



health brigade

formerly FAN FREE CLINIC

1010 North Thompson Street, Richmond, Virginia, 23230 • www.healthbrigade.org • 804.358.6343

March 16, 2019

[REDACTED]

Dear [REDACTED]:

On behalf of our Board of Directors and the people we serve, I respectfully request funds in the amount of [REDACTED] to help support our efforts to provide free quality health care to the low-income, uninsured members of the Greater Richmond community. Last year, through our Integrated Care Services, we helped address the medical needs of 1,604 patients over the course of 5,722 patient visits.

With the enclosed proposal we are seeking to partner with [REDACTED] to provide free quality health care to those most in need. As a Patient-Centered Medical Home, we can provide vital medical care to those who cannot afford insurance or the out-of-pocket costs of essential health care. **Current health care reform does not eliminate the need for the health care we provide** and we estimate that over 52,000 in our service area are low-income, uninsured and eligible for our services.

Thank you for your past support and for this opportunity to ask for your support once again. If you should have any questions or require additional information, please do not hesitate to contact me by phone at (804) 716-5830 or email at [klegato@healthbrigade.org](mailto:klegato@healthbrigade.org)

Sincerely,

Karen A. Legato  
Executive Director



**Summary:** Health Brigade has been providing quality care to the underserved in Richmond for nearly 50 years. We have begun the work of transitioning from a grassroots, “make ends meet” non-profit to a transformational, sustainable organization focused on delivering exceptional integrated health services to those least served. We are seeking funds to underwrite the cost of providing affordable integrated health care to low-income, uninsured adults in Greater Richmond.

Our patients have access to a multi-disciplinary team of primary care, mental health, and public health providers who collaborate to deliver quality care. Services include:

- Primary care
- Linkages to specialty health care, support services
- Nutrition counseling
- Testing, counseling, and prevention education for HIV and other STIs
- Comprehensive Harm Reduction services
- Behavioral health
- Medical social work and care navigation
- Specialty mental health services

**Purpose:** In today’s landscape, the need for the affordable integrated care we provide continues to be a priority. In Virginia, a family of three earning \$27,000 a year earns too much to qualify for Medicaid, yet not enough to secure comprehensive coverage through the ACA. Even those that can afford ACA premiums find the deductibles and out-of-pocket limits prohibitively expensive. As recently as 2017, the Kaiser Family Foundation reported that nearly 45% of uninsured adults indicated that they did not have coverage because it was too expensive. Even with the upcoming Medicaid expansion in Virginia, it is anticipated that there will still be over 300,000 Virginians that will remain uninsured.

The uninsured are less likely to access preventative care and treatment; are more likely to be hospitalized for avoidable health problems, and have poorer health outcomes.

While other organizations may serve the low-income, uninsured population that Health Brigade serves, they offer programs that only feature individual components of our Integrated Health Care; to our knowledge we are the only area provider (safety net or private) that offers all these care components as part of ongoing service and in a single, integrated setting.

The comprehensive array of integrated services we offer is only one part of the equation. What also makes us uniquely qualified to support and empower low-income, uninsured adults is our ability to establish meaningful relationships with those we serve. What is seen in both formal marketing surveys and in informal conversation is our reputation as a safe and welcoming place to seek care.

Health Brigade provides vulnerable populations equal access to quality health services in a safe, person-centered, and welcoming environment that addresses the whole person and the social circumstances that make it difficult for them to access and remain in care.

**Expectation of Care:** Rather than focus on conditions in isolation, our continuum of care seeks to address the needs of the “whole person”. Patients that have both primary care and mental health needs are treated by a multi-disciplinary team of primary care, mental health, and public health providers who work together to deliver care and education.

Integrated care at Health Brigade begins with the primary care visit. Primary care is often the first or only entry point into care for many patients and it may be the place a patient is most comfortable. Further, the logistics of going to multiple appointments for individual services on different days can be an enormous barrier to care for many of those we serve, as attending each visit may require loss of wages, demand the coordination of affordable transportation or childcare, etc.

Integrating our care has helped make the most of each visit for our patients. A primary care visit in our Medical Clinic involves meeting with a medical provider who can provide preventive care (cancer screenings, heart health assessments, diabetes screenings, etc.), address any primary care issues (prescribe medications, create treatment plans, etc.) and connect patients to free medical services outside of Health Brigade (labs, diagnostics, specialty care, etc.).

