Near North Health Community Health Centers

Principles of Community Health Care

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MISSION: The mission of Near North Health is to provide access to high quality, primary healthcare and to improve the health and well being of the diverse populations and communities we serve. We are a culturally sensitive, patient-centered health center that empowers individuals through education and preventive health measures, regardless of one's ability to pay.

1. Identify the high risk/underserved and/or disadvantaged populations in the community(ies) that you serve and describe specifically the actions you have taken, based on relevant assessment data, to increase their accessibility to health services.

Near North Health, (NNH) is a 501(c)3, nonprofit, Federally Qualified Health Center (FQHC) in the City of Chicago. NNH ensures that high quality, culturally competent services are accessible to patients in the geographic target areas of Chicago—Near North, Near West, and Near South. NNH has been serving Chicago's low-income individuals, families, and communities for 55 years, since its inception in 1966. It offers nine health centers and two independent nutrition/WIC sites, as well as a new mobile healthcare service.

Patients are all ages. They come from 54 zip codes in Chicago, and 50 additional zip codes near Chicago. The target areas are designated Health Professionals Shortage Areas (HPSA) for primary medical, mental health, and oral health care. NNH serves approximately 45,000 medically underserved, uninsured, and low-income people a year with integrated primary care. A majority are from racial minorities, putting them at significant, increased risk of chronic disease.

NNH target areas are designated as Health Professionals Shortage Areas (HPSA) for primary care, mental health, and oral health by the U.S. Department of Health and Human Services. The majority of our patients living in these HPSAs are African American (70%) and Hispanic/Latinx (23%). Some live in communities that are up to 97% single-race. These communities are also among those hardest hit by the HIV epidemic.

In 2020, NNH's uninsured population was 40.6%, its Medicaid population was 46.8%, and its Medicare population was 3.9%. Application of our federal sliding fee scale improves access to services for these populations, especially since no one is denied care based on their ability to pay. Sixty percent of NNH's patients were at 100% of the federal poverty level, and 78% were at or below 200% of poverty. Only 3% of patients were over 200%. Our Medicaid patients made up 47% of our population, 8% had private insurance, and 4% had Medicare. NNH screens patients without insurance to ensure that all eligible discounts are applied, based on the patient's or family's income qualifications. In 2020, NNH's eligibility staff assisted 12,500 individual patients with insurance enrollment.

Like many large, inner-city populations, Chicago is experiencing an inequitable distribution of wealth, with pockets and clusters of significant poverty in certain communities. CBS News Chicago culled U.S. Census data for a feature story on the extreme poverty in sections of Chicago. It cites poverty rates of 40% to 60% in North and West side neighborhoods. These areas include much of NNH's target population.

In addition, in 2021 Chicago's unemployment rate is 7.9%, according to the Bureau of Labor Statistics. That is the lowest rate since 2001. However, the unemployment rate for Black Chicagoans rose to 7.3% for persons 16 and older—nearly double the rate of all other races/ethnicities. (The bureau reports rates for Asians at 3.5%, Whites at 3.7%, and Hispanic/Latinx at 4.7%.)

These issues—poverty, unemployment, lack of access to health care—are among the social determinants of health (SDOH) that contribute to higher rates of disease and premature death. Other SDOH include neighborhood and physical environment, social support networks, community violence, and intimate partner violence. These determinants affect a wide range of health and quality-of-life outcomes. NNH addresses this disparity through the strategic location of its sites. For example, in 2013, at the corner of North Avenue and Kostner Avenue in Chicago, NNH built a new facility and launched new services. The North/Kostner Health Center required an investment of $13 million from both public and private partners. In order to achieve this goal, Near North Health secured support from government, corporate, foundation, individual, and organization partners. The center has had a transformational impact on the lives of children and families on Chicago's West Side. For years, these Chicagoans have experienced high rates of poverty and a lack of access to health care.

In 2017, the Sunnyside Health Center was launched to increase access to healthcare for the diverse populations living in Chicago's Uptown neighborhood. Many residents live in single-room occupancy facilities (SROs), senior living apartments, and lower-cost housing units. The demand for healthcare services has grown significantly. A key feature is the location, in a small but visible strip mall, just blocks from lively train and bus stops. Sunnyside offers WIC, and one-stop shopping for the patients' comprehensive health and nutrition-related needs.

