LAURIE FRANCIS, BSN, MPH

Executive Director, Partnership Health Center

Laurie has been working in health care for the past 20+ years, pursuing strategies to improve health and well-being in individuals and communities systemically. Laurie now serves as executive director of Partnership Health Center (PHC) in Missoula, MT. PHC experiments with programs that attend to drivers of health while focusing significantly on powerful teams, data-driven decision-making, and joy at work.

During the summer of 2017, Laurie returned to health center leadership after six years at the Oregon Primary Care Association as the senior director of innovations. She led an incredible team of talented individuals there while advancing the understanding and implementation of advanced and emergent models of care, services, and partnerships to move upstream to dramatically improve population health and well-being.

She has publications in the areas of health literacy, outcomes, and self-efficacy and has served or continues to serve on numerous boards. Her educational background includes a bachelor's degree in human biology from Stanford, a bachelor's degree in nursing at Montana State University, and a Master of Public Health from the University of Washington. Laurie has two daughters, one living in Southern California and working with Hulu and the other in her fourth year of medical school.

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LEANING *into* our CHC LEGACY

CHAD Conference
September, 2021

Laurie Francis

OUTLINE

I. OPENING
   A. My Background and PHC's Strategies
   B. Your situation

II. History of CHCs, PHC and Root Causes of Wellbeing

III. Using PRAPARE to better understand these causes
   A. Other ways to use this tool or other tools?

IV. Connecting SDOH Data and Health Outcomes
   A. Who else is disaggregating data?

V. In Pursuit of Health Justice

VI. QUESTIONS, IDEAS, CONCERNS

YOU and ME

I. YOU!
   A. Who is (still…) in the “room”???
   B. How many are doing SDoH screening
      1. Using PRAPARE – all or some?
   C. Have it all figured out?!

II. PHC and ME
   A. My Background and PHC’s Strategies

LAURIE

CHCs and PHC

History of CHCs -first health center – 1965 in Mississippi

I. Awareness of poverty and health linkages
II. Connection to racism, health, and health outcomes
III. Designed to target roots of poverty by:
   A. Combining local strengths - POWER
   B. Adding federal support
   C. Establishing neighborhood clinics
   D. Rural and urban America
   E. Integration of all care to offer whole person, whole community care

IV. PHC grew out of this history
   A. 8 sites
   B. 275 employees (30 temps came and went with Covid…argh)
   C. 16,000 unique patients
   D. Medical, BH, Dental, Pharmacy, In-house FM residency, Co-appl. With County
   E. Pursing EQUITY and JUSTICE

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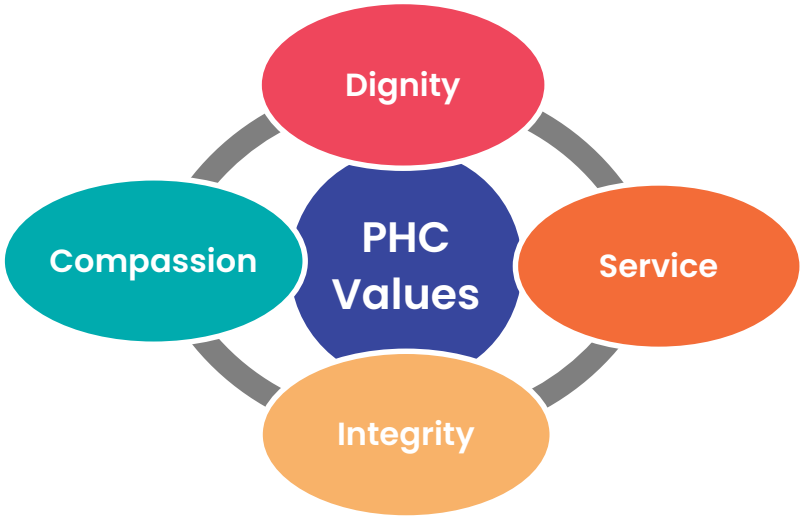

VISION, MISSION AND VALUES

Vision

Healthy People, Strong Communities

Mission Statement

Partnership Health Center promotes optimal health and well-being for all, through comprehensive, patient-focused, accessible, and equitable care.

