

# 2020- 2022 Key Community Benefit Initiatives

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## INITIATIVE #1: ACCESS TO EQUITABLE HEALTH CARE SERVICES

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### Community Need Addressed

Access to primary, specialty and behavioral health care.

### Goal (Anticipated Impact)

Increased accessibility for timely care; Increased patient establishment with PCP; Increased navigation and supportive services to vulnerable populations; Increased access to clinic based Behavioral Health Services.

### Scope (Target Population)

Broad community.

**TABLE 1. OUTCOME MEASURES FOR ADDRESSING ACCESS TO CARE**

Outcome Measure	Baseline	FY22 Target
<b>Increased same-day appointment capacity (Immediate Care)</b>	375 appt/month	550 appt/month
<b>Increased PCP assignment</b>	3400 Medicaid assigned individuals	4500 Medicaid assigned individuals
<b>Increased capacity for internal mental health referrals (wait times)</b>	10 Days	2 days

**TABLE 2. STRATEGIES AND STRATEGY MEASURES FOR ADDRESSING ACCESS TO CARE**

Strategy(ies)	Strategy Measure	Baseline	FY22 Target
<b>Hire additional LCSW/LPC for primary care clinic</b>	Staff #	4	5
<b>Hire additional Behavioral Health Consultant for Primary Care Clinics</b>	Staff #	2.3	3.3
<b>Signage and program materials translated to Spanish</b>	-	-	All
<b>Hire bilingual/bicultural financial advocate</b>	Staff Members	0	1

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## INITIATIVE #2: SOCIAL DETERMINANTS OF HEALTH

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### Community Need Addressed

Access to Healthy Food/Food Insecurity.

### Goal (Anticipated Impact)

Increased access to healthy foods to vulnerable patient population, open eligibility beyond diabetic patients.

### Scope (Target Population)

Vulnerable populations.

**TABLE 3. OUTCOME MEASURES FOR SOCIAL DETERMINANTS OF HEALTH**

<b>Outcome Measure</b>	<b>Baseline</b>	<b>FY22 Target</b>
<b>Increase access to healthy food options for vulnerable population</b>	0-20 boxes/month	50 boxes/month

**TABLE 4. STRATEGIES AND STRATEGY MEASURES FOR SOCIAL DETERMINANTS OF HEALTH**

<b>Strategy(ies)</b>	<b>Strategy Measure</b>	<b>Baseline</b>	<b>FY22 Target</b>
<b>Develop identification and tracking method for distribution</b>	N/A	N/A	N/A
<b>Hire community health worker to manage distribution program</b>	Staff #	0	1
<b>Offer food cooking Demos and Nutrition Tip of the Month</b>	Demo #	0	12

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### INITIATIVE #3: PATIENT EMPOWERING EDUCATION

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#### Community Need Addressed

Providing access to information and education on wellness, health promotion and disease prevention. Offering free educational opportunities to allow the community access to a variety of health care topics, giving them the information to make empowered decisions about their own well-being.

#### Goal (Anticipated Impact)

People get the language-appropriate information they need or want on paper, online or video to be able to access the services they need.

#### Scope (Target Population)

Low-income and vulnerable populations.

**TABLE 5. OUTCOME MEASURES FOR ADDRESSING PREVENTION AND PROMOTION**

<b>Outcome Measure</b>	<b>Baseline</b>	<b>FY22 Target</b>
<b>Increase access to MCMC programs online</b>	1 online course	3 courses
<b>Interpreter services available at MCMC Programs</b>	0	2 courses

**TABLE 6. STRATEGIES AND STRATEGY MEASURES FOR ADDRESSING PREVENTION AND PROMOTION**

<b>Strategy(ies)</b>	<b>Strategy Measure</b>	<b>Baseline</b>	<b>FY22 Target</b>
<b>Digitize MCMC specialty programs to increase access and promote distance health education</b>	Courses	1	TBD