PROMISING PRACTICES October 2013 – September 2014

This report highlights many of the promising practices in Federally Qualified Health Centers that received operational site visits during October 2013 through September 2014.

Executive Summary of Promising Practices

October 2013 – September 2014

Federally Qualified Health Centers (FQHCs) continued to demonstrate their leadership in the health care field October 2013 through September 2014. In addition to solid performance relative to health center requirements, many health centers have an objective basis for claiming superior effectiveness in one or more particular areas of operations (e.g., clinical services, governance, management, and/or finance). When experts in these areas of operations conducted 554 Operational Site Visits (OSVs) of FQHCs on behalf of the Bureau of Primary Health Care (BPHC) during Fiscal Year (FY) 2014, they cited more than 120 FQHCs with a promising practice in at least one area. Even when the citation is for a single area of operations, virtually all of these citations are for multiple promising practices combined to address that area. These promising practices have the potential to be successfully replicated in other organizations. Instituting promising practices enhances the care provided to any population, and is especially valuable for underserved and vulnerable populations.

This report highlights many of the promising practices in health centers that received OSVs during October 2013 through September 2014. The types of funding received from the Bureau of Primary Health Care are identified for each health center. A list of commonly-used acronyms is at the end of the report.

The commendable work of health centers includes, but is not limited to, the following:

CLINICAL SERVICES

Claiborne County Family Health Center, Port Gibson, Mississippi (CCFHC) – *Patient Assistance Program:* CCFHC developed the patient assistance program to help patients obtain necessary medications at little or no cost. When it is determined during a provider-driven visit that the patient requires help getting medication, the provider refers the patient to the patient advocate. The patient advocate explains the application process, assists the patient with the application, submits the documentation required by the pharmaceutical company, and ensures that the patient obtains the medication when it arrives.

Aunt Martha's Youth Service Center, Inc., Olympia Fields, Illinois (AMYSC) – *Four-Question Oral Health Screening:* AMYSC has implemented a four-question oral health screening that is conducted at each clinical visit. Staff training for this program utilizes the Society of the Teachers of Family Medicine (STFM) and American Dental Association (ADA) program curriculum. Primary care providers make appropriate referrals based on the screening results.

Cedar Riverside People's Center, Minneapolis, Minnesota (CRPC) – *Referrals by Medical Assistants (MAs):* CRPC had been performing low in adult weight screening and follow-up. In 2011 and 2012, less than 5% of adult patients had a follow-up plan documented if their Body Mass Index (BMI) indicated that they were overweight or underweight. The center now allows MAs to automatically make a referral to the registered dietitian if a patient's BMI is less than 18 or more than 25. This has resulted in an increase in the performance of this measure to 35% in 2013.

Hennepin County Community Health Department, Minneapolis, Minnesota (HCCHD) – *After-Hours Shelter Phone Number Cheat Sheet:* HCCHD is a Health Care for the Homeless (HCH) program, and so the after-hours coverage requirement takes on a different emphasis since the majority of patients are housed in adult or family shelters after hours. The health center's providers may need to find a patient who has life-threatening laboratory results and so they have created an after-hours shelter phone number cheat sheet (for critical labs). This "cheat sheet" is in the form of a grid with the shelter name, after-hours phone number, and on-site shelter staff member's name. It is printed and is also available to the providers on the shared drive of the electronic health record (EHR) system. This tool affords the providers the opportunity to find patients needing immediate or urgent follow-up and helps the shelter staff deal with potentially sick clients quickly.

Primary Connection Health Care, Inc., Wausau, Wisconsin, dba Bridge Clinic – *Wheelchair Lift Operatory Suite:* Bridge Clinic offers an innovative service for wheelchair-bound patients that is state-of-the-art. There is a wheelchair lift operatory suite that allows dental staff to provide patient care in the best ergonomic positions possible. The lift allows wheelchair patients to back into the tilting deck and recline to a comfortable position for both patient and provider. The lift is ideal for dentistry, podiatry, physical therapy, wound treatment, and many other medical uses.

Centro de Servicios Primo de Salud, Inc., Florida, Puerto Rico (CDSPDS) – *Targeted Home Visit Program:* CDSPDS has a well-organized and active home visit program targeting individuals who have mobility or other health issues that prevent them from coming in to the center. Nurses visit patients' homes for lab draws, and a general practice doctor provides a follow-up visit. This practice decreases the no-show rate, ensures that patients do not forgo needed care, and is sensitive to the specific needs of the community.

Newark Community Health Centers, Inc., Newark, New Jersey (NCHC) – *Assigned Clinical Measures:* NCHC has implemented a process that assigns each of the clinical measures to one of the providers. That provider is responsible for the tracking and development of quality improvement (QI) activities designed to improve the performance on the individual clinical performance measures. Not only does this encourage continuous monitoring, it engages the

provider staff in the QI process and helps their understanding of the process and the overall importance of outcomes measures in patient care.

Squirrel Hill Health Center, Pittsburgh, Pennsylvania (SHHC) – *Regular Sharing of Promising Practices and Lessons Learned:* SHHC engaged in extensive collaborations with five other area health centers over a three-year period, meeting regularly to share promising practices and lessons learned. As a result, the health center successfully achieved Patient-Centered Medical Home Level 3 recognition.

Santa Rosa Community Health Center, Inc., Santa Rosa, California (SRCHC) – *Emergency Room/Hospital Care Reduction Program:* SRCHC started a program targeting high users of emergency rooms/hospital care. A part-time nurse practitioner monitors and provides clinical/psychosocial evaluation/interventions for a panel of 50 patients and, as a result, medical expense savings in the first six months surpassed $500,000.

University of California, Irvine, Irvine, California (UCI) – *Group Appointments:* UCI has implemented group appointments for its diabetic patients. This has improved performance on the HbA1c measure and also improved patient adherence to medications and diets. The group model is a great way to help diabetic patients learn from each other and also have group sessions that allow for teaching more than one person at a time.

GOVERNANCE

Roanoke Chowan Community Health Center, Inc., Ahoskie, North Carolina (RCCHC) – *Board of Directors Mentoring Program:* RCCHC has a board of directors mentoring program that begins with potential members from the community being appointed as non-board/ community members. RCCHC's objective is to keep members of the community informed of the health center activities and to prepare a pool of individuals interested in serving on the board. Once the RCCHC board identifies community members voicing an interest in being on the board, these members participate in RCCHC board committees, board meetings, and in other activities sponsored by the health center. The community members are presented with information about the health center before they are elected to fill board positions as incumbents' terms end. As board vacancies occur, the health center has a pool of knowledgeable community members ready to fully participate in board activities. Board members who were mentored by RCCHC's board members begin their terms in office better prepared to participate in decision- and policy-making issues earlier than most board members who have not been exposed to such programs.

Andersonville Valley Health Center, Inc., Boonville, California (AVHC) – *Regular Joint Board Meetings:* AVHC and the county Health Center Program grantees have a shared services agreement, and the boards of these entities meet regularly to enhance communication among the organizations. A cross-organization strategic planning approach has been initiated.

Asian Health Services, Oakland, California (AHS) – *Patient Leadership Council:* AHS has a patient leadership council that meets monthly with impressive participation of approximately 350 people to develop advocacy, patient rights, and leadership.

MANAGEMENT AND FINANCE

Miami Beach Community Health Center, Miami Beach, Florida (MBCHC) – *Scribe Program:* MBCHC recently instituted a scribe program. The health center trains MAs who accompany the provider in the exam room, enter and reconcile information such as medication lists and problem lists, make appointments, schedule follow-up referrals and labs, and perform other duties not specifically required to be performed by the provider. The provider reviews the information obtained by the MA for accuracy. This subsequently leaves the provider more time for patient care and addressing preventive and chronic care issues.

Southside Medical Center, Inc., Atlanta, Georgia (SMC) – *Medical Answering Service Coupled with Internal Call Center:* SMC had patients who were having problems obtaining timely appointments, in part because the health center's call center did not have the capacity to answer all of the calls. By contracting with a medical answering service to operate simultaneously with the health center's internal call center, encounters and provider productivity increased, and the no-show rate decreased.

HealthPoint, Renton, Washington – *Paying Vendors Via Credit Card:* HealthPoint has developed a system of paying vendors via credit card payment. The credit card company then reimburses HealthPoint the sum of 1.44% of the total amount of charges, which has resulted in a return of $78,000 to HealthPoint in the most recent two-year period.

