prominent but others are seamlessly merged into clothing or jewelry. The mural as a whole represents the many cultures that makeup the Belmont Cragin neighborhood and make it a unique place to live.

Click to View Unveiling Video

PrimeCareHealth
COMMUNITY HEALTH CENTERS

100 Years at One Community Health Center

Jackie Gibson, VP of Marketing and Business Development, Pillars Community Health

Pillars Community Health, headquartered in La Grange, turns 100 in 2021. Only one currently operating free clinic predates this organization—by eight years—in St. Joseph, Missouri, the Social Welfare Board of Buchanan County.

"I have asked myself whether it is appropriate to celebrate this anniversary year while so many are suffering from COVID-19, so many have suffered family loss and devastating economic consequences, and racial and cultural disparities are so devastatingly impacting those we serve," says President and CEO Angela Curran, JD, LLM. "But all this turbulence just makes it more important to celebrate a 100-year commitment to looking after our neighbors, regardless of race, income, or politics. This is a celebration of community."

The story of Pillars Community Health can be traced back to the end of World War I, in the wake of the Spanish flu epidemic and the Women's Suffrage movement. The local women's club became a local chapter of the Illinois Child Welfare League. They hired a physician to examine babies in La Grange once a week at the town hall in 1919. Then on January 24, 1921, the first paid community nurse, Marion Jean MacLeod, began her work six days a week. Her salary was $150/month, which the Public Welfare Committee paid for through fundraising.

Pictured: 1921 Nurse: Marion Jean MacLeod (left), began providing well-baby checkups from the back of a drugstore in La Grange in 1921. MacLeod was the organization's only community nurse until 1944, making her the longest-serving nurse employed by the organization.

Four services were initially offered to the community in 1921: bedside nursing and well-baby checkups; community welfare including delivery of food and gifts to low-income children around the holidays; a thrift shop, which would remain open until 2020; and mother's conferences, in which mothers were invited to come together to have their babies weighed and discuss nutrition.

Pictured: 1921 Conferences: The organization's first Mother's Conference were held in La Grange in 1921.

In 1924, the association became the La Grange Community Nurse and Service Association. The nurse, together with the committee, installed a dental chair at Cossitt School, opened tuberculosis clinics, and distributed milk to area schools, among other activities.

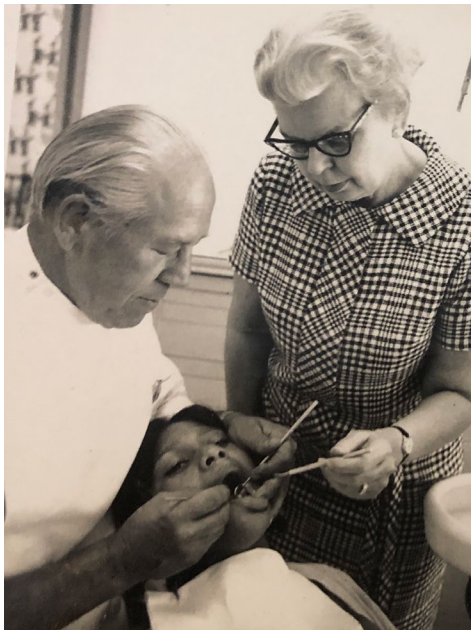
Social welfare work increased amid the Great Depression. In addition to her clinical work, Nurse MacLeod began providing eyeglasses to patients, referred people to job opportunities and legal assistance, and advocated for the introduction of silver nitrate for newborn babies' eyes, and prohibition of dogs in grocery stores. This additional work became too much for one employee to handle, so the association hired a social worker in 1932. By 1934, news articles reported that the organization "has become a prop upon which the entire village has leaned, especially in these last few years of unsettledness."

"From the very beginning, and often with only a couple of people sitting around the table, staff and board members and funders have innovated and problem-solved and piloted new initiatives to ensure people have access to the

100 Years at One Community Health Center (continued from page 21)

they need, when they need it," says Curran. "Over and over, we see people who won't take no for an answer, or who hear no and say, 'Then let's go find another way to get it done.' It's really remarkable."