During this same primary care visit, a patient can also:

- Meet with a Behavioral Health Specialist who can help patients follow their medical treatment plans (smoking cessation, medication adherence, etc.) and support specific behavioral changes such as helping a diabetic overcome a fear of needles, sleep hygiene, exercise management, and more
- Meet with a Public Health Provider to receive an HIV test, HIV counseling and prevention education as part of the regular annual exam, or by request
- Meet with a Nutritionist who can provide customized nutrition education, healthy eating plan, and recipes
- Meet with a Medical Social Worker who can provide linkages to support services available on site or in the community that can help address needs in other areas that impact health such as food assistance, housing, transportation, employment, crisis services, and other factors that impact health. On-going case management is provided as needed
- Receive free or low-cost medications through our Medication Assistance Program and other free supplies to self-manage disease.
- Receive a referral and/or warm handoff to one of our on-site specialty mental health providers to assess mental illness or other mental/emotional conditions impacting health. Psychiatric assessment, psychotropic medications, and on-going therapy are provided as needed.

By serving as a patient centered health home for those lacking access to primary care, we are able to reduce the overall health costs for everyone by diverting those needing primary care from resorting to high cost emergency department care. Our comprehensive health services impacted the lives of over 15,000 individuals last year:

- 4,965 patient visits to 1,466 low-income, uninsured adults
- 3,996 mental health encounters
- 16,412 health outreach encounters
- 1,682 HIV tests
- 75 patients served through health outreach case management

**Program Sustainability:** Our staffing model is similar to that of other free clinics with a base staff augmented by a large professional cadre of volunteer nurses, physicians, psychiatrists, and counselors. We could not achieve our mission without these skilled and compassionate volunteers. It is widely known that delivering high quality integrated health care is expensive, and without professional volunteers we could not provide the level of care we currently deliver. Our total annual revenue is just over \$2 million but when in-kind services and volunteer hours are included, that amount jumps to over \$7 million.

Our revenue comes from a diverse portfolio of foundation, individual and earned income efforts. As a non-profit, revenue dollars are subject to fluctuation year over year. As we prepare for Medicaid expansion, we anticipate that ongoing adjustments to our expenses will need to be made to account for patients transitioning in and out of Medicaid eligibility. Although Health Brigade will not be a Medicaid provider, we are taking on the role of “navigator” for our current patients who will find themselves eligible for Medicaid after January 1, 2019.

By building and diversifying our sustainable revenue and requesting general operating funds such as these, we will ensure that we have the resources necessary to maintain the significant improvements to quality and capacity that we continue to implement. Maintaining the quality improvements through our expanded service capacity directly benefits those we currently serve and enables us to accommodate additional patients. Without general operating support, it is very difficult to maintain the quality and capacity of our services at a time when access to care for vulnerable people is greater than ever.

**The Challenges We Face:** As our organization evolves, so do the tools with which we do our work. A little over a year ago, Health Brigade implemented an electronic medical record (EMR) system. This has allowed us to increase efficiency during the patient visit and has freed us from utilizing paper charts. We do however continue to encounter minor errors in data entry, as providers have become acclimated to the system. We are providing comprehensive system trainings and have trained “Super Users” to assist volunteer providers. Over the course of the year, we’ve seen a reduction in patient count of roughly 9%, which is a superior outcome over the 50% reduction we were anticipating with the EMR implementation. We have also hired a Quality Improvement and Relationship Coordinator who oversees data quality (entry, extrapolation, analysis) as it pertains to our integrated health programming.

Another challenge we face is identifying and serving the complex needs of our patients. A patient’s health status does not exist in a vacuum - personal, social, economic, and environmental factors all influence health and health behaviors beyond genetics and medical advances. These “determinants of health” include the availability of resources to meet daily needs - safe housing,

access to healthy foods, access to job opportunities, transportation options, and safety from violence.

These complexities are significant for those living in poverty, as they typically face challenges in some, or even all of these areas. While medical providers are able to address issues related to physical health care, they are not usually equipped with the resources needed to address non-medical determinants of health that impact the health of someone who is socially or economically disadvantaged. Nor is it efficient or cost effective for them to do so. To address these complex needs, we have medical social work services to assist patients with navigating health systems and social service systems. Our medical social workers are an essential part of the care team often coordinating the communication and continuity of care for patients with all members of the team and any outside referral resources. This model has allowed us to provide more holistic comprehensive care to our patients, thereby improving overall health outcomes.