Health Delivery, Inc., Saginaw, Michigan – *Comprehensive Transportation Services:* Health Delivery established a transportation strategy that covers all 24 sites (on alternate days), five days a week, during regular hours of operation, with six total vans (five for transportation and one for reserve). One of the vans is a lift van to accommodate wheelchairs and individuals who have mobility issues. Transportation appointments are made 48 hours prior to a patient's appointment(s), and there are some open slots for more urgent cases. There are board-approved policies and procedures that help guide this strategy. There has been discussion to improve this process by a more formal incorporation of transportation with the newly-established and operational call center. Candidates interviewed to work for the program have a thorough background check, receive training in CPR, and will be receiving training to de-escalate riders

(patients) who have mental or behavioral issues (e.g., stress, anxiety, depression, and/or violent and suicidal thoughts/behaviors). From January 2014 until the June 2014 site visit, there were 8,981 requests for transportation services with 7,924 rides given. The net difference of 1,057 represents no-shows, cancellations, or turn-aways/declines (by patients). This is an 88% show rate of requests and rides.

International Community Health Services, Seattle, Washington (ICHS) – *Model Contract Management Policy:* ICHS has a contract management policy that ensures appropriate consideration and planning prior to execution of all written contracts and compliance with all required terms, and provides for sufficient monitoring of specific performance of all parties to the agreements. There is also a contract and review and routing form that is completed on all new and renewal contracts to ensure compliance with regulations of the organization and to ensure that the contract is the best fit in accordance with the strategic direction of the health center.

Multnomah County Health Department, Portland, Oregon (MCHD) – *Discreet Communication Method:* MCHD has school-based health centers where students may be offered a set of small laminated cards at the front desk that are pre-printed with possible chief complaints. This provides a discreet method for a patient to communicate a presenting problem when other students are within hearing distance.

Yakima Valley Farmworkers Clinic, Toppenish, Washington (YVFC) – *Thorough Insurance Coverage Reviews:* YVFC reviews every uninsured patient visit to determine if any insurance coverage is available. Since January of 2014, staff members have enrolled more than 41,000 patients into either Medicaid or other third-party health insurance plans.

Community Healthlink, Inc., Worcester, Massachusetts – *Housing First Model:* Community Healthlink utilizes a Housing First model, emphasizing the primary importance of establishing a stable housing situation for each client.

The grantee secured funding to provide increased access to housing subsidies and provides intensive supportive case management that is funded through local foundations. The health center serves approximately 225 people who are experiencing (or have experienced) homelessness, and strongly supports the Housing First model as a means to reduce/end homelessness. Once housing is secured, other services – work, education, finances, treatments – can follow.

New River Health Association, Inc., Scarbro, West Virginia (NRHA) – *Communication Center Covering Multiple Sites:* NRHA has a well-organized, large communication center that is staffed by a nurse and eight full-time phone secretaries trained to respond to all types of phone calls pertinent to all 16 service sites, including nine school-based health centers that are spread

out over several counties. Instant and reliable clinical and operational communication links reduce misunderstandings, delays, and errors, and increase staff and patient satisfaction.

Westside Family Healthcare, Inc., Wilmington, Delaware (WFH) – *Model Contract Template:* WFH had a performance improvement initiative to create a contract/memorandum of agreement (MOA) template that clearly outlines the roles of each organization during all aspects of the service partnership and includes each of the required Health Resources and Services Administration (HRSA) components for referred services. The resulting compact template is clear, concise, and complete.

East Valley Community Health Center, West Covina, California (EVCHC) – *Real Time Patient Flow Monitoring:* EVCHC monitors patient flow in real time. The in-house information technology (IT) contractor designed software for the EHR system that displays patient flow according to check-in times of every patient, waiting room stays, exam room stays, provider interactions, lab, pharmacy, enabling services, and check-out times. This information is displayed on overhead monitors at several key staffing locations in the health center sites. The information protects patient privacy through the display of only first names and with patient numbers. The display is easy to read at a glance and serves as a quick scorecard of patient flow. A banner across the top serves to summarize activity, documenting total patients who have checked in, total missed appointments, total patients checked out, and average cycle times. This system allows constant monitoring of patient flow and pinpoints areas that need improvement. It also allows sophisticated examination of utilization by patient type, provider, day of week, and more. Summary data are able to be downloaded and printed for QI purposes.

La Maestra Family Clinic, San Diego, California (LMFC) – *Expedited Billing Using Electronic Medical Record System:* LMFC has implemented a procedure to expedite billing by using an electronic medical record (EMR) system. All providers' patient chart and encounter forms that are required to be completed online must be closed out within three business days of the patient visit or the system will lock that provider out of the system from entering more information for that patient chart. Each day the billing director runs a report of all open encounter forms that have been locked out and shares it with the chief medical officer (CMO), chief financial officer (CFO) and chief executive officer (CEO). The CMO is responsible for following up with the providers regarding the reason for any non-completed/non-closed encounter forms. The goal is to promote timely completion of the patient chart; close out of the encounter in a manner to be billed; and to promote efficient, timely and accurate billing of patient claims.

San Francisco Community Clinic Consortium, San Francisco, California (SFCCC) – *Monitoring Deliverables from Subcontractors:* SFCCC has developed a detailed contract policy and process for monitoring deliverables from subcontractors. The policy outlines contract notification procedures for sub-recipients experiencing compliance issues, staff responsible for

notification, and notification of the board's finance, audit, and personnel committees. Each month the grantee's contract manager develops a matrix to track the number and percent of key deliverables as well as data processed. Approval of payment to sub-recipients is based on the monthly contract report.

St. Thomas Community Health Center, Inc., New Orleans, Louisiana (STCHC) – *New Employee Orientation/Competencies Process:* STCHC instituted a new employee orientation process that documents receipt of general new hire, payroll and benefits information, and then formally documents employee competencies using skills checklists that are consistently updated to reflect changes in required job competencies. The result is complete documentation of orientation and employee competencies.

Promising Practices

October 2013 – September 2014

The promising practices of Federally Qualified Health Centers are listed below by state, with the states in alphabetical order. The promising practices are identified in the categories of Clinical Services, Governance, and Management and Finance, with the type of promising practice (e.g., information sharing, group appointments) and a brief description immediately following the category.

For each health center, the categories of funding from BPHC are designated by the following abbreviations: Community Health Center (CHC), Migrant Health Center (MHC), Healthcare for the Homeless (HO) and Public Housing (PH).

At the end of the report there is a chart showing the promising practices identified by category, with the categories in alphabetical order and the states of the health centers within those categories in alphabetical order.

ALABAMA

Grantee: **Bayou La Batre Area Health Development Board, Inc. (BLBAHDB)**
Bayou La Batre, Alabama (CHC)

Clinical Services*, Quality Program Plan, Do, Study, Act (PDSA) Studies:* The health center's quality program has completed two PDSA studies, "Referral Tracking and Follow-up" and "Appropriate Testing for Children with Pharyngitis." These studies have been well documented with comprehensive written reports that describe the PDSA processes taken to create change in the health center. The written reports are documented in the QA/Process Improvement (PI) and provider minutes and presented in the QI report to the board.

ALASKA

Grantee: **Sunshine Community Health Center, Inc. (SCHC)**
Talkeetna, Alaska (CHC)

Management and Finance*, Including QA/PI in New Employee Orientation:* SCHC has a QA/PI process for new employee orientation. SCHC values the involvement of each staff

member in its QA/PI program. As part of SCHC's new employee orientation, every employee meets with the medical director for a half-hour introduction to the QA/PI program and to determine which QA/PI team he/she would like to join. Every staff member, regardless of his/her department, is required to be on a QA/PI team in order to encourage collaboration and communication.

Grantee: **Yukon-Kuskokwim Health Corporation (YKHC)**
Bethel, Alaska (CHC)

Clinical Services, *Credentialing/Privileging Processes:* YKHC demonstrated promising practices in relation to credentialing/privileging processes. Credentialing personnel have established an effective system for a large, complex corporation with remote Community Health Center sites that is able to individualize and monitor clinical privileges, medical staff reappointments, and peer review through clear policies that meet multiple accrediting and grant funding requirements.

Clinical Services, *Employee Health Tracking System:* YKHC demonstrated promising practices in relation to the employee health tracking system. Employee health/infection control staff have met the challenge of instituting a database for tracking new employee hires and updating records for over 1,500 active corporation-wide employees in numerous sites across an area the size of the state of Oregon. YKHC maintains impressively high employee influenza vaccine rates through effective tracking and employee prompting.

ARIZONA

Grantee: **Ajo Community Health Center (also known as Desert Senita Community Health Center) (DSCHC)**
Ajo, Arizona (CHC)

Governance, *Information Sharing:* DSCHC has implemented a monthly board meeting practice that allows for input from board members, staff, and consumers in attendance. During the monthly meetings, the chair conducts a board roundtable to ensure all members have been heard or to provide an opportunity for each to provide their perspective. In addition, the chair holds a "call to the audience" for staff or consumers in attendance to ask questions or provide input. In addition, the CEO provides a monthly calendar to communicate her current activities.