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STRATEGIC PLAN 2021

Joy at Work

PHC achieves high levels of engagement through recruiting, developing, connecting, and compensating talented staff to provide safe and culturally affirming care to its patients.

Impeccable Quality

PHC provides safe, effective, appropriate, timely, and human-centered health care services to improve health outcomes for all it serves.

Operational Excellence

PHC has systems that support timely patient care, staff efficiency, diversity, and responsiveness to opportunities and threats readily.

Barrier-Free Access

PHC ensures the availability of comprehensive, affordable, culturally and linguistically appropriate health services in a timely manner.

Innovations in Population Health

PHC addresses systemic barriers to good health and wellbeing by partnering with the community and implementing new programs grounded in evidence-based and emerging best practices.

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SPECIFIC SERVICES

- Integrated Behavioral Health
- BH Groups, Individualized Counseling
- HIV Prevention / Primary Care/ PrEP
- Liver Clinics
- Pre-Release RN
- Reach out and Read
- Cancer Control Team
- Healthcare for the Homeless
- IMAT
- Health Equity Community Organizer
- Refugee Program
- Foster Care-kiddos
- 0-5/School readiness
- Good to be Home
- FUSE/Housing Navigator
- Diabetes Education
- Clinical Pharmacy
- Physical Therapy
- Dental Care Manager
- Medication Assistance Program
- Medical Legal Partnership
- Mental Health Coordinator
- Geriatric Program
- Mobile Crisis Unit

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Structural Inequities

(Classism, Racism, Sexism)

