Trillium Health - Jessica Wilson

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Organization Profile

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Mission/Vision Mission: Trillium Health, a Community Health Center, provides extraordinary care for all, including LBTQ+ health, ensuring equitable, judgment-free and affordable care.

Vision: Trillium Health will be recognized as the premiere inclusive Community Health Center in New York State for providing barrier free, innovative care that enriches and saves lives by 2025

Receive County Funds? no

Div. of Corp. N/A? no

Proposal Information

Project Name Project ACCESS

Summary Trillium Health (TH) proposes to advance MC's goal of increasing public health by increasing linkage to healthcare and supportive services across the county by enhancing its Point Of Entry (POE) engagement capacity at its Food Cupboard (FC), Harm Reduction and Syringe Exchange Program (SEP), Primary Health Clinic, and the Mobile Access Clinic (MAC). Medical Case Managers and Outreach Specialists will work to identify, enroll, and refer individuals in need of healthcare and supportive services to TH's primary, specialty, and behavioral health clinic, Food Cupboard, and other community-based partners, with the goal of decreasing barriers. To further expand the FC's reach, and support the goal of reducing the percentage of food insecure people in MC, TH will increase capacity at its FC to meet the demands and needs of the community.

TH's proposed program model demonstrates a long-term framework that supports and recognizes the critical linkages between community wellness, mental health, and public safety. This project will promote equity by providing much-needed resources in hard-to-reach areas in Rochester; reaching many individuals, including, the LGBTQ+ community, socioeconomically disadvantaged individuals, Black and Hispanic individuals and other POC, and those adversely affected by the COVID-19 pandemic.

Workforce/Economic?	Health/Safety?	Infrastructure/Sustainability?
no	yes	no

Description a. TH's proposed project advances MC's goal of increasing public health by increasing linkage to healthcare and supportive services across the County. TH will enhance its point of entry (POE) engagement capacity by identifying, enrolling, and referring individuals in need of healthcare and supportive services to TH's primary, specialty, and behavioral health clinic, Food Cupboard, and other community-based partners.

The most commonly utilized POE at TH includes: Food Cupboard (FC), Harm Reduction and Syringe Exchange Program (SEP), Primary Health Clinic, and the Mobile Access Clinic (MAC). Each site being a critical access point for new and current patients.

TH will hire four FTE Medical Case Managers (MCM), each will be located at TH's identified POE with the primary goals of identifying and reducing barriers to care, increasing linkage to food, mental health, physical and sexual health and medication. TH's MCM's will conduct SDOH and physical health assessments on all individuals accessing services at one of the four identified POE – SDOH and health needs will be identified, appropriate referrals will be made (internal and external), and case management services will be provided to ensure continuity of care.

TH will hire two FTE Community Health Workers (CHW) to provide outreach, education, testing and linkage to care at its community partner location, including, Ibero American League's Community Center, Father Tracey Advocacy Center, Urban League, and, public housing through Rochester Housing Authority.

TH's Food Cupboard (FC) is a unique POE for community members experiencing food insecurity. The program strives to break the stigmas associated with food insecurity by "feeding people without barriers". TH reports a 30% increase in food cupboard recipients

since the onset of the COVID-19 pandemic; the current economic landscape and trends indicates this rate will increase.

To further expand the FC's reach, and support the goal of reducing the percentage of food insecure people in MC, TH will increase the FC's efficiencies and capacity by redesigning the current workflow to better align with current needs and trends; replace the current walk-in freezer/cooler to increase food storage; and, increase buying power to increase the amount of food the FC is able to purchase and distribute. The proposed FC capacity enhancements will allow TH to expand food distribution to its satellite locations, including, Harm Reduction, MOCHA Center, the MAC, and to new and established external community-based organizations.

b. No, the holistic model of care proposed is not possible without ARPA funding. TH recognizes that in order to maintain a viable program post funding, sustainability during all phases of the project must be considered. TH will focus on the following sustainability factors to ensure the proposed outcomes are maintained and sustained:
Collaborative Partners: Partnerships are crucial to the viability of the proposed project as they provide client/patient referral sources to TH billable services.
Monitoring and Feedback: Data will be collected and analyzed by all stakeholders on a monthly basis to ensure timely programmatic course correction if necessary. This process allows for increased buy-in at the program level which conceivably leads to increased utilization of services.
Funding: Each billable service and medication filled at TH's pharmacy, as a result of a referral/linkage to care through the POE's model, will generate revenue that will be reinvested back into the program.
Volunteers: Volunteers work in TH's Food Cupboard, and support staff by receiving, organizing and delivering food. Volunteers will help to scale TH's FC program as it increases distribution of food through new workflows and infrastructure.