ARKANSAS

Grantee: **Healthy Connections, Inc. (HCI)**
Mena, Arkansas (CHC)

Clinical Services, *Self-Management of Diabetes:* The DIMES program (Diabetic Information, Management, Education and Support) was initiated when it became apparent to HCI's senior management team that very few diabetic patients knew anything about self-management of their disease through proper nutrition, exercise, and other non-medication interventions.

In 2002, two members of HCI's senior management team were selected to attend the University of California at Los Angeles (UCLA)/Johnson & Johnson Health Care Executive Program in Los Angeles, California. As a part of their curriculum, they developed a Community Health Improvement Project, or CHIP, which is today the DIMES program at HCI.

In 2007, multiple partnerships, contacts, and resource streams enabled HCI to launch the DIMES program as a pilot program. A registered dietician and a certified diabetic educator provide the services to HCI patients at both American Diabetes Association recognized sites using a Cherokee model of care delivery. Originally designed to integrate behavioral health care into the primary care setting, this model of care has allowed HCI's diabetic patients to be served at the point of care in conjunction with their office visit.

CALIFORNIA

Grantee: **Northeast Community Clinic, Inc. (NECC)**
Alhambra, California (CHC)

Clinical Services, *Mental Health Screening Tool Pilot:* NECC is currently piloting a mental health screening tool that utilizes tablet technology. Patients complete a mental health screen using a private and linguistically appropriate interface. The initial screen is done at the time of the patient's first visit with the health center and is then repeated at every annual physical. Results of the tests are printed for provider review and can be trended over time to measure interventional effectiveness.

Grantee: **El Proyecto del Barrio (EPDB)**
Arleta, California (CHC)

Clinical Services, *Ensuring Up-to-Date Immunizations:* EPDB is linking patient family charts for OB/GYN and pediatrics to ensure immunizations are up-to-date if a mother comes for an

appointment. As the organization becomes more comfortable with the EHR and data analytic tools, plans are to expand to link more family member charts.

Grantee: **Clinica Sierra Vista (CSV)**
Bakersfield, California (CHC/MHC/HO)

Management and Finance, *Teaching Health Center Initiatives:* CSV has strategically taken steps to strengthen the health center workforce through its development of teaching health center initiatives in two locations at the Bakersfield and Fresno sites. CSV was awarded two HRSA Teaching Health Center grants and is collaborating with two California medical schools for the family medicine graduate medicine training programs.

Grantee: **Andersonville Valley Health Center, Inc. (AVHC)**
Boonville, California (CHC/MHC)

Clinical Services, *Obesity Prevention Program:* AVHC has adopted Obesity Prevention Program in Schools (OPPS), an AmeriCorps collaboration with the school health nurse that includes BMI testing, education, and pedometer intervention for students. OPPS encourages family involvement as well as access to primary care and oral health services. Nutritional and physical activities were monitored with a 6% reduction in BMI documented over the program year. Family involvement was encouraged as was access to oral health and primary care services.

Clinical Services, *Sharing Staff with Other Organizations:* There is a shared services agreement between AVHC and the county Health Center Program grantees. All health centers participate in a collaborative relationship to support the health care needs of the underserved and vulnerable population of Mendocino County. This is remarkable in that services are not duplicated, and staff members are shared in formal and informal arrangements across all of the Health Center Program grantees. The boards of these entities meet regularly to enhance communication among the organizations. The CEOs are beginning a cross-organization planning approach by inviting the other Health Center Program CEOs to their organizational strategic planning sessions.

Grantee: **Borrego Community Health Foundation**
Borrego Springs, California (CHC/MHC)

Clinical Services, *Increased Dental Services Access Through Schools:* The Borrego dental program has a strong commitment to prevention. The program has two fixed dental sites and three mobile dental units. The mobile dental units are dispatched for three-week rotations at area schools where preventive and restorative services are provided. An overarching goal is to increase the number of low-income children receiving preventive dental services through school-based programs. Efforts are underway across the service area to educate communities about the

importance of oral health. The dental program is well structured and thoughtfully developed to align with the needs of the target population and is integrated into the Borrego Springs quality program.

Grantee: **CommuniCare Health Centers, Inc. (CCHC)**
Davis, California (CHC/MHC)

Management and Finance, *Enrollment of Homeless Individuals in Benefits Programs:* Yolo County (SMART-Y) is CCHC's Yolo County extension of the Specialized Multiple Advocate Resource Team Program. This is a benefits advocacy project that originated in Sacramento and is focused on enrolling chronically homeless individuals in federal and state benefits programs, such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), and Medi-Cal. SMART-Y provides a continuum of services for homeless patients. Services include case management, benefits enrollment, transportation, housing referrals, and primary care services.

Clinical Services, *Model Pain Management Program:* Patients living with chronic pain have unique and special needs. CCHC's chronic, non-malignant pain management program standardizes optimal chronic pain management and ensures that care is delivered to these patients in a safe and effective manner.

Clinical Services, *Warm Hand-Off for Dental Care:* Pregnancy causes hormonal changes that increase the risk of developing gum disease. These changes can affect the health of the developing baby. The commitment to provide "warm hand-offs" between perinatal and dental services allows dental staff to provide important oral health care to pregnant women, protecting their unborn children. Warm hand-offs occur at the time the patient is seen in the perinatal program. When a dental need is identified, perinatal staff are able to schedule their patients in the dedicated appointment slots early in the patient's pregnancy. This process was so successful that it was expanded to primary care pediatric patients. When a dental need is identified, MAs can schedule a dental appointment for the child during the primary care visit. The importance of the dental appointment is reinforced by the medical provider.

Clinical Services, *Care for Pregnant Women with Diabetes:* At CCHC, pregnant women who screen positive for diabetes are referred into the Sweet Success program and are initially seen one-on-one by a team of health educators, a certified nurse-midwife (CNM), a registered dietician, and a social worker. During group sessions, each woman is seen individually by the CNM for her specialized prenatal care. This care involves the usual steps of assessing maternal vital signs, weight gain, fundal height growth, physical symptoms, and fetal heart rate. In addition, the CNM checks the woman's blood sugar values, reviews dietary plans developed between the patient and the registered dietician, and, in concert with the supervising physicians, adjusts any needed medications.

Grantee: **South County Community Health Center, Inc. (SCCHC)**
East Palo Alto, California (CHC)

Clinical Services, *Model Tracking Policy/Procedure for Specialty Referrals:* SCCHC's tracking policy and procedure regarding specialty referrals is innovative in that it details instructions for staff to promote patient self-management (e.g., using motivational interviewing), as well as identifies and addresses possible barriers for patient compliance.

Grantee: **Mendocino Coast Clinics, Inc.**
Fort Bragg, California (CHC)

Governance, *Consumer Participation on Board:* There is a high level of consumer participation on the board of directors. A total of 89% of the current board has received care at the health center in the past 24 months.

Grantee: **University of California, Irvine (UCI)**
Irvine, California (CHC)

Clinical Services, *Group Appointments:* UCI has implemented group appointments for its diabetic patients. This has improved performance on the HbA1c measure and also improved patient adherence to medications and diets. The group model is a great way to help diabetic patients learn from each other and have group sessions that allow for teaching more than just one person at a time.

Grantee: **Antelope Valley Community Clinic (AVCC)**
Lancaster, California (CHC)

Clinical Services, *On-Site Specialty Care:* AVCC does an exceptional job at providing on-site specialty care, including endocrinology, podiatry, infectious disease, mental health, pediatric endocrinology, cardiology, and pain management. A registered dietician-led diabetes and healthy heart education class and a retinal imaging program are available for AVCC's diabetic patients. Ready communication among AVCC providers allows a patient to be seen quickly by on-site specialists. AVCC's internal referral system is rapid and efficient.

Clinical Services, *Prescription Medication Abuse Program:* AVCC responded to the substantial problem of narcotic and controlled prescription medication abuse by the health center patients and in the service area by initiating a specific program aimed at this problem. AVCC is collaborating with other health care providers in the Antelope Valley to address this problem. A protocol was developed to train AVCC's providers and staff to identify patients abusing controlled medications and then effectively divert them to appropriate care. Every patient requiring a controlled medication has a urine test and a CURES (Controlled Substance

Utilization Review and Evaluation System) report examined prior to obtaining a prescription. Patients were educated in this new process, and the impact of this program was observable within two weeks. Prescription drug abuse has significantly decreased.

Clinical Services*, Mental Health Program:* AVCC has made a significant impact in meeting the mental health needs of the community by starting a mental health program. AVCC's mental health program has given many of its patients quick access to much-needed counseling and/or psychiatric care. Mental health continues to be a major unmet need in the community. The time to get an appointment with AVCC's mental health providers is significantly faster than that of other agencies. The health center offers same-day appointments and screening for patients who have urgent needs.