**Patient Demographics:** In FY2018, Health Brigade provided primary care to **1,466** low-income, uninsured adults. Of these:

**99.8%** reported an annual income of less than \$25,000

**59%** identified as women, **30%** identified as men, **11%** identified as transgender or gender fluid

**68%** were age 18-49, **32%** were age 50 and older

**29%** identified as African American, **28%** as White, **36%** as Hispanic. **7%** were of other races or did not provide this information

Over **50%** of our patients are living with at least one chronic condition (e.g., diabetes, heart disease, hypertension, etc.) and nearly **30%** are living with two or more chronic conditions. Among the most prevalent conditions treated last year were obesity, hypertension, depression, and high cholesterol.

**Goals & Outcomes:** This past year, we served over 1,466 low-income, uninsured adults who may not otherwise have had access to care. Agency-wide, we provided the following to people in need:

- 4,965 patient visits
- 3,996 mental health encounters
- 16,412 health outreach encounters
- 1,682 HIV tests

Continued and increased funding will allow us to maintain the quality and capacity to serve patients with the excellent integrated care we provide. With increased funding we seek to serve 1,500 patients in the coming year (July 2019-June 2020) through 5,000 patient visits and 4,000 mental health encounters. All data will be tracked in our electronic medical records system.

**Measuring Success:** Our electronic medical records system supports and captures data across the organization as it relates to our integrated care model. openEMR has greatly enhanced efficiency, improved outcome reporting, and mirrors the integrated care we provide. A full time Outcome and Data Analyst developed and now monitors this system, which we know is critical to our ability to better serve our patients and better tell our story when communicating to stakeholders.

Also, our Quality Improvement Coordinator oversees data quality and meets with program directors regularly to review patient/client individual and aggregate data to keep on track of expected outcomes and implement interventions if needed.

**Continued Learning:**

The recent expansion of Medicaid in Virginia will now provide health insurance for an additional 400,000 Virginians. Approximately 700 or 50% of our current patient caseload will potentially be eligible. By analyzing current no-show rates and client satisfaction surveys, it was determined that our existing intake process was not efficient for handling an increase of patients qualified for Health Brigade services, nor the added requirements for enrolling eligible patients into Medicaid.

The intake process was redesigned to include a new intake form that is comprehensive yet trauma informed and additional volunteers have been trained to perform the intake process. All paperwork was redesigned to an appropriate literacy level for most of our patients to understand. These changes were made – based on collected data - to enhance the patient experience and reflect our mission of a compassionate and non-judgmental environment.

**Health Brigade  
Integrated Health Care  
Program Budget**

Organization Name	Health Brigade		
Program/ Project Title	Integrated Health Care		
Fiscal Year	2020		
<b>INCOME SOURCES</b>	<b>AMOUNT</b>	<b>COMMENTS (optional)</b>	
<b>SECURED INCOME (income that has been received/committed)</b>			
Private Sector Support	\$	1,100,000	Includes Individuals, Special Events, Corporate, Foundations
Earned Income	\$	1,050,000	Patient contributions, Public and Private Sector Contracts
Other	\$	5,250	
<b>Subtotal Secured Income</b>	<b>\$</b>	<b>2,155,250</b>	
<b>PENDING INCOME (outstanding requests/anticipated contributions)</b>			
<b>Amount of this request</b>	\$	80,000	
Foundations	\$	235,000	
Corporate			
Government			
Earned Income			
Individuals			
Special Events			
United Way	\$	50,000	
<b>Subtotal Pending Income</b>	<b>\$</b>	<b>365,000</b>	
<b>TOTAL INCOME</b>	<b>\$</b>	<b>2,520,250</b>	
<b>EXPENSES</b>	<b>TOTAL PROGRAM/ PROJECT BUDGET</b>	<b>FOUNDATION REQUEST</b>	<b>% SUPPORTED BY FOUNDATION REQUEST</b>
Staff Salaries*	\$	1,877,925	\$ 80,000 4.3%
Program Expenses	\$	75,600	0.0%
Professional Expenses	\$	126,840	0.0%
Occupancy Expenses	\$	108,045	0.0%
Business Expenses	\$	37,380	0.0%
Development Expenses	\$	41,160	0.0%
Other*	\$	-	\$ -
<b>TOTAL EXPENSES</b>	<b>\$</b>	<b>2,266,950</b>	<b>\$ 80,000 3.5%</b>

\*Use this space to explain the expenses marked with an asterisk above.