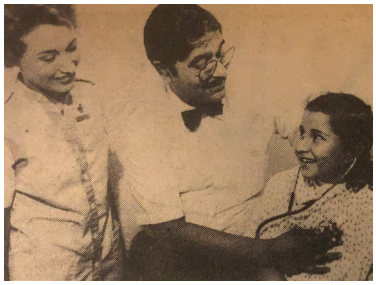
Flash forward to the middle part of the 20th Century, and by now Community Nurse has opened a dental clinic, a licensed preschool, and a formal pediatric medical clinic staffed by multiple clinicians.



Pictured: 1971 dental: With the donation of a dental chair and a $100 donation from the LaGrange Rotary Club, Community Nurse opened its first dental clinic in 1963. The organization focused on expansion of the dental program in the 1970s (photo: 1971).

In the mid-1990s, Community Nurse launched the area's first flu shot clinics at partnering churches and grocery stores, before pharmacies started offering them more widely. They also operated a meningitis vaccination clinic, before meningitis vaccines became widely available at pediatrician's offices.

Nearly 90 years into the organization's already long life, two major shifts happen: First, local funder Community Memorial Foundation spearheaded the founding of the Community Healthcare Network of the Western Suburbs. Community Nurse managed the effort, in partnership with Pillars (a nonprofit provider of mental health and social services), La Grange Memorial Hospital, ACCESS DuPage, and about 50 local medical specialists. The Network's goal is to provide a continuum of care to low-income, uninsured, or medically underserved adults ages 19-64.



Pictured: In 1981, an electrical fire forced Community Nurse to temporarily provide services from a nearby bank. Quick renovations allowed the pediatric clinic to reopen a few months later; the children's dental clinic reopened in 1983.

And second, Community Nurse became a Federally Qualified Health Center in 2012. Soon after, the medical program doubled in size, the organization began providing services to individuals experiencing homelessness, and the partnership with Pillars deepened.

Pictured: 2018 merger: With the creation of Pillars Community Health came a new tagline: Healing. Caring. Educating. The agency also rolled out a new logo, which combined the greens from the legacy Community Nurse logo with the blues from the legacy Pillars branding and the visual of a paper clip in the heart symbolizing the two organizations coming together.

100 Years at One Community Health Center (continued from page 22)

Pictured: 2020 COVID: Entering its 99th year, 101 years after the end of the Spanish flu pandemic, Pillars Community Health and its staff were faced with addressing the COVID-19 pandemic. The agency quickly shifted its service offerings, launching virtual services, three COVID-19 testing sites, and most recently a vaccine clinic.

By 2018, as health care shifted toward value-based and integrated care, Pillars and Community Nurse formally merged to become Pillars Community Health. Today the organization has locations in La Grange, Berwyn, and on-site at Anne M. Jeans Elementary School in Willowbrook as well as a formal partnership to provide services to individuals experiencing homelessness at BEDS Plus in La Grange. With the COVID-19 pandemic came the launch of telehealth for the organization as well as the opening of three COVID-19 testing sites and a vaccination clinic.

"The work of community health centers is more important than ever as the pandemic has shed a glaring light on the health care disparities we have been addressing since 1965 (when the community health center movement was launched as a small demonstration program as part of President Johnson's Office of Economic Opportunity)" says Curran. "We feel an enormous responsibility to use our time with this organization and its community health center to secure its future."

Pillars Community Health
Healing. Caring. Educating.

Eagle View Community Health System COVID-19 Pandemic Story

Emily Higgins, Marketing & Outreach Specialist, Eagle View Community Health System

In March of 2020, the world came to a grinding halt at the announcement of the COVID-19 global pandemic. Restaurants and shops had to close their doors to customers, social gatherings were strongly discouraged, and thousands of health clinics found themselves caught in a demanding situation. How could they continue to provide their essential health services in a manner that was safe for both their patients and their staff? Some clinics had no other choice but to close their doors due to limited staff and supply of proper PPE; while other clinics closed for a couple of weeks and then re-opened, operating as though nothing had happened.