Grantee: **QueensCare Health Centers (QHC)**
Los Angeles, California (CHC)

Clinical Services*, Obesity Program for Children and Their Families:* QHC developed and implemented a program called ENERGY (Eating Nutritiously, Exercising Regularly and Growing Wisely™) in October of 2005 to provide high-quality obesity prevention, treatment and management services for children 2 to 17 years old and their families, free of cost. Participants come to the program through a referral from their primary care physician (sometimes though not necessarily a QHC provider) or a school nurse. From there, families commit to attending once-weekly sessions for an eight-week period. Each class incorporates 75 minutes of nutrition education, including a weekly cooking demonstration and other interactive activities, and 30 minutes of physical activity for the entire family. Fifteen minutes of each class is dedicated to tracking each participant's (adult and child) height and weight for outcome analysis. The classes empower families to modify nutrition/eating and physical activity habits in ways that are culturally appropriate while meeting accepted guidelines to improve childhood nutrition, improve the way parents feed their children, and help children develop healthy eating and physical activity patterns that have long-term positive outcomes. Families also have additional ongoing contact with a community health worker to ensure they have the support they need to make healthy choices at home.

Clinical Services*, Pediatric Asthma Program:* QHC introduced the Pediatric Asthma Disease Management (PADM) program in 2008. PADM is a multifaceted and comprehensive program integrating high-quality clinical treatment of asthma (and related conditions) by board-certified pediatricians with crucial bilingual, culturally sensitive chronic disease management services. Services include patient and family education to emphasize self-management delivered by highly-trained Community Health Workers/Promotoras de Salud (CHW/Ps); home environmental assessment visits to identify and remediate environmental triggers of asthma in the homes; and follow-up, case and psychosocial management support to empower the family to self-manage the child's chronic disease. This is a highly effective program that helps low-income

families whose children have been diagnosed with asthma to learn better ways to manage the disease, reduce exacerbations and stay out of the emergency room. The program's goal is to reduce and prevent expensive emergency room visits, hospitalization and missed school and parent workdays.

Grantee: **Asian Health Services (AHS)**
Oakland, California (CHC)

Management and Finance, ***Game Show Format for Training:*** AHS has used a game show format during staff meetings as a creative, fun, and engaging way to provide/reinforce training. AHS is developing a year-long curriculum to improve geriatric care (medical, dental, and behavioral health) that will be presented during monthly provider meetings.

Clinical Services, ***Translation of Health Education Documents:*** Beyond its impressive commitment to multilingual staff to directly interpret and provide care, AHS has a health education committee that reviews patient literature and approves translations to be made internally.

Clinical Services, ***Mental Health Screening Tool:*** AHS has developed a culturally-appropriate mental health screening tool that combines elements from existing validated tools regarding depression, anxiety, and level of function. AHS now performs annual screening with its own five-question Patient Health Questionnaire (PHQ-5).

Governance, ***Participation in Patient Leadership Council:*** AHS's Patient Leadership Council has monthly meetings with impressive participation (about 350 people attend) to develop advocacy, patient rights, and leadership.

Grantee: **La Clinica De La Raza, Inc. (LC)**
Oakland, California (CHC)

Management and Finance, ***Agreement for Access to Specialty Services and Inpatient Care:*** LC has obtained an agreement with John Muir Hospital to cover the cost of specialty services and inpatient care for its low-income and uninsured patients. The hospital, a not-for profit institution, agreed to this financial relationship as a community benefits contribution. The benefit to LC patients is measured in access to specialist care that would otherwise not be affordable to them, and in continuity of care for the most vulnerable of the LC patients.

Clinical Services, ***Gynecological Interventions without Hospital Day Surgeries or Overnight Stays:*** Through a philanthropic contribution, LC has established a gynecological treatment room where patients, and specifically uninsured patients, can receive interventions such as Loop Electrosurgical Excision Procedure (LEEP) and colposcopy, which otherwise would require a

hospital day surgery or possibly an overnight stay at considerable expense to the patient and the hospital.

Clinical Services*, Using Data to Manage Diabetes and Hypertension:* LC has an active and well-structured system in place for management of diabetes and hypertension. LC's panel managers routinely review HbA1c and hypertension data; the data are used for patient education as well as for population health management through LC's regular medical matrix meetings.

Grantee: Community Health Alliance of Pasadena (CHAP)
Pasadena, California (CHC/HO)

Management and Finance*, iPad Use by Outreach Workers:* CHAP has a robust outreach department: five community outreach workers, and six community HealthCorps members. Community HealthCorps is an AmeriCorps Program. In Los Angeles County, the program is administered by the Community Clinic Association of Los Angeles County. CHAP is a program site.

All outreach staff utilize iPads when out in the field. The iPads allow outreach staff to immediately access an online receptacle of documents via a Google Drive that CHAP has created. Staff can then be more responsive to each person's individual needs and questions. The iPads also assist staff in bringing health insurance screening out into the community by utilizing a HIPAA-compliant web-based health insurance screening tool. Lastly, the iPads create a direct link between outreach and enrollment staff.

Grantee: La Maestra Family Clinic (LMFC)
San Diego, California (CHC/HO/PH)

Management and Finance, *Facilitating Close-Out of Encounter Forms/Timely Billing:*
LMFC has implemented in the EHR system a procedure whereby all provider patient chart and encounter forms that are required to be completed online to close out a patient visit must be completed by the provider within three business days of the patient visit.

If the encounter is not closed out in the system by that time, the EHR system will lock that provider out of the system and prevent them from entering any more information for that patient chart. Each day, the billing director runs a report of all open encounter forms that have been locked out. That report is provided to the CMO (medical director) as well as the CFO and CEO. The report also indicates which provider saw the patient.

The CMO is responsible for following up with the providers regarding the reason for any non-completed/non-closed encounter forms. The billing director may also follow-up on these open

items as well. The intent of this approach is to:

1. Establish a benchmark for reasonable completion of open encounter forms (open patient chart) in the system from the day of visit.
2. Emphasize the significance of completing/closing the encounter forms in order that the billing staff can perform their review and bill the claims in a timely manner.
3. Involve the clinical leadership in the process in support of an executive team that has already agreed that this process is good for the organization and reasonable for completion of the encounter form and patient chart process.

The goal is to promote timely completion of the patient chart; to close out of the encounter in a manner to be billed; and to promote efficient, timely, and accurate billing of patient claims.

Grantee: **San Francisco Community Clinic Consortium (SFCCC)**
San Francisco, California (HO)

Clinical Services*, Services to Facilitate Patients Showing at Appointments:* SFCCC has an outreach program with a goal to link patients to a primary care provider. This program has implemented an evidence-based intervention to improve linkage to first appointments and is utilizing the quality improvement process to measure success. Two performance improvement projects have been completed. The first was a 2010 project that collected information on the number of outreach patients seen over a six-month period who discussed primary care with a staff person and were then successfully (re)connected with a primary care clinic within 180 days. Of the 120 patients who met the study criteria, 75% had a primary care discussion documented in their chart and 40% of those who had a primary care discussion were seen by a primary care clinic within six months.

A second outreach primary care referral study, completed in April 2014, collected information on the number of patients referred by staff for a primary medical appointment over a six-month period. Of the 114 patients who met the study criteria, 20% received intensive patient navigation services (scheduled appointments, two or more reminder calls, and transportation assistance up to and including patient accompaniment), and 80% received drop-in clinic information and one reminder call. The patients who received intensive patient navigation services connected with primary care services and kept their scheduled appointments over 60% of the time. The patients who received drop-in clinic information and one reminder call connected with primary care services 30% of the time.

Management and Finance*, Monitoring Deliverables from Subcontractors:* SFCCC has developed a detailed contract policy and process for monitoring deliverables from subcontractors. The policy outlines contract notification, procedures for sub-recipients experiencing compliance issues, staff responsible for notification, and notification of the board's

finance, audit and personnel committee. Each month SFCCC's contract manager develops a matrix to track the number and percent of key deliverables as well as data processed. Approval of payment to sub-recipients is based on the monthly contract report.

Grantee: **Santa Rosa Community Health Center, Inc. (SRCHC)**
Santa Rosa, California (CHC/HO)

Clinical Services*, Access for Patients with Acute Concerns:* The "Standby Clinic" at the Vista site of SRCHC provides same-day access for patients with acute concerns by designating one MA who monitors openings in the entire system (slots that are unfilled or become open due to cancellation or no-show) and fits patients in appropriately (prioritizing continuity, as able). About 100 patients, on average, are seen each day via this system, thus maximizing use of available capacity without needing to designate a "walk-in" provider.