Socioeconomic Environment

Physical Environment

Health Behaviors

Health Care

Mortality

Socioeconomic Environment

Education
Good Jobs
Access to Food
Legal Support
Social Support

Physical Environment

Housing

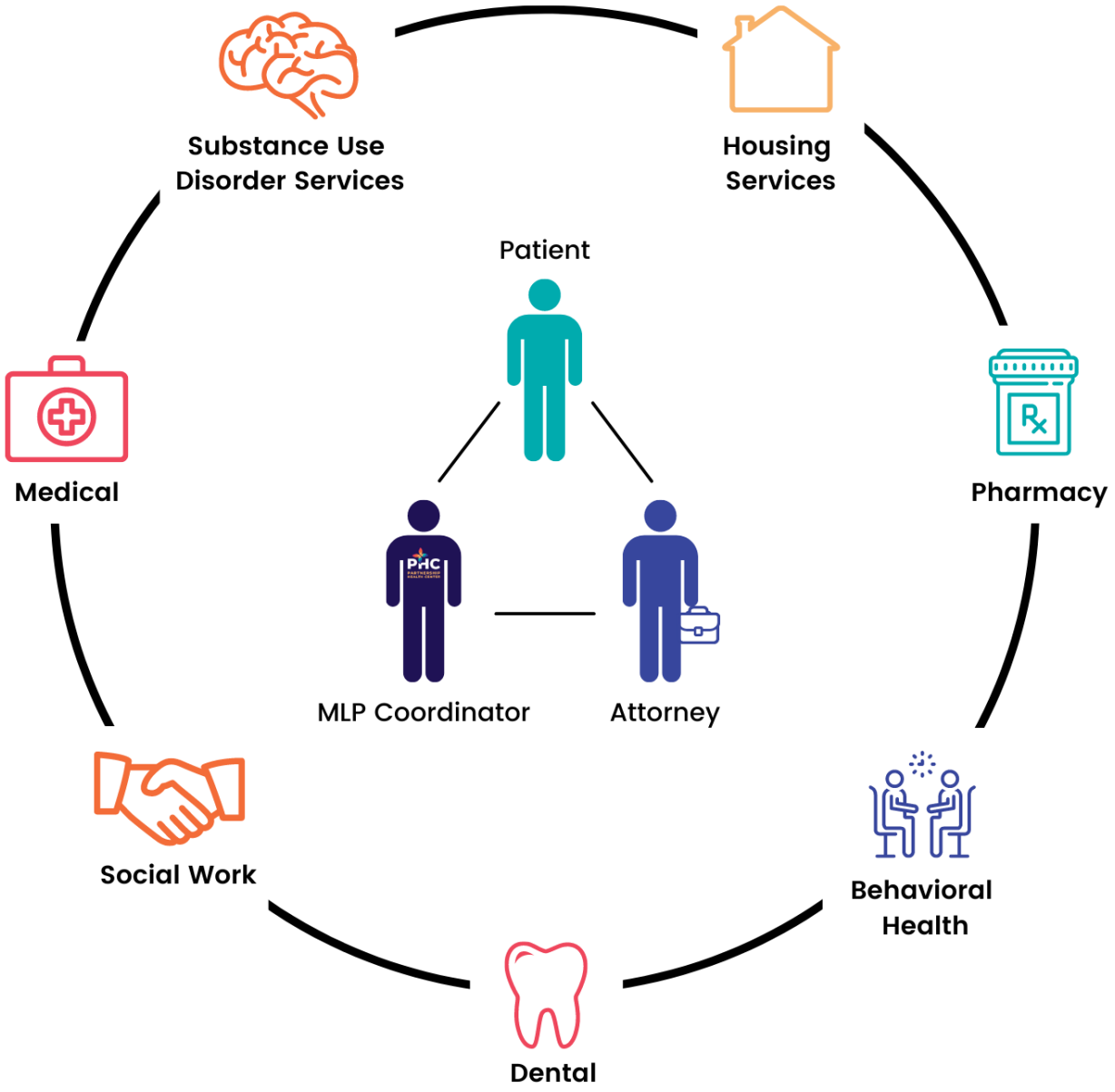
Health Behaviors

Sexual Activity
Tobacco Use
Diet & Exercise
Chronic Stress
Alcohol Use

Health Care

Medical
Dental
Behavioral Health
Pharmacy

We have the resources to help you.



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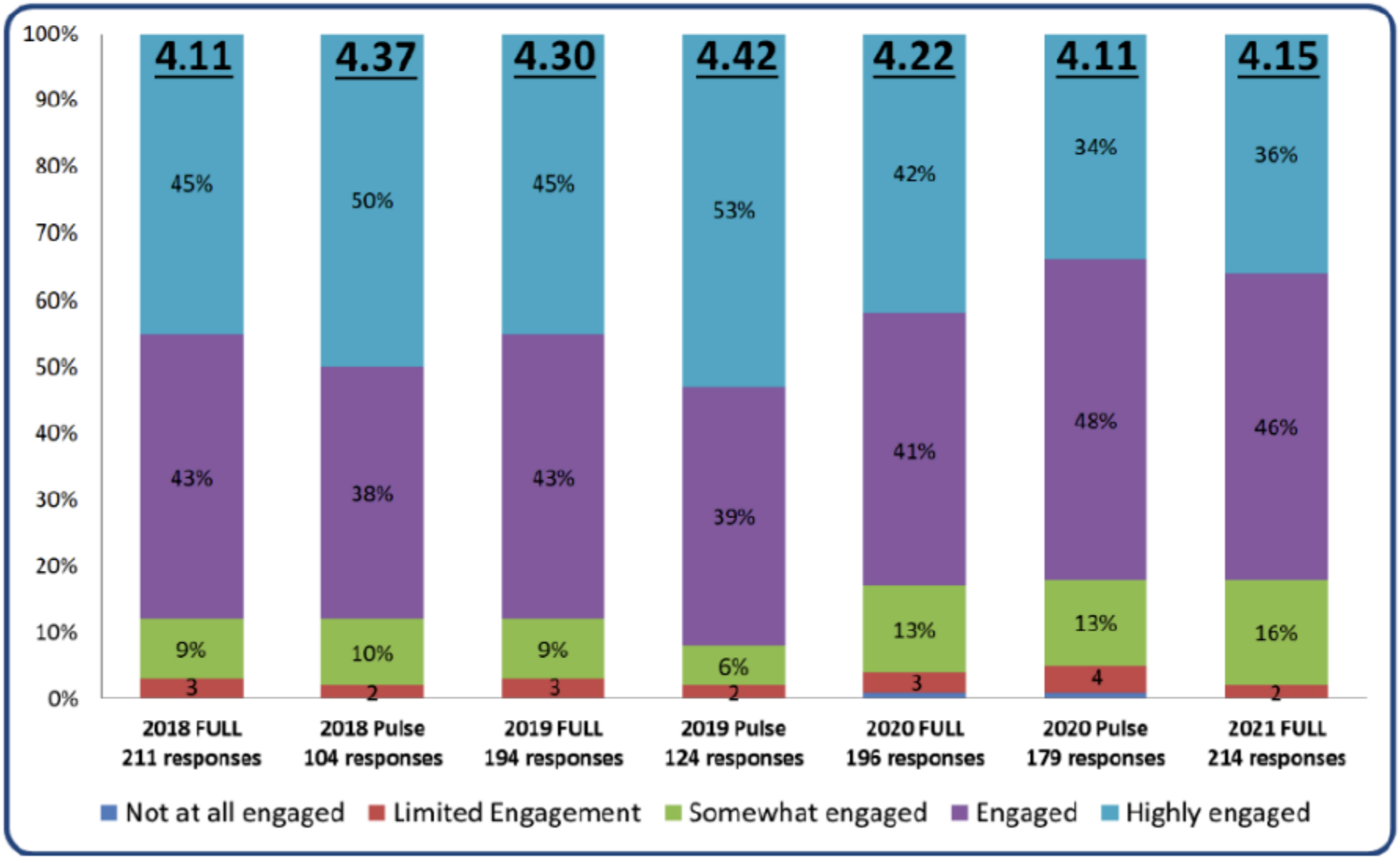
2021 Staff Engagement Survey Results