MC ARPA funding supports TH's business model for sustainability as it helps to build the necessary infrastructure as we prepare for implementation of NYS's 1115 Medicaid Waiver – a plan designed to improve access, quality and cost effectiveness of health services for the poorest and most at risk residents.

c. TH's history of a person-centered service delivery model has been continuously strengthened to ensure access to all services and includes:
• Sliding fee scale discounts, extended hours of operation, Mobile Access Clinic, and enabling services to reduce/eliminate barriers and increase access for the target populations.
• Collaboration with service area healthcare providers ensures patients have access to the full continuum of care while minimizing duplication of services.
• Service provision in a culturally and linguistically appropriate manner.
• Comprehensive outreach, marketing, and education efforts to ensure the target population and general community are aware of available services and how to access them.
• A consumer-majority Board of Directors, representative of the patient population and communities served to assist in the governance of the health center.
• A commitment to health equity. TH is a recognized health care provider with the Human Rights Campaign (HRC), having maintained "Leader" status for 10 years.

d. Objective #1: Reduce Food Insecurity by Serving More Individuals in MC
Outcome #1A: Increase the number of unique individuals served through TH's FC by 50% over 12 months (Baseline: 500 unique individuals; Goal: 750).
Outcome #1B: Increase the number of collaborative partnerships to distribute food by 100% over 12 months (Baseline: 5 community partnerships; Goal: 10 new partnerships).

Objective #2: Increase Linkage to Care
Outcome #2: 100% of unique individuals who has an identified unmet need(s) will be referred to services. (Baseline: data not currently collected; Goal: 5,000 unique individuals).

Objective #3: Increase utilization of Behavioral Health Services in MC for vulnerable populations.
Outcome #3: 20% of unique individuals, based on referral, will utilize BHS at Trillium Health or Villa of Hope. (Baseline: 300; Goal: 360)

e. TH's holistic model of care will have immeasurable impacts on Rochester and Monroe County. TH will leverage its existing Food Cupboard, Harm Reduction Program, Mobile Access Clinic, and Clinic, as a POE into care with the goal of reducing food insecurity, increasing linkage to care including behavioral health services. The expansion of TH's FC will increase its efficiency and output, addressing food insecurity in the community, beyond 2026.

Company Strengths Trillium Health (TH), Inc., a Federally Qualified Health Center (FQHC) Look-Alike and supportive services center have been providing integrated, personalized primary, specialty health and support services to residents of the Greater Rochester, Finger Lakes and Southern Tier regions of New York State since 1985. Today, TH serves over 12,000 individuals a year.

Based on TH's more than 30 years of experience as a community-based health provider, 29 years as a Ryan White HIV grant recipient, and four years as a Federally Qualified Health Center Look-Alike, TH is uniquely positioned to provide critically-needed health care services to the most vulnerable residents of the Rochester area, which includes a long standing history of providing person-centered, trauma-informed, comprehensive integrated model of care that addresses both medical needs and social drivers of health.

TH has successfully built a multidisciplinary team approach to patient-centered care that includes medical providers, nurses, clinical pharmacists, dietitians, care managers and peer navigators. In 2021, TH served 10,538 patients which represents a 308% increase in the patient census over the last five years. The Mobile Access Clinic helped administer vaccines to almost 2,000 people since the COVID-19 vaccine became available; over 600 more patients received medical care and treatment through the MAC in 2021. TH's Harm Reduction Syringe Exchange Program, the only program of this kind in the Finger Lakes Region, had 6,547 encounters through July of 2020 and have prevented hundreds of overdoses and continue to engage individuals in care.

Community Resources TH has cultivated numerous relationships within the community who operate in similar spaces. These valued partnerships would be utilized to connect community members to food, healthcare, and promotion of the program. The following partnerships are in place:

• Foodlink –TH and Foodlink have successfully partnered for 15+ years to improve community health outcomes. Trillium Health partners with Foodlink to operate its Nutrition Health Education program and its Food Cupboard operation.
• St. John Fisher University – TH and SJFU's partnership started in 2008 when TH became a host site for SJFU pharmacy interns. This partnership has grown to include Mental Health Counselor student interns who provide BHS to TH patients/clients; collaborates with SJFU to develop training for trainees, facility, and staff pertaining to working with LGBTQ individuals in integrated care.
• Villa of Hope (VOH) – provides BHS and substance use disorder services for TH clients and patients and provides trauma-informed training to TH employees. TH provides primary healthcare to VOH clients. This partnership was formed in 2018.
• Ibero American Action League, Inc. – referral source for primary and specialty care; collaborates on COVID-19 testing, vaccine and treatment events. TH has successfully partnered with IBERO in various capacities for over a decade.
• Urban League of Rochester – TH provides food to support Urban League's "Backpack Program". TH has successfully partnered with Urban League in various capacities for two years and will expand its partnership through this funding opportunity to increase distribution of food on-site, address SDOH, provide linkage to primary and behavioral healthcare, and, provide testing on-site to their program participants.
• Rochester Housing Authority – TH provides COVID-19 testing and vaccine through its MAC to RHA tenants. This relatively new partnership stemmed from the COVID-19 pandemic. Through this funding, TH will expand services to include pharmacy lockers at low-income housing complexes -- increasing access to critical medication; will distribute food on-site, address SDOH, provide linkages to healthcare, and, provide testing on-site.
• Father Tracy Advocacy Center – TH has provided primary healthcare, STI/HIV and HepC testing, wound care, health literacy, and COVID-19 testing and vaccine through its MAC to community members of the S. Clinton neighborhood for three years. Funding will support on-site food distribution, outreach, and linkage to care.
• Brand Specialties – MWBE utilized for printing and marketing material for over four years.

c. Foodlink – provides funding to purchase food and % of staff salary; TH Operational budget, inclusive of fundraising efforts – provides funding to support mission-critical programs that are not fully funded (i.e., Food Cupboard); Federal Ryan White funding to support HIV+ patients with transportation, care management, housing, and nutrition education; NYSDOH- supports HCV Patient Navigation and Harm Reduction Syringe Exchange programs; Farash Foundation, RACF and GRHF to support COVID-19 testing, vaccine and treatment; Empire State Supportive Housing Initiative to support aging and HIV+ population (21 units); HOPWA City and State funds to support housing subsidies and services for HIV+ patients (largest provider of HOPWA services in the City of Rochester).

Audience a. The proposed project will target and engage historically underrepresented, vulnerable, underserved and minority populations in Monroe County who lack access to healthcare and are impacted by SDOH; this includes Black and Hispanic individuals and other people of color (POC), the LGBTQ+ community, individuals who are homeless and experience food insecurity, socioeconomically disadvantaged people, and, people who use and inject drugs (PWUD).

There are stark disparities in access to care and health outcomes across Monroe County for underrepresented populations. POC face disproportionately higher rates of physical health disparities such as incidence and prevalence of HIV/STIs, heart disease, diabetes, asthma, and cancer. These individuals are also at a higher risk of adverse SDOH, including lower educational attainment, lack of economic mobility, higher rates of homicide, and limited access to healthcare (including mental health), healthier food, housing, and employment .

Outreach strategies, relationship building, extraordinary care, incentives, diverse team members who reflect the target population, and, patient voice and choice are primary engagement modalities.

b. There are no obligations of the targeted individual(s) to participate in the proposed program. TH is committed to reducing financial barriers by providing a Sliding Fee Discount program and/or charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Trillium Health strives to ensure that the financial capacity of people who need health care services does not present a barrier to them from seeking or receiving care. Any patient who is uninsured and would like to apply for medical insurance coverage will be referred to an Agency Insurance Navigator. TH will never turn a patient/client away because they cannot pay and will never report to collections.

Cost 1st Year	***Cost All Years***	***Residents 1st Year***	***Residents All Years***	***FT Employees***	***PT Employees***
$1,548,052.00	$4,908,546.00	7,500	10,500	7	5

Volunteers
21

Staffing Medical Case Managers to complete SDOH and physical health screenings on all clients/patients who enter an identified POE; provides linkage to care and referrals and care coordination, patient education, and crisis counseling. Qualifications: Degree in Health and Human Services, Social Work, or a closely related field and/or 2 years of experience working in the field of community health, HIV/AIDS, behavioral health, substance abuse or other chronic illnesses. Possess an understanding of community level work and the importance of collaborating and coordinating with community based organizations. Fluency in Spanish and/or ASL preferred. Must be accustomed to diversity.

Community Health Workers will provide outreach, education, HIV/STI and HepC testing and linkage to care at its community partner location/sites. Qualifications includes: High School diploma or equivalent. Must demonstrate comfort and confidence working within diverse communities; ability to build relationships and trust to facilitate linkage to care.

Program Supervisor will assist in the development, implementation, management, and evaluation of the proposed program; will plan staff development, assess competencies and provide guidance as needed; will develop and maintain relationships with community agencies and medical facilities to obtain new referrals and ensure unduplicated services for existing patients/clients. Master’s degree in Health and Human Services, Social Work, or a closely related field with 1 year of experience OR Bachelor’s degree in Health and Human Services, Social Work or a closely related field with 2 years of related experience.

Support staff to provide leadership, administrative support, and ancillary services that support and align with the proposed project goals.