Clinical Services*, Continuity of Care Between Inpatient and Outpatient Settings:* The Care Transition Program is a pilot program funded by the County Medical Services Program (CMSP) that seeks to improve effective communication and continuity of care between inpatient and outpatient settings for indigent patients by establishing a face-to-face connection with patients while they are still in the hospital and providing intensive case management. Success has been measured by tracking dollars saved (average per patient cost/month has gone from $3,783 to $1,300 for the approximate 100 enrolled patients).

Clinical Services*, Emergency Room/Hospital Care Reduction Program:* The reduction complex care management program is a Partnership Health Plan-funded pilot program targeting high users of ER/hospital care. A part-time nurse practitioner monitors and provides clinical/psychosocial evaluation/interventions for a panel of 50 patients. Success stories have been identified and medical expense savings in the first six months surpassed $500,000.

Clinical Services*, Information Sharing:* White bulletin boards are mounted in shared clinical work areas for teams to provide daily updates (e.g., average wait times for selected specialty appointments, and selected QI data).

Clinical Services*, Decreasing Pediatric Obesity:* The Roseland Pediatric Clinic uses "Sugar Shocker" patient education posters and handouts to promote patient/family discussion of the many unexpected sources of sugar in typical diets and to combat pediatric obesity.

Clinical Services*, Information Sharing:* SRCHC includes a methodology tab on all data reports. This helps clinical staff and other readers understand what is being measured and how data is extracted from the IT system.

Grantee: **Vista Community Clinic (VCC)**
Vista, California (CHC/MHC)

Clinical Services, *Information Sharing:* VCC has computers in exam rooms, and the computers have screen savers with bilingual messages targeted at patients regarding services, wellness, and general health education.

Management and Finance, *Facilitating Close-Out of Encounter Forms/Timely Billing:* In the EHR, providers are closing approximately 95% of encounters on the date of service, and 98% by the following day. Any encounter open 72 hours is locked and requires special attention in order to complete.

Grantee: **East Valley Community Health Center (EVCHC)**
West Covina, California (CHC)

Clinical Services, *Real Time Monitoring of Patient Flow*: EVCHC has an innovative practice in real time monitoring of patient flow. The in-house IT contractor designed software for the EHR system that displays patient flow according to check-in times of every patient, waiting room stays, exam room stays, provider interactions, lab, pharmacy, enabling services and check-out times. This information is displayed on overhead monitors at several key staffing locations in the health center sites. The information protects patient privacy through the display of only first names and with patient numbers. The display is easy to read at a glance and serves as a quick scorecard of patient flow. The monitor screen is split into sections that document the patient status by clinic location: there is a waiting room window; a counseling window that includes many ancillary services; an exam room window with all exam rooms noted by colors according to their status as empty, patient occupied without a provider, or patient-provider occupied detailing both patient and provider and time of original appointment; and a check out window. A banner across the top serves to summarize activity, documenting total patients who have checked in, total missed appointments, total checked out, and average cycle times. This system allows constant monitoring of patient flow and pinpoints areas that need improvement. It also allows sophisticated examination of utilization by patient type, provider, day of week, and more. A data summary report is able to be downloaded and printed for QI purposes.

COLORADO

Grantee: **Peak Vista Community Health Centers (PVCHC)**
Colorado Springs, Colorado (CHC/HO)

Clinical Services, *Interpretation Services:* PVCHC has a significant Spanish-speaking patient population. Although the center has a number of Spanish-speaking staff, they are not always

available on-site to provide translation services. The health center has placed wireless phones in the hallways of some of the sites. In the event that a provider requires translation support, they can access a staff member by phone who can facilitate the process.

Grantee: **Southwest Colorado Mental Health Center, Inc. (SWCMHC)**
Durango, Colorado (CHC/HO)

Management and Finance, *Corporate Compliance and Ethics:* SWCMHC has implemented an effective and well-documented corporate compliance and ethics plan. All new employees and board members receive orientation at the time of engagement. Annually, the compliance and ethics plan is reviewed with the staff and board and, subsequently, all complete annual attestations of compliance and ethical behavior. The most impressive aspect of the SWCMHC program is the general awareness by employees, the familiarity with the high-priority topics, and the simple incorporation of reporting processes into the routine operations.

Grantee: **Sunrise Community Health (SCH)**
Evans, Colorado (CHC/MHC)

Clinical Services, *Expanded Duties for Lower Cost Staff:* SCH employs expanded duties dental assistants (EDDAs) who are able to provide some oral health services typically provided by dentists.

Clinical Services, *Patient Consultation Services:* SCH's 340B program hosts PharmD students who provide patient consultation services.

CONNECTICUT

Grantee: **Community Health Services, Inc. (CHS)**
Hartford, Connecticut (CHC)

Management and Finance, *Information Sharing:* The new CEO at CHS has established a series of "Lunch and Learn" programs to facilitate the change process in CHS. The lunch and learn programs have included financial awareness, patient satisfaction, how to be a learning organization, and excellence. The lunch and learn programs are inexpensive to CHS (the cost of a lunch) and have been well attended.

Grantee: **Cornell Scott Hill Health Center (CSHC)**
New Haven, Connecticut (CHC/HO/PH)

Management and Finance, *Training Workshops:* CSHC has developed and implemented an intensive four-day workshop (academy) designed to train new MAs and nursing staff and to reinforce training for existing staff. The training incorporates the organization's mission and values, core clinical competencies, the MA and nursing roles and responsibilities, the impact of clinical support staff on the larger organization, customer service, implementation of the Patient-Centered Medical Home (PCMH) model, and importance of preventive care services. The academy is designed to increase the staff's level of engagement, effectiveness, and accountability, as well as enhance staff roles in improving client satisfaction, retention in care, quality of care, and health outcomes. The health center piloted the first academy in the fall of 2013 and holds two training sessions each month.

Clinical Services, *Co-location of Services:* The depth and breadth of the integration of services by CSHC demonstrates the grantee's commitment to holistic care and quality services. All sites, except for one stand-alone dental site, offer medical and behavioral health or substance abuse services. In addition, CSHC has co-located a behavioral health provider within the medical clinic at the main site to provide immediate assessment and referral services to medical patients, and has plans to expand this service at all sites. CSHC is commended for developing a service model that promotes access to a continuum of care at one service point.

DELAWARE

Grantee: **Westside Family Healthcare, Inc. (WFH)**
Wilmington, Delaware (CHC/MHC)

Management and Finance, *Model Contract Template:* WFH recently began a performance improvement initiative to create a contract/MOA template that clearly outlines the roles of each organization during all aspects of the service partnership and includes each of the required HRSA components for referred services. The resulting contract template is clear, concise, and complete.

FLORIDA

Grantee: **Health Care District of Palm Beach County**
dba C. L. Brumback Primary Care Clinics (CLBPCC)
Lake Worth, Florida (CHC/MHC/HO)

Clinical Services, *Quality of Care:* In a short period of time, the QI/QA committee has been able to transition from an organizational phase to a fully operational program. Meetings are well organized, cover a reasonable range of performance improvement areas, and document substantive activities. The program has the advantage of having a clinical informaticist who is able to provide timely and accurate data for analysis.

Grantee: **Rural Health Network Monroe County (RHNMC)**
Marathon, Florida (CHC/HO)

Clinical Services, *Information Sharing:* RHNMC utilizes a secure text messaging system that allows staff to communicate with each other without interfering with the patient encounter. Staff members are able to send information and reminders to providers. This feature has helped improve the providers' time management of the encounters. Staff also use the system to communicate after hours. The center's answering service also has access to the system online. The text messaging system is HIPAA-compliant. It is a multi-platform, secure, real-time messaging application for the enterprise that allows text messages to be deleted from both the sender's and receiver's phones after expiration, which could be a set period of time or after reading. The messages cannot be saved, copied, or forwarded by recipients. All communications are encrypted in transit and at rest, and recipients are authenticated before messages are sent. The user is also able to send and share files, including spreadsheets, images, and PDFs.

Grantee: **Miami Beach Community Health Center (MBCHC)**
Miami Beach, Florida (CHC)

Clinical Services, *Scribe Program:* MBCHC recently instituted a scribe program. The health center trains MAs who accompany the provider in the exam room, enter and reconcile information such as medication lists and problem lists, make appointments, schedule follow-up referrals and labs, and perform other duties not specifically required to be performed by the provider. The provider reviews the information obtained by the MA for accuracy. This subsequently leaves the provider more time for patient care and addressing preventive and chronic care issues.

GEORGIA

Grantee: **Southside Medical Center, Inc. (SMC)**
Atlanta, Georgia (CHC)

Management and Finance, *Medical Answering Service Coupled with Internal Call Center:* SMC identified the fact that health center patients were having problems obtaining timely appointments. Part of the problem was that the health center's call center did not have the capacity to answer all of the calls. It was reported that only one-third of the calls to the health center were being answered. Then SMC contracted with a medical answering service that operates simultaneously with the health center's internal call center. When patients call into the center, the answering service, which has access to the scheduling component of the EMR system, is able to make appointments. When there is no appointment open at one site, the answering service is able to identify other health center sites that have available appointment slots and refer patients to them. This has resulted in increased encounters and provider productivity, along with a decrease in the no-show rate.

