

Community Health Center Medical Home Grantee Meeting...Sharing the Experience

May 1, 2008

Presenting Community Health Centers

Caring Health Center in Springfield

Caring Health Center (CHC) has identified the growing immigrant and refugee patient population the City of Springfield as the target population for this project. Many of these newly arriving refugees and immigrants present with chronic health conditions including tuberculosis, parasitic infection, HIV, Hepatitis, malnutrition and anemia. Mental health is another area of need for the refugee population who suffer from histories of trauma experienced in their countries of origin, complicated by the stress of relocation. CHC estimates that it has served approximately 2,300 refugees and thousands of immigrants.

Community Health Programs in Great Barrington (Berkshires)

In Project "Close the Loop," Community Health Programs is testing an innovative model of sending a Mobile Outreach Treatment Team (MOTT), comprised of a nurse and a patient assistance coordinator), to community sites throughout southern Berkshire County.

The target population is 650 low-income individuals who are in need of the whole range of primary health care and social services. The MOTT provides comprehensive health screenings; enrollment in insurance and other public assistance programs; and assistance in addressing any access barriers faced by clients.

Duffy Health Care for the Homeless in Hyannis

The Duffy Health Center of Hyannis, a HRSA 330(h) health care for the homeless program since 2002, supports its newly expanded mobile medical care outreach team to enroll hard-to-reach persons who are homeless or at risk of homelessness into a medical home, by assigning them to a medical home, and provides direct health services and care management.

The project's mobile medical team activities include outreach with community agencies notifying them of the program, and with homeless and at risk individuals to establish a trust relationship which will be key to continuity of care. Medical care management by a nurse practitioner ensures clients have access to and receive medical or behavioral health care.

Lynn Community Health Center in Lynn

Lynn Community Health Center is developing an automated tracking system within the electronic health record that will provide data on immunizations and well child visits to be used by our Pediatric and Family Medicine providers. This system supports the development of a medical home by identifying those patients who have fallen behind on immunizations and well child visits and creating a follow up system that will reconnect them with their usual Health Center provider.

Greater New Bedford Community Health Center in New Bedford

Greater New Bedford Community Health Center is developing the Maternal Child E-Health project, which will provide e-health record software, training in its use, and creation of a protocol for systematic tracking and follow-up of the 590 pregnant women who initiate care through the Health Center's Maternal Child Health program annually. MassCHIP statistics indicate that 25% of pregnant women in New Bedford do not get the regular prenatal care they need and the teen-age pregnancy rate is more than twice the statewide average. In addition, the city has a higher than average infant mortality rate.