This year, NNH opened another new facility, the Razem Health Center at 2844 N. Milwaukee Avenue. Similar to the North/Kostner site launch, the project required rigorous planning, follow-through, collaboration, and partnerships.

Also in response to regional disparities, NNH has added school-based health care. Many WIC (Women, Infants, Children) clients are directly impacted by gentrification. They not only get displaced from their community but also their medical home. Retention becomes difficult as phone numbers change, addresses are in flux, and outreach is hindered. NNH had already begun reaching these patients via pop-up clinics. They are very successful. In one year, participation increased 800%, from one Head Start site with about 60 clients to 13 sites with 480 clients. In 2021, a new mobile healthcare project will strengthen these outreach and service delivery efforts. A van outfitted with medical and dental equipment will travel to schools, houses of worship, shopping areas, entertainment venues, parks, and other places where children, families, homeless persons, and others often gather. The service addresses these patients' geographic challenges.

To ensure that current services and any new service updates will improve health outcomes, NNH engages in rigorous strategic planning and annual review. The planning occurs at the Board of Directors level, and includes the CEO and senior management staff. It is a continual process. A key component occurs every year, as NNH completes a comprehensive community health needs assessment. The goal is to understand changes in patient origin data; areas showing increased need for services; and, both forecasted and unanticipated changes in relevant neighborhoods.

This is accomplished with the help of Universal Data Survey (UDS) data, using its most current reports. UDS data informs leadership on a monthly basis of patient usage statistics, including location, vital statistics, and services. The NNH assessment also includes a thorough review of published community health needs assessments involving area hospitals. And, NNH uses data from national initiatives, such as Healthy People 2030. Senior managers use the data to improve access and enhance services. They examine month-to-month and year-to-date trends, as well as managed care data to understand utilization and disease prevalence among managed care users.

In addition, agencies typically viewed as competitors are considered for potential collaboration, since need in the area almost always exceeds current physical resources. The strategic plan is reviewed, as part of the annual service area analysis, to ensure the priorities are aligned. Results are discussed among all agency leaders. Plans are formed, with input from staff and patients, and results are shared with patients and community partners. Plans for the next 12 months are developed using this process. NNH has used this methodology to inform and direct its continuous growth over its history. Sites have been added, and the programs and services that have grown include: nutrition, behavioral health, ophthalmology, school-based health care, dental care, and medical care.

The pandemic has exacerbated the public health problem communities face when they lack healthcare services. However, since NNH is continually adapting to respond to community need, it was able to maintain excellence in service delivery during this turbulent time. When the pandemic hit, NNH, like every healthcare delivery organization, was forced to rapidly rethink and reconfigure its healthcare delivery model. We quickly applied learning from the psychiatry department to expand the use of tele-health in the medical department, and for off-site services.

NNH expanded telehealth to a range of services, and all of them have been successful. In total, they include: women's health, OB/GYN, medical, pediatrics, dental, psychiatry, psychology, mental health, substance use disorder, medication-assisted treatment, opioid use disorder, and nutrition education and training.

As evidence of this success, in 2020 Near North Health was able to maintain 98% of its pre-pandemic UDS patient users. It provided 36,492 individual patients with medical, dental, and behavioral health primary care services. Visits totaled 98,193. Critically, 8,580 patients received COVID-19 testing under a new, remote model. They completed a total of 10,980 visits. In addition to clinical services, this model now includes non-clinical services such as provider training, administrative meetings, and continuing medical education.

2. Describe specifically the strategies you have used to gather input from high risk, underserved and/or disadvantaged population and their leaders as a basis for program or service development.

NNH involves the target population in shaping its goals and activities. Currently, requirements, 71% of board members are current, registered patients of the health center. These consumer board members represent the individuals we serve, including persons of every ethnicity, race, sex, and gender identity.

In addition, NNH continually solicits—and acts on—input and feedback from its patients and clients. Input comes from patient surveys, program advisory boards, focus groups, and post-program evaluations. We ask every patient to complete a patient satisfaction survey. The surveys are collected randomly, and they are offered in languages and literacy levels that serve the patient population. Patients access them via the NNH website, on-site kiosks, or personal devices that are on-site, and powered by free Wi-Fi. For any patient who wishes to report a complaint, NNH staff assist them with steps and forms they need to complete the process. All complaints are investigated and the complainant learns of the solution within 10 days.