214 respondents

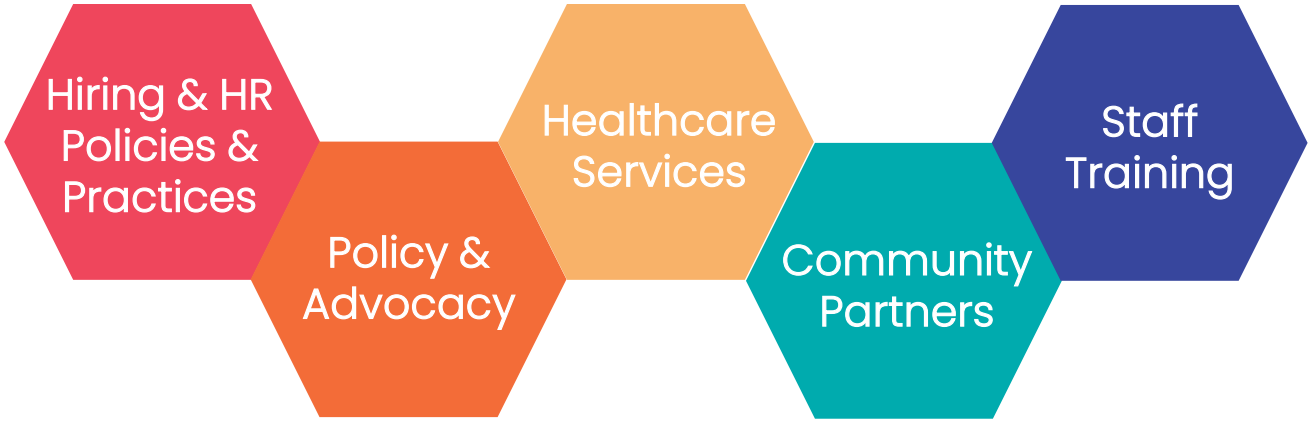
Average Engagement Scores Across Time

1=Not at all engaged 5= Highly engaged



DIVERSITY, EQUITY, & INCLUSION ADVISORY COMMITTEE

- "Leading with race"; racial justice is inextricably linked to health justice
- ~20 group members, with representation across PHC departments and FMRWM
- Driving culture change, with anti-racist policies and practices throughout all domains of work



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PHC'S TIMELINE FOR THE FUTURE

NEXT 2-18 MONTHS

Clinical Operations
Open/reopen
MFB and CC
Lowell
Superior
BH expansion

Dashboard #
Track/refine

Super Utilizer

Creamery
Added providers
Foster care
Same Day Access
Team transformations
PSR changes
Population of Focus
Vaccine outreach

