



# Healthcare Providers: On the Front Line to Make Communities Stronger

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OHS FORUM: IMPROVING COMMUNITY HEALTH

JANUARY 8, 2020



**46 ALBION ST**



# 6 Locations



**968 FAIRFIELD AVE**



**762 LINDLEY ST**



**510 CLINTON AVE**



**1046 FAIRFIELD AVE**



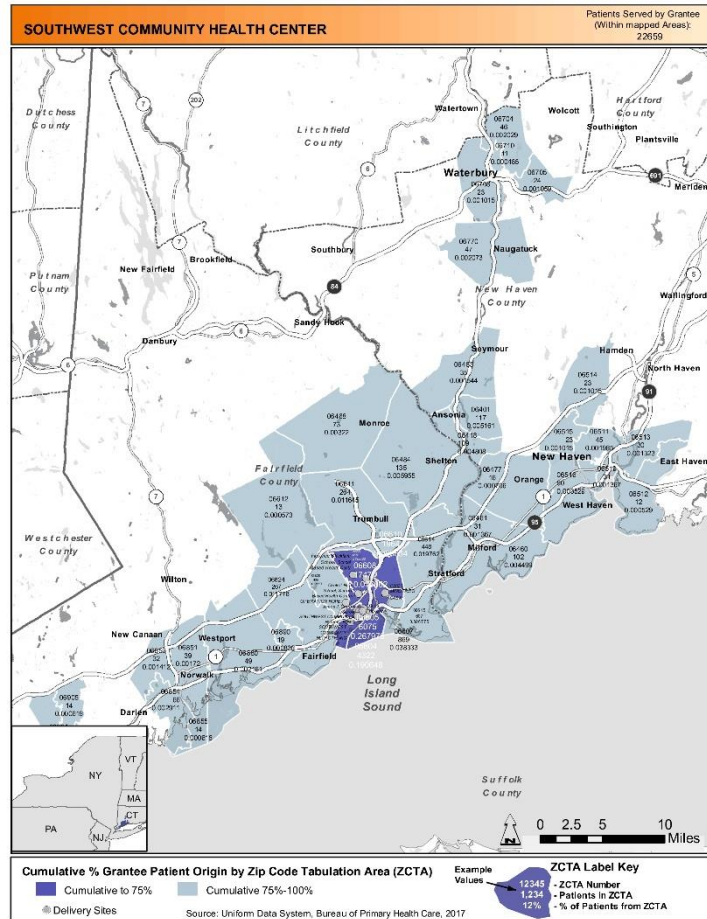
**743 SOUTH AVE**

# Sites

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- ❖ 6 Main Facilities
- ❖ 6 Homeless Shelters
- ❖ 8 School Based Health Centers
- ❖ A WIC Site
- ❖ A Site within a Substance Abuse Treatment Facility

# Service Area



# Our Patients – 2018 Snapshot

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❖ **146,247 Total Visits:**

- 85,082 Medical
- 21,462 Dental
- 39,703 Behavioral Health

❖ **26,668 Unduplicated clients served:**

- 15,586 Medicaid – 58.4%
- 6,485 Uninsured – 24.3%
- More than 95% under 200% of FPL
- 87% of patients are racially/ethnically diverse



# Barrier- Free Access to Care

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- ❖ Targeting Low Income, Medically Underserved Residents of Greater Bridgeport
- ❖ Sliding fee discounts- up to 200% FPL
- ❖ Evening and weekend hours
- ❖ Neighborhood locations
- ❖ Convenient public transportation - tokens
- ❖ Multiple comprehensive services
- ❖ Culturally competent/diverse workforce

# Southwest Services

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- ❖ Internal Medicine
- ❖ Obstetrics and Gynecology
- ❖ Pediatrics
- ❖ Family Practices
- ❖ Dental
- ❖ Behavioral Health
  - Mental Health Treatment
  - Substance Abuse Treatment
  - Medication Assisted Treatment
  - Co-Occurring Treatment
- ❖ Nutrition
- ❖ Podiatry
- ❖ Program Entitlement Enrollment
- ❖ McKinney HCH Program
- ❖ The Ryan White HIV/AIDS Program
- ❖ 340b Discount Drug Program
- ❖ School Based Health Centers
- ❖ WIC

# Redefining Healthcare

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## ❖ Transformation

- Adoption of Quadruple Aim
  - Patient Experience + Population Health + Reduce Costs + Care Team Well-Being
- Patient and Family Centered Care – coordinated, enhanced access
- Data-driven Continuous QI – culture of quality and safety, optimize technology, transparency
- Sustainable Change – staff retention, smart investments, efficiency
- Fostering connectedness – HEC, disease-specific state and local initiatives, specialty care referrals
- Focus on Integrated Care



# PCMH+ Initiative Supports Our Efforts

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**PCMH+ (Person-Centered Medical Care +)** is a grant-funded, Husky Medicaid program designed to improve health outcomes and the care experience of Medicaid members and contain the growth of health care costs.

**Southwest Patient Attribution:**  
14,045

# PCMH+ Approach

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## ❖ Enhanced Care Coordinators (ECCs)

### ❖ Targeted outreach:

- Intensive Care Management patients
- High Risk patients
- ED/Hospital discharge patients
- Gaps in Care patients
- Children and Youth with Special Healthcare Needs (CYSHCN)
- Patients who have behavioral health conditions
- Transition age youth (TAY)

## ❖ Care coordination

## ❖ Focus on social determinants of health

## ❖ Community Advisory Board

# PCMH+ Enhanced Care Coordinator Vignettes

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So many patients are grateful for their services :

- ❖ A newly disabled, non-English-speaking patient who was assisted with accessing medical transportation and disability housing
- ❖ A hungry, non-English-speaking diabetic who was assisted with SNAP reinstatement after his benefits had been terminated.
- ❖ A parent of a child with autism who was assisted with accessing DDS and the Kennedy Center for autism resources
- ❖ A learning disabled teen mother who was assisted with developing a Transition Age Youth plan and assisted with accessing a teen mothers program and free school supplies so that she could stay in school.
- ❖ Many homeless patients who were assisted with finding stable housing



Thank You!

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