Eagle View Community Health System was not spared the task of making these decisions. As per the recommendation of the American Dental Association (ADA) and the Illinois Department of Public Health, they temporarily closed their dental clinics and restricted patients' traffic into the buildings. However, these new restrictions did not stop Eagle View from providing quality health care services to their community. Despite the hardships that seemed imminent, management and staff came together to assess how to best continue to serve their patients in a safe manner. Eagle View quickly implemented their "curbside" care in their clinic parking lot. This service allowed patients to be seen in person by their provider without the need to enter the clinic. Telehealth was also introduced for their services including medical, dental and behavioral health in order to help those who could not get out of their house or were apprehensive to do so.

Of course, this still left their dental clinics. Due to the aerosols that are produced with certain dental procedures, the risk of infection and contamination were much higher for their dental staff. It was determined early on that they would not fully re-open their dental clinics until they knew that they were providing every precaution for the safety of their patients and their staff.

After copious amounts of research and deliberation, a solution was finally found. Eagle View, with the help of Motefusco, HVAC, installed a negative air pressure system and hi-tech suction domes in their Oquawka dental office. This negative air pressure area would help significantly reduce the risk of infection and the suction domes would help limit the aerosols produced during dental procedures. Once these systems were fully tested, Eagle View's Oquawka dental office was fully re-opened in June of 2020. This project was paid for using HRSA-COVID funds. Eagle View also implemented a similar system in their Stronghurst office as of January 2021 with funds from the Illinois Children's Healthcare foundation, so now both offices have fully functioning dental clinics.

Eagle View Community Health System took their time at the beginning of the pandemic to explore multiple options to provide the safest dental care possible; and they did not hesitate to implement non-conventional ways to meet the needs of their medical patients. It is because of these actions that Eagle View now offers some of the safest healthcare services and can continue to grow.

Daily Reflections of an ACT Team Worker

Deana Perez, Associate Director Clinical Operations Community/Specialty Services, Heartland Alliance Health

It is 5:30 a.m. in the morning and it is a cold Chicago Friday morning. Nevertheless, our intrepid staff bundles up and rides the blue line from the western suburbs into downtown before transferring to the redline, ending in Uptown. His riding buddies are our participants. People that have been forgotten and marginalized on the best of days, blamed for their behavior on the worst. Due to COVID, general lack of space in shelters, and for some their unwillingness to go to shelters, the trains have become mobile havens for those without homes or a place to go. A new person gets on the train, sits down without a word, takes out drug paraphernalia and proceeds to prepare a shot of heroine. To the staff's surprise the presence of others is not a deterrent, this speaks to the relentless nature of addiction and perhaps where this person is at this point in time. Another person gets on, someone who happens to be a registered participant in our Assertive Community Treatment (ACT) Team program. Staff and that person say good morning, and then proceed to take the long cold ride all the way to uptown. Even before his shift starts staff listens to the needs and obstacles this participant has regarding nearly every aspect of engaging in community life. They make it to the Lawrence stop on the redline and exit together, staff going to 4750 N. Sheridan to continue their day, and participant to another participant's home to try and get their needs met by any means necessary.

It is 8:30 a.m. and the day is supposed to start, even though effectively it started hours earlier. We review the team needs for the day in our half-hour long daily scheduling meeting. It has been identified that a participant needs to be hospitalized. She is not eating, not cashing her checks, she has been un-medicated for some time now and is in danger of losing her housing. It is the team's hope that we could elevate her to a higher level of care, but she refuses. That pesky self-determination that we all enjoy means she, like all our participants, has a choice in her care. The steep decline she is presenting with, inability to care for self, means it is time to take that decision away from her. We take the time as a team to reflect on the gravity of that decision and agree it is time and it is in her best interest. Staff and a partner staff go to the participant's home after scheduling to assess the situation. It is much the same, her apartment door is open, she is nude with no obvious understanding of how vulnerable that makes her, and there is no food in the fridge. We call one of the partnerships the team has developed with district 19 of the Chicago Police Department (CPD) and prepare for a coordinated response.