3. Describe specific partnerships with other providers and community-based organizations to promote continuity of health care for high risk/underserved and/or disadvantaged populations.

Here is a listing of most, but not all, of Near North Health's referral partners.

Heartland Health Outreach – refers homeless patients for medical services at NNH's Sunnyside Health Center.

Northwestern Memorial Hospital – provides specialty care for indigent patients, collaborates to deliver wellness programs, and provides continuity of care to NNH patients.

University of Chicago Medical Center – NNH participates in UCMC's Project ECHO, which creates communities of practice for primary care providers and specialists. Providers work together to gain and spread new medical knowledge and apply it to specialty patient care.

John H. Stroger Hospital of Cook County – provides primary, specialty, and tertiary healthcare services. NNH is able to refer patients for low-cost prescriptions and specialty care for serious illness, such as cancer and diabetes.

Ann and Robert H. Lurie Children's Hospital – a primary referral destination for difficult cases, and it provides continuity of care for NNH's pediatric patients.

Safety-net hospitals – NNH refers patients to safety-net hospitals, such as those mentioned above, Mt. Sinai, Humboldt Park Health, UI Health, and more than a dozen smaller hospitals in Chicago and nearby Oak Park (Pipeline West Suburban Hospital).

AIDS Foundation of Chicago – provides case management and transportation services to Near North Health's Early Intervention Services (EIS) patients.

State & local health departments – work to ensure every person has access to care.

Chicago Department of Children and Family Services – NNH provides drug counseling and treatment for families and individuals involved with this agency.

Cook County Bureau of Health Services – NNH works with their community access program for specialty and diagnostic referrals, as well as their Neighborhood Referral Program.

4. Provide two examples of how you have used the community-oriented approach to program development specified in the attached principles to develop a program of service for high risk/underserved and/or disadvantaged populations specified in the guidelines. Include

in each description components of the current program and the following quantitative information for the most recent year available:

EXAMPLE 1: Chronic Care Coordination

Over the past six years, NNH has established and expanded its Chronic Care Management (CCM) Department. CCM works to improve clinical outcomes of people at high risk for chronic disease. All patients are offered care coordination to improve their outcomes, and patients have two or more chronic diseases are offered Chronic Care Coordination. They receive more intensive disease management, health education, and help with social determinants of health.

The CCM program is critical to NNH in meeting two of its primary goals—addressing health disparities and preventing premature health decline and death due to chronic disease. Care coordination assists a patient to follow a treatment plan, and self-manage their health. The CCM team risk-stratifies patients who have diabetes, hypertension, depression, and HIV. These receive more phone contact, in-person contact, and other support than patients at medium or low risk. They discuss healthy behaviors and sticking to treatment, current medications, preparing for upcoming visits, and any questions that arise. All interactions with patients are documented in the patient's electronic medical record. And, specially-designed software identifies who is at risk, and how well they are meeting their goals. These patients are less likely to delay or leave conditions untreated, or to seek care from an emergency room or hospital instead of their doctor.

Number of clients served	37,102
Total amount budgeted by your organization for the program	$885,653
Percent that program budget is of total agency budget	2.7%
Percent of program budget that is directly reimbursed by third party payers	8%
Percent of program budget that is covered by public/private grants	90%

EXAMPLE 2: Improving Maternal Child Health

Near North Health provides comprehensive care to young families. This starts before a baby is born. NNH serves the target population with maternal/child health programs, such as Family Case Management, Better Birth Outcomes, and Healthy Families Illinois.

The Family Case Management program supports the pregnant woman to find a doctor for her prenatal care, find a doctor for her infant's care, understand proper nutrition for herself and her infant, and understand the stages of her infant's development. The program also assists the mother to access: nutrition education and WIC EBT cards, family planning, substance abuse treatment, prenatal/parenting classes, child care / transportation, immunizations, Kid Care (health insurance), and various community resources.

Number of clients served	4467
Total amount budgeted by your organization for the program	$2,273,000
Percent that program budget is of total agency budget	7%
Percent of program budget that is directly reimbursed by third party payers	2%
Percent of program budget that is covered by public/private grants	96%