Grantee: **Community Health Care Systems, Inc. (CHCS)**
Wrightsville, Georgia (CHC)

Clinical Services, *Participation in Research to Improve Health Outcomes:* In 2011, CHCS participated in a study of interventions to help patients bring their blood pressure under control. Centers for Disease Control and ICF (a research company) paired to conduct a study of the Consortium for Southeastern Hypertension Control (COSEHC) guidelines for hypertension control. These were known as AT GOAL (Aggressively Treating Global Cardiometabolic Risk Factors to Reduce Cardiovascular Events). The participation in a research study sponsored by a leading research institute speaks to the grantee's commitment to improved care for patients and excellence in medical practice.

ILLINOIS

Grantee: **Community Health Partnership of Illinois (CHPI)**
Chicago, Illinois (CHC/MHC)

Management and Finance, *Teleconferencing System:* CHPI, an organization serving an extended geographic area equal to 30,000 square miles, has implemented a system of teleconferencing that enables staff at multiple sites to visually participate in organization-wide conferences and training. The distance between the administrative office and the sites ranges between one and one-half hours and two and one-half hours driving distance (assuming no traffic

delays). One example of efficiency has been the improved ability to implement quick changes related to the EMR, thereby eliminating the need for multiple emails. For example, staff at remote locations are assisted technically with connections without the need of an actual visit by the IT support staff.

Grantee: **Aunt Martha's Youth Service Center, Inc.** (**AMYSC)**
Olympia Fields, Illinois (CHC/HO)

Clinical Services, *Four-Question Oral Health Screening:* AMYSC has implemented a formal four-question, patient-driven, oral health screening that is conducted at each clinical visit. If a patient reports that they have not been seen by a dentist in the past six months, the primary care provider does an evaluation and makes appropriate referrals. Staff training for this program utilizes the Society of the Teachers of Family Medicine (STFM) and American Dental Association (ADA) program curriculum.

INDIANA

Grantee: **HealthNet, Inc.**
Indianapolis, Indiana (CHC/HO)

Governance, *Board Manual:* HealthNet has developed a governing board manual that is comprehensive and presents information in a way that is visually appealing and easily understandable by all board members.

Grantee: **Jane Pauley Community Health Center Inc. (JPCHC)**
Indianapolis, Indiana (CHC)

Management and Finance, *Use of Electronic Records:* JPCHC has done a masterful job of integrating its EHR system with the systems of its partner organizations. The grantee has also worked to optimize the utility of its EMR system for its quality management program.

IOWA

Grantee: **Community Health Care, Inc. (CHC)**
Davenport, Iowa (CHC/HO)

Management and Finance, *Services to Facilitate Patients Showing at Appointments:* CHC has a centralized scheduling system. CHC's centralized scheduling department manages the medical and dental appointments for all of the health center's sites. A modified open access

model permits appointments to be scheduled up to three days in advance. A triage nurse is an integral part of this department. Since the centralized scheduling system was instituted, CHC has seen a dramatic decrease in its no-show rate, from 30% to 10%.

Grantee: **People's Community Health Clinic, Inc. (PCHC)**
Waterloo, Iowa (CHC/HO)

Management and Finance, *Interpretation Services:* PCHC has a comprehensive cultural and linguistic support network. The city of Waterloo is home to a large meat packing industry. There have been multiple waves of immigrants, including Hispanics, Somalis, and Burmese. PCHC employs immigrants as interpreters and encourages/supports the interpreters to seek additional education and moves the employees through the organization, including into management positions.

Management and Finance, *Services to Facilitate Patients Showing at Appointments:* In 2013, a PDSA model was put in place to reduce the patient no-show rate. In all no-show categories, the health center realized several significant reductions in the no-show rate.

Clinical Services, *Electronic Health Records:* PCHC's pediatric co-medical director works with Alliance of Chicago's centrally hosted EHR to improve the use and usability of the EHR/practice management system. Specifically, the PCHC co-medical director contributes to clinical content development for the customization of software to optimize for Community Health Center use; ability to support more robust clinical decision support; sharing of clinical expertise both internally and externally; and benchmarking of clinical standards (including pediatric developmental screening).

LOUISIANA

Grantee: **St. Thomas Community Health Center, Inc. (STTCHC)**
New Orleans, Louisiana (CHC)

Management and Finance, *New Employee Orientation/Competencies Process:* STTCHC has instituted a new employee orientation process that demonstrates excellent recordkeeping and ensures employees are thoroughly oriented. The process documents receipt of general new hire information, payroll, benefits, and then continues to formally document orientation using employee skills checklists that are consistently updated to reflect changes in required job competencies. The result is not only a remarkably complete orientation process, but also a record of documentation that can be retained by human resources (HR) for future reference should circumstances so dictate.

Grantee: **Primary Health Services Center (PHSC)**
Monroe, Louisiana (CHC/HO/PH)

Management and Finance, *Revenue Generation:* PHSC captures and monitors the revenue generated by each provider and compares it to their salaries. It has set a benchmark of each provider to capture at least three times the amount of their salary in revenue to pay for the support staff. This ratio is captured monthly and reported to the finance department and board.

MAINE

Grantee: **Katahdin Valley Health Center (KVHC)**
Patten, Maine (CHC)

Clinical Services, *Quality of Care:* KVHC's quality program is comprehensive and detailed. It includes the major areas of service quality, peer review, risk management, and hospital utilization. The plan is implemented thoroughly and effectively. Here are several examples of how this is done:

1. Clinical quality measures are published by provider, with the providers' names identified. This allows providers to learn from promising practices in the organization.
2. Incident reports are tracked and trended by type and provider/site. In a recent situation, management was able to identify a provider/staff team who made two identical immunization errors. This was detected immediately, and corrective action was taken.
3. A peer review system was recently implemented. Peer reviews are now done quarterly, with findings and corrective actions being reported by provider and aggregately.
4. Hospital utilization is closely monitored. Emergency room visits by the health center's patients are tracked by reason for visit (chief complaint), patient's primary provider, and the emergency department access. Results are given to the care coordinator for follow-up.

Grantee: **York County Community Action Corporation (YCCAC)**
Sanford, Maine (CHC/HO/PH)

Governance, *Information Sharing:* The director of health services of YCCAC provides detailed monthly reports to the board of directors on the many activities required by the health center. The 2014 Needs Assessment was discussed over several months, in detail, including the purpose of the Needs Assessment, the various components of the assessment, the outcomes of the assessment, and how the assessment will be used in determining service area challenges and designing a strategic plan. The health center services are discussed in detail with connections made to the service area, target populations, staffing, and short- and long-range planning. The

organization's PCMH process is discussed in an ongoing manner, with detail provided to assist the board in understanding changes to service delivery.

Clinical Services*, Continuum of Care:* YCCAC works closely with the York County Shelter Programs (YCSP) to coordinate a seamless continuum of care for the homeless. YCSP is located in Alfred, Maine (Shaker Hill), on land owned by the Brothers of Christian Instruction (YCSP is in the process of acquiring the property and facilities). The YCSP Shaker Hill site provides emergency and transitional housing, a food pantry, meals kitchen and bakery, a recycling program, two shared-use community kitchens, and an extensive behavioral health/substance abuse counseling program. The Shaker Hill site is rural and tranquil. The staff works with YCCAC's providers and assists the homeless in traveling to the YCCAC Nasson Health Care clinic for medical and dental services.

As a community action agency, YCCAC provides oversight for a variety of programs designed to assist the poor and working poor. The organization's management team and program leadership are co-located and coordinated to best serve the target population with heath care, social services, education, housing, heating, and other services.

Grantee: **Islands Community Medical Services, Inc. (ICMS)**
Vinalhaven, Maine (CHC)

Clinical Services*, Telemedicine:* ICMS has instituted a telemedicine program that serves both medical and behavioral health clients. Because weather conditions and island isolation can limit access, telemedicine is a valuable adjunct service. Importantly, ICMS has clearly communicated the fee structure and reporting requirements for the use of this service. As the health center is presently limited to on-site providers, there is no added credentialing required. The process works like this:

- The Maine Seacoast Mission (Seacoast), a nonprofit agency, has a grant to operate "The Sunbeam," a boat that travels around to isolated islands in Maine. A nurse hired by Seacoast acts as a case manager and arranges the schedules of island visits. Island residents are notified of the service. For those island residents of Matinicus, which is included in ICMS's scope, providers from ICMS coordinate care visits with the Seacoast nurse.
- Behavioral health and general medical visits are included in the telemedicine visits. Only individual visits are reimbursable as core services at this point, but group visits are also available for behavioral health patients due to the need and the acceptance of these by remote islanders. Visit planning is coordinated through Seacoast and ICMS.
- All patients seen by ICMS via telehealth have an EHR, and routine charting of the visit occurs by an ICMS provider. The patient and nurse can communicate to an ICMS provider through an audiovisual station in a private room at ICMS. Prescriptions can be

sent electronically as needed from the EHR. Care is documented as provided by ICMS through a Medicare Part B code specific for telemedicine (0780). No deductible is necessary for this Medicare service.