The staff wait until the CPD officers arrive. Upon arrival they review the involuntary hospitalization paperwork, the participant state of mind and what they will find in the home. With CPD help, staff are able to verbally deescalate the participant. She is yelling, screaming, scared, and unable to understand. The relationship we built with district 19 pays off as the officers are understanding and wait while staff manage the behavior. CPD transport the participant to Masonic Hospital and staff meets them there. He waits for a nurse to debrief with and review the participant behavior. The participant is accepted for hospitalization and the team will follow up at least three times a week, advocating for what is best for her physical and mental health needs. It is 12:00 p.m.

Instead of lunch, staff starts a marathon of participant visits. One participant needs housing. A second participant needs help understanding why they have an oversized gas bill. A third participant is actively hallucinating and is laying in the street on Sheridan. A fourth participant is screaming at a nurse in the clinic and cannot be deescalated by staff they do not know. And so goes the hurricane of support that is required from an ACT worker. There is no way to vet the needs, they just keep coming. Through the struggle of the day, the staff tries to be intentional, genuine and true to the population with whom we work. And then, it is done. It is 4:30 p.m. and the team comes together again for daily debrief. Catharsis, team, understanding is what they can find there. We review the day but more than that we come together in a shared understanding of how hard we work and that we are not alone.

HEARTLAND ALLIANCE HEALTH

Robert Wood Johnson Foundation Funds Research of Innovative Care Team Model at HHC-Albany Park

Gordon Mayer, Communications Consultant, Heartland Health Centers

In December, Heartland Health Centers (HHC) and University of Illinois School of Public Health received a $300,000 grant from the Robert Wood Johnson Foundation to collaboratively study the impact and effectiveness of the relationship-based care model initiated in 2019 at HHC-Albany Park.

There's a growing consensus that we can improve healthcare by shifting roles and relationships among providers, other staff and even patients. That's especially important in caring for those in communities where lack of income and other issues affect physical health.

In 2019, we reorganized team roles at HHC-Albany Park to explore better ways to deliver care. We created a care team coordinator position as part of that process.

"In our emerging new model, clinicians focus on the activities where they add the most value, and the care team coordinator ensures patient needs are tended to holistically," says Jeff Panzer, MD, Heartland Health Centers' Vice President of Care Transformation, who is helping to lead the new research.

The grant comes from a Robert Wood Johnson Foundation initiative to support research to advance models of care for Medicaid-eligible populations. It's part of their commitment to building a "Culture of Health" that provides everyone in America a fair and just opportunity for health and well-being. Eight other institutions including Sinai Health System and National Opinion Research Center in Chicago, received grants.

Panzer and Emily Stiehl, PhD, Clinical Assistant Professor of Health Policy & Administration at U of I, will lead the project, which will include patient surveys, qualitative research on interactions among Heartland Health Centers care team members, and healthcare quality data.

HEARTLAND
HEALTH CENTERS
HEALTHCARE FROM THE HEART

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AHS Family Health Center
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Beloved Community Family Wellness Center
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Community Health Partnership of Illinois
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Crusader Community Health
Eagle View Community Health System
Erie Family Health Center, Inc.
Esperanza Health Centers
Family Christian Health Center
Friend Health
Grand Prairie Services
Greater Elgin Family Care Center
Hamdard Center for Health & Human Services
Heartland Health Centers
Heartland Alliance
Heartland Health Services
Howard Brown Health
Inner City Muslim Action Network
Knox County Health Department
Lake County Health Department/CHC
Lawndale Christian Health Center
Legacy Medical Care, Inc.
Macoupin County Public Health Department
Mile Square Health Center
Near North Health Service Corporation
PCC Community Wellness Center
Pillars Community Health
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PrimeCare Community Health, Inc.
Promise Healthcare
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AllianceChicago

WHO WE ARE

IPHCA is a nonprofit trade association that serves as the voice of and champion for Illinois' community health centers. Guided by our mission to educate, empower and advocate for our member health centers, we work to expand community primary care options across Illinois. By advocating on behalf of health centers, IPHCA also advocates for access to cutting-edge, compassionate care for every patient.

To learn about membership options for health centers, businesses and organizations, visit iphca.org.

IPHCA