General Operations
Increase staff
HR
Infrastructure
Finance

EHR Improve

Virtual care

Facilities
Creamery
Superior
Seeley

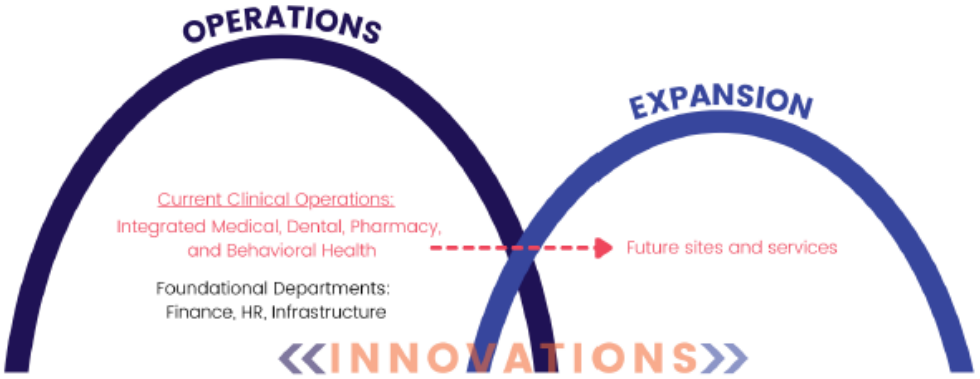
Refine
MST
MLP
Medicare Well

Develop Sub-population Work
Co-design
Native American
Vaccine
PFAC
HTN grant/POF

0-5 Learning Center

Staff/Patient Childcare

DEI work - staff/patients



NEXT 6-36 MONTHS

Expansion Work
Staffing
Manager/support
Task Force
Areas of Development

New Sites
Detention
Stevensville
Trinity

Buildings/Space
Childcare
Offices

New Programs/Services
SDoH ideas
HS program/site
Sustainability model
St. Pats/Providence ideas

PAST and NEXT PRAPARE STEPS

I. THIS IS ROCKET SCIENCE

A. Who asks questions?
B. Avoid adding trauma and pain, 'collecting data' - Collaborative Screening/Empathic Inquiry
C. Where to reflect information?
D. What to do next?

II. Looking at how SDoH relate to UDS data

III. Addressing SDoH inside our organizations

A. What are you doing?

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SDOH/PRAPARE Journey

SDOH phone Outreach to pts

Phone Outreach to pts not seen recently and new pt. follow up during first few months of pandemic.

3-6/2020

2020: PHC decided to utilize the 28 questions from the PRAPARE form in conjunction with Empathic Inquiry to screen all patients for SDOH.

13/27 asked annually

4/2020

At each apt with adult pts, during Rooming process, MA asks pt if they are experiencing Food or Housing insecurity and refers to SW for support.

Added Food/ Housing screen to every visit

15/27 asked annually

PHC SDOH Strategic Goal set

Impeccable Quality/Equity:
"Create plan and timeline for universal SDOH screening by 5/21"

1/1/2021

7/13/2021

At each apt with adult pts, during Rooming process, MA asks pt. if they are experiencing Transportation (medical or non-medical related) barriers and refers to SW for support.