- Services are accepted well by staff and patients. There are many opportunities for expansion without added staff. The contractual dentists are on the mainland, which is several hours away. Currently, the dentists are called several times a week and review digital x-rays sent remotely. They then coordinate care telephonically with the dental assistant or hygienist. Use of telemedicine would allow a scheduled review, as well as a reimbursement channel. Many other similar uses are possible if equipment is available on the patient end.

MARYLAND

Grantee: **Health Care for the Homeless (HCH-Baltimore)**
Baltimore, Maryland (HO)

Clinical Services*, After Hours Call System:* The health center has a unique after-hours call system that rotates call among providers (which is not unusual). What makes this a promising practice is how the health center utilizes the call center after-hours system to incorporate 24-hour access by phone for clients. This is a homeless program that is ideally located to reach clients at shelters nearby and a major area where homeless clients gather. However, there are a number of clients unable to get to the clinic by public transportation (without funds), and, by utilizing the on-call provider, clients can and do receive advice regarding their health needs through the answering service that places clients in contact with the on-call provider.

Grantee: **Three Lower Counties Community Services, Inc. (TLC)**
Salisbury, Maryland (CHC/MHC)

Clinical Services*, Therapeutic Children's Summer Program:* TLC has implemented a therapeutic summer program for children ages 5 to 19. Identified children are those who have been screened for at-risk behavior and are currently receiving mental health treatment services. All children served are at or below the Federal Poverty Guidelines. This program provides a safe and highly-structured child-centered clinical program for these at-risk children. Each child receives a treatment plan that is based on improving social skills, and teaching anti-bullying, anger management, empathy skills, and respect for authority.

TLC tracks several indicators to identify the success of the program: children's attendance, which reflects personal responsibility; report cards documenting behavior and academic success; and recognition of individual talents each child exhibits.

Grantee: **Community Clinic, Inc. (CCI)**
Silver Spring, Maryland (CHC)

Clinical Services*, Information Sharing:* CCI has teamed up with Family Services, Inc. and Cornerstone Montgomery, Inc. to promote the exchange of health information among behavioral health and medical care providers to achieve overall better care. The Health Integration Project (HIP) helps licensed substance abuse and mental health practitioners better coordinate patient care with their clients' primary care providers, ensuring appropriate access to real time relevant patient information, such as current medications and medication history, which promotes the overall health of patients. The co-location of CCI and the outpatient mental health clinic has shown to improve services and facilitate a "warm hand-off" in transition of care. Using data to support the HIP project, results have shown a reduction in HbA1c levels, improvement on total cholesterol including HDL and LDL, a significant reduction in blood pressure, a reduction in symptoms of depression, and a significant increase in social functioning.

CCI collaborates with the International Rescue Committee (IRC) and the Maryland Office of Refugees and Asylees (MORA) to improve the health care and monitor medical conditions of refugees and asylees after their arrival into the United States. IRC was founded in 1933 and is a global leader in emergency relief, rehabilitation, protection of human rights, post-conflict development, resettlement services, and advocacy for those uprooted or affected by violent conflict and oppression. After approval by the government, the refugees and asylees are matched with a resettlement agency like MORA, which is part of IRC. The resettlement agency provides core services such as case management, orientation, and referrals (such as to medical services). Upon arrival in Maryland, the refugees and asylees are given an initial health screening by the local health department to identify and treat communicable diseases that would present a public health threat to the general population. During the resettlement process, the refugees and asylees are brought to CCI for primary care concerns. The refugees come from diverse regions of the world and bring with them health risks and diseases common to all refugee populations, as well as some that may be unique to specific populations. Many new arrivals have serious health conditions needing immediate attention and follow-up. In addition to contagious diseases, many refugees have experienced trauma and may be suffering from mental health conditions, hypertension, diabetes, skin, vision and dental problems, and/or malnourishment.

There are many challenges to overcome when providing medical care to this population. Many factors contribute to these challenges, foremost being the language barrier and others such as cultural values regarding preventive care, trust issues, cultural differences such as gender roles, and expectations versus reality. For most refugees, this is the first interaction with the U.S. health care system. All refugees have up to eight months to receive their benefits, upon which time their primary medical home should be established. CCI's collaboration with these resettlement agencies plays a significant role in refugee health, which facilitates the opening of pathways to

wellness and supports the physical and emotional well-being of refugees by enhancing and coordinating care through the primary health care system.

MASSACHUSETTS

Grantee: **Codman Square Health Center**
Dorchester Center, Massachusetts (CHC)

Management and Finance, *Performance Improvement Approach:* Quality improvement begins with "front line staff" and includes all aspects of the organization. The performance improvement committee's strategy includes an ongoing/updated project list (organized by month covering multiple years). The performance improvement committee solicits projects using a charter process by which providers and staff request project consideration that includes an opportunity statement, expected outcomes, measures of success, team methodology/process improvement, customer service, support for the eight change concepts of Patient-Centered Medical Home, and reporting plans. Calendar year 2014 projects included: meeting department visit goals; integration of behavioral health in the primary care setting; improving patient phone experience; pharmacy use; improving telephone access; improving urine specimen turnaround time; improving turnaround time for critical laboratory value results; improving customer service; patient satisfaction surveys; incident reporting trends; building school wellness; improving hypertension control in patients with diabetes; social needs assessment during clinic visits; and a colonoscopy navigation project.

Grantee: **Community Health Connections, Inc. (CHC)**
Fitchburg, Massachusetts(CHC/HO/PH)

Clinical Services, *Pet Policy:* CHC's dental program established a pet policy enabling physically handicapped patients' pets to accompany them during dental visits in order to "provide owners safety, mobility, sense of normalcy and emotional stability."

Clinical Services, *Suboxone Clinic:* CHC's medical staff, under the guidance of the CMO, implemented a Suboxone clinic (an opiate treatment program) in response to trending in the morbidity and mortality committee report of deaths related to opiate substance abuse. Suboxone is a pharmaceutical agent specific to the treatment of opiate dependence.

Grantee: **Duffy Health Center, Inc. (DHC)**
Hyannis, Massachusetts (HO)

Clinical Services, *Suboxone Clinic:* DHC's medical staff, under the guidance of the clinical director, implemented an integrated (behavioral health services and medical) Suboxone clinic (an

opiate treatment program). Suboxone is a pharmaceutical agent specific to the treatment of opiate dependence.

Clinical Services, *Colorectal Screenings:* DHC applied for and was awarded a grant from the Massachusetts League of Community Health Centers to assist patients and health centers to achieve higher rates of colorectal cancer screenings. DHC will use the funds to provide a motel stay for the pre-procedure prep. The case managers will accompany the clients and provide transportation to and from the specialist's location, and ensure that patients have their basic needs met during this time.

Grantee: **Lowell Community Health Center (LCHC)**
Lowell, Massachusetts (CHC)

Management and Finance, *Interpretation Services:* LCHC's Metta Health Center focuses on Lowell's Southeast Asian and other refugee populations. "Metta" means loving kindness in the Buddhist Pali language. The Metta Health facility offers Eastern and Western approaches to medicine for servicing the large Asian population. The health center has an extensive bilingual capacity to effectively communicate to the non-English speaking patient population. The health center offers an intensive 40-hour professional medical interpreter training program that prepares participants for national certification. A large majority of the staff have completed the program.

Management and Finance, *Monitoring Operations:* LCHC has an effective operational plan that consistently monitors health center operations. The plan has two parts: "Mission Possible I," and "Mission Possible II." They track everything from patient wait times to the impact of down days on patient encounters and, ultimately, revenue. For example, the provider productivity report directly relates to revenue. Encounter tracking can indicate, among other things, that dips in encounters are related to inclement weather or federal holidays. The health center is proactive in scanning the market for opportunities and threats. LCHC anticipates a large increase in Congolese patients. Therefore, LCHC is working to hire staff and interpreters who speak French to better serve this patient population.