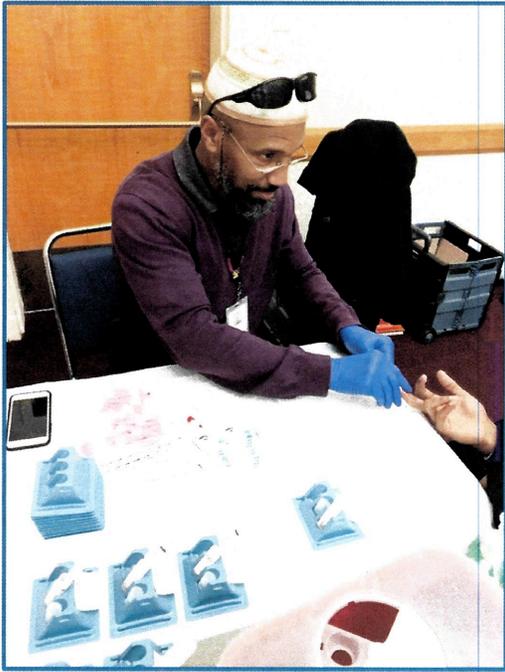
medical clinic, mental health, and health outreach staffing



# health brigade

## Health Brigade FY19 Approved Operating Budget

	<u><b>FY19 Budget</b></u>
<b>Ordinary Income/Expense <u>Income</u></b>	
<b>Private Sector Support</b>	1,213,000
<b>Earned Income</b>	1,127,000
<b>Special Event</b>	60,000
<b>Other Income</b>	4,100
<b>Total Income</b>	<u>2,404,100</u>
<b><u>Expense</u></b>	
<b>Program Expenses</b>	100,600
<b>Personnel</b>	1,972,400
<b>Professional Fees</b>	107,000
<b>Nonpersonnel Expenses</b>	100,000
<b>Occupancy Expense</b>	103,200
<b>Business Expenses</b>	34,600
<b>Development Expense</b>	32,800
<b>Total Expense</b>	<u>2,450,600</u>
<b>Net Operating Deficit</b>	<u>(46,500)</u>



Health Brigade HIV Test Counseling



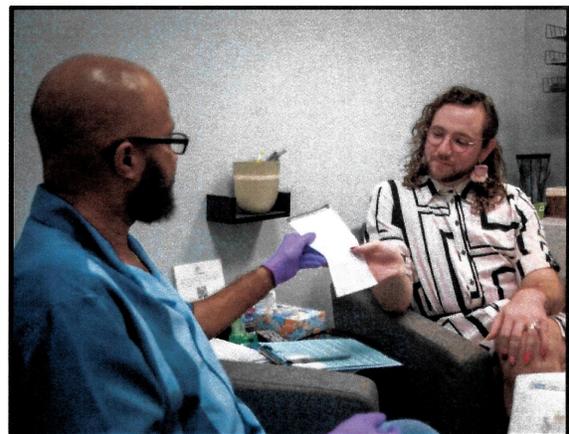
Health Brigade Medical Staff



Health Brigade Group Therapy Session



Primary Care at Health Brigade



Health Brigade Trans Health Services



## Satisfying Hunger and Improving Health

### A LOCAL ORGANIZATION FINDS A WAY TO ACCOMPLISH BOTH AND PAY IT FORWARD.

words | TINA JOYCE

photos | HAL TYLER & SID KOERIN

*Making health a priority often falls behind paying bills, caring for families or working. However, a few local residents will be given a chance to make improving their health a top priority this year.*

Last summer, 15 fortunate patients of Health Brigade, formerly known as the Fan Free Clinic, were selected to participate in a pilot health program called Food Farmacy. The program resulted in such positive outcomes that a second cohort of participants has been screened and will begin the program on January 18, 2018.

Health Brigade, an organization that conducts approximately 5,700 medical visits each year, is

**“In the past, a traditional food pantry tried to solve many of the needs of patients. Now, instead of simply trying to satisfy hunger, we are also trying to improve health.”**

- Johanna Gattuso

and meet other screening requirements in learning to make healthier food choices to accompany their prescribed medications to control diabetes. Often, medications alone cannot combat the life-threatening disease; diet and exercise play an additional and vital role in patients’ treatment.

seeing a growing number of patients suffering from diabetes. “In the past, a traditional food pantry tried to solve many of the needs of patients. Now, instead of simply trying to satisfy hunger, we are also trying to improve health,” shares Johanna Gattuso, a registered nurse and Health Brigade consultant charged with clinical program development.