Added Transportation screening to every apt

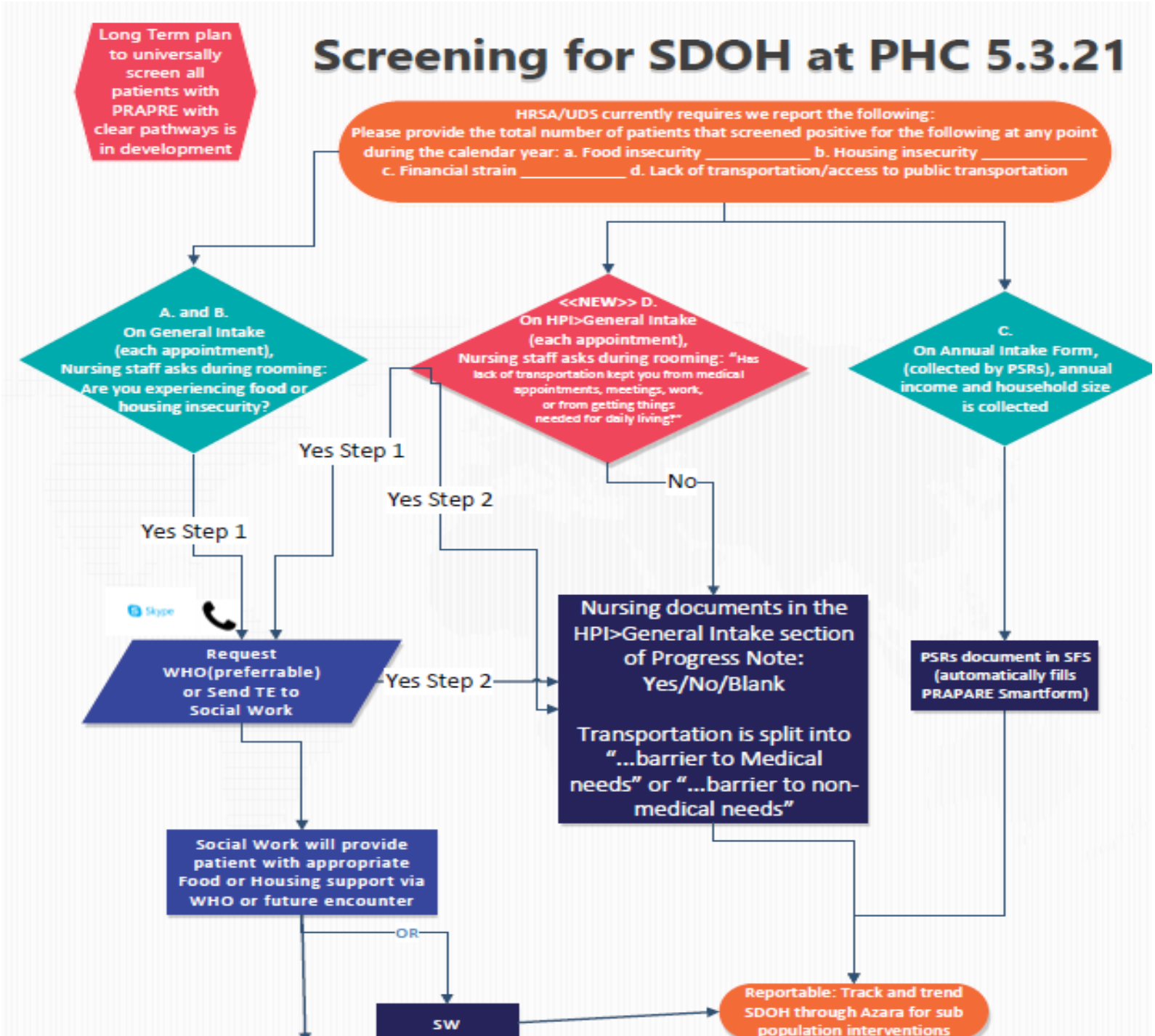
16/27 asked annually

Added more to annual Registration

Added education, jail, refugee, and revised social interactions SDOH ?s to annual registration form.

7/2021

20/27 asked annually

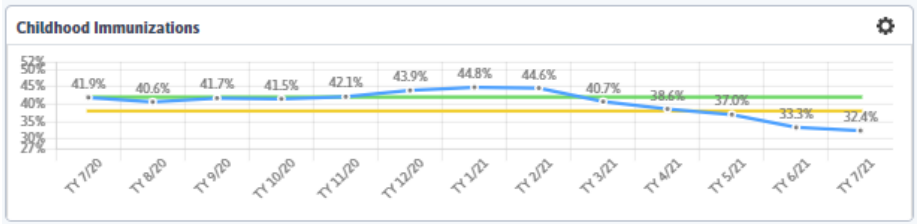

Long Term plan to universally screen all patients with PRAPRE with clear pathways is in development
Screening for SDOH at PHC 5.3.21
HRSA/UDS currently requires we report the following:
Please provide the total number of patients that screened positive for the following at any point during the calendar year: a. Food insecurity _____ b. Housing insecurity _____
c. Financial strain _____ d. Lack of transportation/access to public transportation
A. and B.
On General Intake (each appointment), Nursing staff asks during rooming: Are you experiencing food or housing insecurity?
<<NEW>> D.
On HPI>General Intake (each appointment), Nursing staff asks during rooming: "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?"
C.
On Annual Intake Form, (collected by PSRs), annual income and household size is collected
Yes Step 1
Yes Step 2
No
Yes Step 1
Yes Step 2
Skype
Request WHO(preferrable) or Send TE to Social Work
Nursing documents in the HPI>General Intake section of Progress Note: Yes/No/Blank
Transportation is split into "...barrier to Medical needs" or "...barrier to non-medical needs"
PSRs document in SFS (automatically fills PRAPARE Smartform)
Social Work will provide patient with appropriate Food or Housing support via WHO or future encounter
OR
SW
Reportable: Track and trend SDOH through Azara for sub population interventions

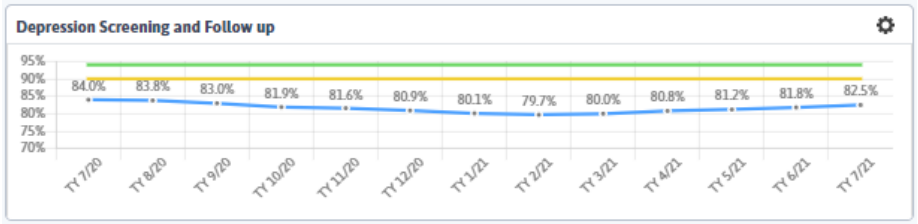
Equity Lens on Impeccable Quality 2021

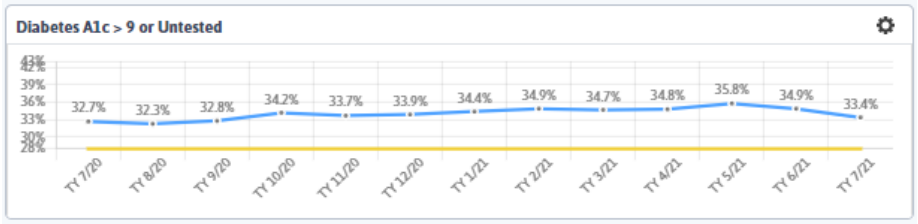
Provide safe, effective, appropriate, timely, and human-centered health care services to improve health outcomes for all we serve.

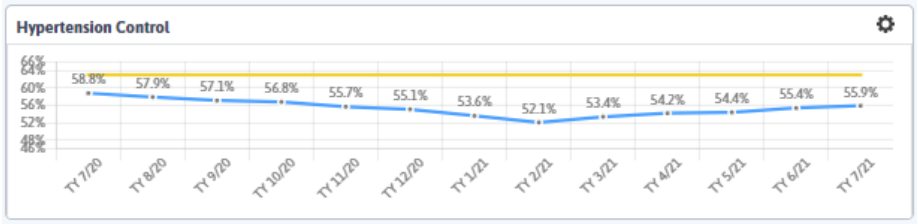
Whole Clinic

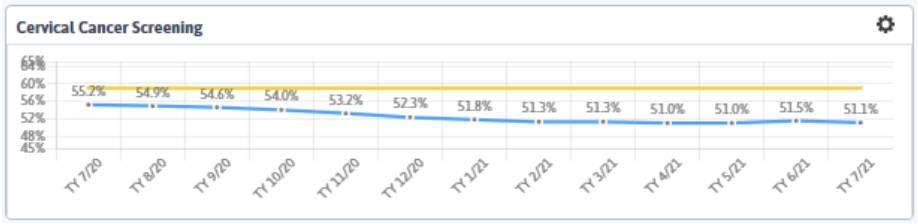
Native American Population











Native American

MEASURE		RESULT	NUM	DENOM	EXCL
DM A1c > 9 or Untested		41.8%	41	98	0
HTN Controlling High BP		52.0%	89	171	4
Colorectal Cancer Screening		44.1%	83	188	3
Cervical Cancer Screening		52.8%	121	229	26

	Native American Patients	Center Average
DM A1c > 9 or Untested (lower=better)	**41.8%**	**33.4%**
Hypertension Controlling High BP	**52.0%**	**55.9%**
Colorectal Cancer Screening	**44.1%**	**49.0%**
Cervical Cancer Screening	**52.8%**	**51.1%**