The Food Farmacy is a program designed to assist patients who have an A1C of at least 7.5

#### WHAT IS AN A1C TEST?

According to the Mayo Clinic, the A1C test result reflects your average blood sugar level for the past two to three months. Specifically, the A1C test measures what percentage of your hemoglobin — a protein in red blood cells that carries oxygen — is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications.



**JOHANNA GATTUSO**

A registered nurse and Health Brigade consultant charged with clinical program development.

## VIRGINIA PREMIER HEALTH PLAN

Virginia Premier is a Managed Care Organization (MCO) that works to educate, encourage and empower its members toward the goal of healthy living. As a proud part of the Virginia Commonwealth University Health brand, Virginia Premier is the first and only university-based nonprofit MCO in the Commonwealth, serving nearly 200,000 members statewide.

In addition to its Medicare and Medicaid plans, Virginia Premier provides third-party administrative services and runs the Virginia Premier Medical Home in Roanoke.

*“VPHP has a long history of engagement with community partners so that we can support the health needs of our community. We’re excited to be part of this already successful program,” shares Carol Wilson, the Director of Disease Management for VPHP.*



### EXPERT CONTRIBUTORS

*Jacqueline Anderson, a 2017 participant of Food Farmacy.*

*Johanna Gattuso, a registered nurse and Health Brigade consultant.*

*Carol Wilson, the Director of Disease Management for Virginia Premier Health Plan.*

The Food Farmacy is a 12-week program, meeting once a week in the evenings. The schedule alternates health coaching and cooking instruction each week to give participants a well-rounded, practical education. “It is truly empowering participants to make lifestyle changes,” notes Gattuso.

A generous pool of volunteers and supporters make the program possible. One local partner, Shalom Farms, donates fresh produce each week for participants. Patients walk away with a giant bag of fresh produce, spices, recipes, divided plates (to learn portion control) and their prescriptions stapled to the bag. This generous donation provides a hands-on approach to cooking. Participants are not simply hearing about recipes and the benefits of reading labels; they actually have the opportunity to prepare healthy, delicious meals.

**“Ya know, it’s cheaper to eat horrible than to eat healthy. I learned so much through the Food Farmacy. I was never a label reader until now, and I never thought I would eat vegetables.”**

*- Jacqueline Anderson*

“Ya know, it’s cheaper to eat horrible than to eat healthy. I learned so much through the Food Farmacy. I was never a label reader until now, and I never thought I would eat vegetables,” acknowledges Jacqueline Anderson, a 2017 participant.

Last year, the participants finishing the program had a 50/50 ratio of men to women. It is important to have the entire family support changes in eating habits for the household for the best long-term results. For those in the program, the average drop in A1C was 2 percent.

The selection process is underway for 2018. Participants are selected through medical recommendations and must meet the following requirements:

- Being motivated to make a lifestyle changes
- Registering blood sugars levels in the high 200s
- Being an established Health Brigade patient
- Having an A1C level over 7.5
- Having reliable transportation
- Being interested in learning more

Additional community partners are proudly supporting the initiative. VCU’s dietetic program sends interns to assist with Food Farmacy, and Virginia Premier Health Plan (VPHP) learned about the program because of their longstanding relationship with Health Brigade.

Carol Wilson, the Director of Disease Management for VPHP, explains, “Our organizations are both focused on prevention and self-empowerment, and we were excited to learn about the Food Farmacy program. Food insecurity is a major social determinant of health, and we are focusing on this issue in all of the communities we serve across Virginia.”

VPHP’s direct involvement includes providing supportive funding, especially to cover the expense of fresh foods over the winter months, providing transportation for participants to a grocery store for education about healthy shopping and giving assistance as needed with health education. Up to five VPHP members will be able to join the class.

“VPHP has a long history of engagement with community partners so that we can support the health needs of our community. We’re excited to be part of this already successful program,” shares Wilson.

The vision and coordination of a specialized health program such as the Food Farmacy represents a community coming together to address a need by developing creative solutions to make a long-term impact on those it serves. The participants completing the program can utilize their newly acquired life skills and pay it forward by teaching others how to improve their own health.

**ON THE WEB**  
More at [ourhealthrichmond.com](http://ourhealthrichmond.com)