PHC COVID-19 Vaccination Equity

Last Updated 05/04/2021

Population Analysis

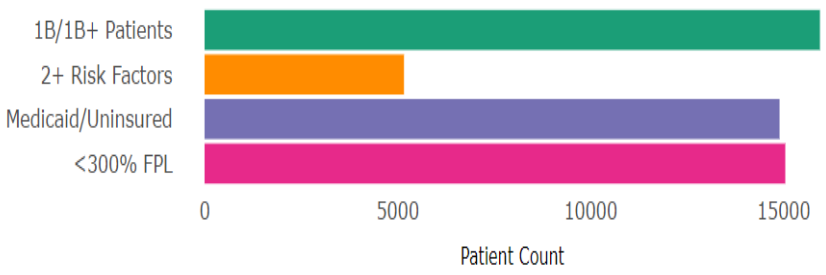
37%
Of PHC Patients With 1+ Vaccine Doses

26922
Total PHC Patients

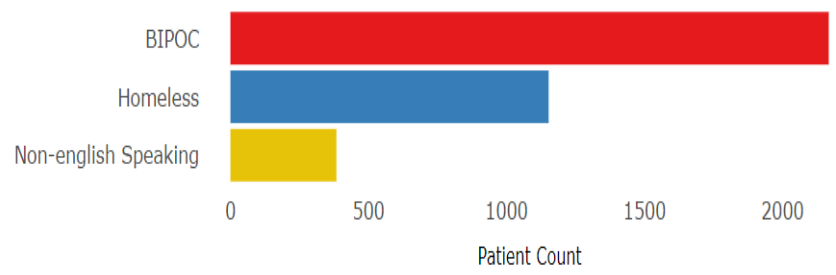
83%
Of Non-High Risk Pts w/ 1+ Doses

3640
Total Non-High Risk Patients

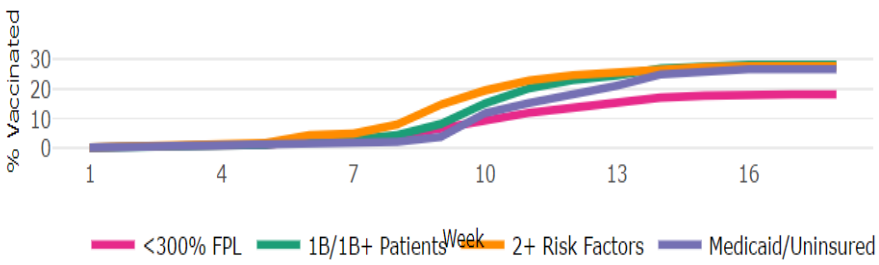
Patient Sub-Population Totals



Patient Sub-Population Totals



Percent Patients With 1+ Vaccine Doses Per Sub-Population



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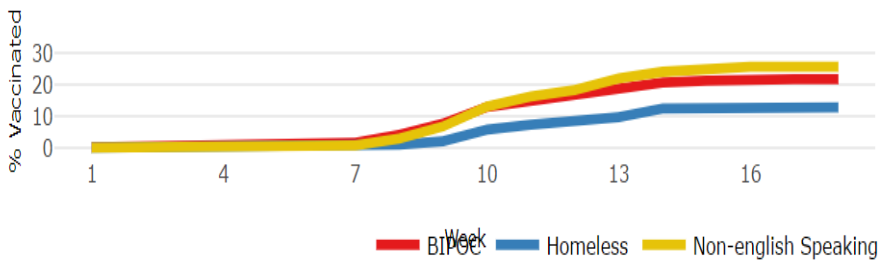

IN Pursuit of HEALTH JUSTICE

I. Addressing SDoH outside our organizations
   A. Partnering with other organizations
   B. Co-designing with those impacted
   C. What else??

II. Courage over comfort in conversations, learning, and growth
   A. Larger Band-Aides vs. Cures
   B. Anti-racism work
   C. Organizers
   D. CHWs
   E. From FEAR to GROWTH

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QUESTIONS/IDEAS

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