Grantee: **Community Healthlink, Inc. (CHL)**
Worcester, Massachusetts (HO)

Clinical Services, *Housing First Model:* CHL utilizes a Housing First model, emphasizing the primary importance of establishing a stable housing situation for each patient. Once housing is secured, other life goals – work, education, finances, treatments – can be achieved. Through its relationship with the local Continuum of Care, CHL's Homeless Outreach and Advocacy Project (HOAP) secured expanded McKinney funding to provide increased access to housing subsidies. CHL currently serves approximately 225 people who are experiencing (or have experienced) homelessness; of these, roughly half are Housing First clients. As a result, CHL/HOAP is the

principal provider of integrated primary health care, mental health care and substance abuse treatment, housing, and other supportive services to Worcester's homeless population. CHL strongly supports the Housing First model as a means to reduce/end homelessness.

Clinical Services*, Team Care Model:* CHL transitioned to a "team care" model of care to support and strengthen the organization's PCMH model. Teams are comprised of providers, nurses, medical assistants, and behavioral health/substance abuse counselors. The model is fully integrated. The teams "huddle" daily, when they identify prevention and screening needs of scheduled patients/clients and review the overall housing status and the behavioral health/ substance abuse counseling needs. The team care model is allowing more time for same-day visits.

Governance*, Advisory Board:* The Homeless Outreach and Advocacy Project has an effective community advisory board. The board is comprised of current and former homeless patients/ clients, and meets monthly. The board functions as a "hands-on" board with a monthly agenda, action items, and updates. the board records and maintains minutes. The board holds annual elections for officers, and works with HOAP management and staff.

Grantee: Edward M. Kennedy Community Health Center, Inc. (EMKCHC) Worcester, Massachusetts (CHC/PH)

Governance*, Training:* EMKCHC routinely conducts formal board training at the beginning of each monthly board meeting; they are well prepared and last about 20 minutes each. Desired topics addressing finance, QA/QI, HR, strategic planning, Robert's Rules of Order and other governance topics are scheduled. In their self-evaluation, board members reported this process has served them well in maintaining current their level of knowledge. New members reported that this was an efficient and effective way to become fully oriented into their governance oversight role.

Governance*, Participation:* EMKCHC's CEO routinely allows senior (second tier) staff members to attend monthly board meetings. They do not merely attend and observe, they "sit at the table" and participate as appropriate. Board members who were interviewed indicated that this enables a strong sense of teamwork and benefits decision-making at all levels.

Clinical Services*, Dental Lab Services:* EMKCHC is one of a few health centers that directly provides dental lab services, including partial and full dentures, a service that is often out of the reach of the uninsured and underinsured.

Clinical Services*, Emotional Health of Staff:* Recognizing the emotional toll of providing clinical care to a challenging patient population, EMKCHC periodically allows the provider staff

to meet as a group with the director of behavioral health to discuss whatever stressors they choose.

MICHIGAN

Grantee: **Health Delivery, Inc. (HD)**
Saginaw, Michigan (CHC/MHC)

Management and Finance, *Comprehensive Transportation Services:* This grantee was proactive in reducing transportation as a barrier to care. HD established a transportation strategy that covers all 24 sites (on alternate days), five days a week, during regular hours of operation, with six total vans (five for transportation and one for reserve). One of the vans is a lift van to accommodate wheelchairs and individuals who have mobility issues. Transportation is often cited nationally as a barrier to accessing care or delaying care. The same is true in Saginaw, Michigan. Some of the 24 sites are on public transportation; however, the cost of public transportation is prohibitive to this grantee's patients.

Transportation appointments are made 48 hours prior to a patient's appointment, and there are some open slots for more urgent cases. There are board-approved policies and procedures that help guide this strategy. There is discussion to improve this process by a more formal incorporation of transportation with the newly-established and operational call center. Candidates interviewed to work for the program have a thorough background check and receive training in cardiopulmonary resuscitation (CPR). From January through June 2014, there were 8,981 requests for transportation services with 7,924 rides given. The net difference of 1,057 represents no-shows, cancellations, or turn-aways/declines (by patients). This is an 88% show rate of requests and rides. So far, 48 users have used the lift van.

Grantee: **Sterling Area Health Center (SAHC)**
Sterling, Michigan (CHC)

Clinical Services, *Diabetes and Obesity:* SAHC maintains a focus on diabetes and obesity patient education with the input of a dietitian on staff who is a certified diabetes educator. This has resulted in 90% of diabetic patient having HbA1c below 9%.

MINNESOTA

Grantee: **Cedar Riverside Peoples Center (CRPC)**
Minneapolis, Minnesota (CHC)

Clinical Services, *Referrals by MAs:* CRPC had been performing fairly low in adult weight screening and follow-up. In 2011 and 2012, less than 5% of adult patients had a follow-up plan documented if their BMI indicated that they were overweight or underweight.

The QI team used a PDSA cycle to see what they could do to improve this measure. They came up with allowing medical assistants to automatically make a referral to the registered dietitian if a patient's BMI was less than 18 or more than 25. As a result of this PDSA effort, the health center was able to increase its performance on this measure to 35% in 2013.

Grantee: **Hennepin County Community Health Department**
Hennepin County Health Care for the Homeless Project (HCHCP)
Minneapolis, Minnesota (HO)

Clinical Services, *After-Hours Shelter Phone Number Cheat Sheet:* As an HCH program, the after-hours coverage requirement takes on a different emphasis when the majority of patients are housed in adult or family shelters after hours. The shelter staff are required to call 911 for after-hours services. However, the HCHCP providers may need to find a patient who has life-threatening laboratory results and the HCHCP program has created what they call an After Hours Shelter Phone Number Cheat Sheet (for critical labs). This "cheat sheet" is in the form of a grid with the shelter name, after-hours phone number, and on-site shelter staff member's name. It is printed, but is also available to the providers on the shared drive of the EHR system. This tool affords the providers the opportunity to find patients needing immediate or urgent follow-up and helps the shelter staff deal with potentially sick clients quickly.

MISSISSIPPI

Grantee: **Center for Family Health (CFH)**
Jackson, Mississippi (CHC)

Governance, *Prospective Board Members:* CFH's board utilizes ad hoc positions on various committees as kind of a "farm team." This provides a way to evaluate the prospective board members regarding their skill set, dependability, and for both parties to see if it is a good fit.

Clinical Services, *Group Appointments:* CFH's women's health department is participating in a group prenatal care program. The CMO states that the first group of participating patients has completed the program and has delivered their babies. Currently, about 10% of the prenatal patients are participating in group prenatal care comprised of eight to ten patients per group according to their due date. Outcome data is being collected for review, but subjective observation has been very positive. This change in the way obstetrical (OB) care is delivered requires a great deal of effort and support from the providers and other staff, in addition to patient acceptance. CFH's women's health department has successfully developed and implemented the processes required to perform group prenatal care by utilizing the professional resources within the health center, including: OB physicians, pediatricians, dietitians, and RN educators. The CMO, an obstetrician/gynecologist, was instrumental in the decision to implement the project and voices positive comments.

Grantee: **Claiborne County Family Health Center (CCFHC)**
Port Gibson, Mississippi (CHC)

Clinical Services, *Patient Assistance Program:* CCFHC realizes that some patients are not able to pay for their medications due to no insurance or insurance policy coverage issues. The patient assistance program was developed to help patients obtain necessary medications at little or no cost.

During a provider-driven visit, if it is determined that the patient requires help getting medication, the provider refers the patient to the patient advocate to assist in the application process for patient assistance. The patient advocate explains the application process, assists the patient with the application, notifies the patient of necessary documentation required by the pharmaceutical company, and completes the application process for the patient.

The patient advocate explains to the patient that they will need to call for refills every three months and reminds the patient when the application needs to be renewed.

MONTANA

Grantee: **Yellowstone City & County Health Department**
dba RiverStone Health (RSH)
Billings, Montana (CHC/HO)

Clinical Services, *Group Appointments:* RSH uses the group visit model for several clinical and behavioral health services including prenatal care, diabetes, lifestyle change support, anger management, etc.

Clinical Services, *Polypharmacy:* RSH's clinical pharmacist addresses polypharmacy by meeting with all patients who take five or more chronic prescriptions.

Grantee: **Lincoln County Community Health Center**
dba Northwest Community Health Center (NWCHC)
Libby, Montana (CHC)

Management and Finance, *Policies:* NWCHC has excellent, board-approved policies in several areas. NWCHC's standards of conduct and procurement policies are simple and clearly written so that they can be readily understood by board members who are approving them and staff and others who are following the policies. In addition, in a footer in the policies, all policies indicate when the policy was last approved by the board. This enables easy tracking to help flag when a policy should be reviewed.

Governance, *Agenda/Minutes:* The NWCHC board operates productively and efficiently. Board agendas indicate action items (i.e., those requiring a vote) and minutes track directly back to the agendas. This makes it very easy for staff, board members, and others to determine that required authorities are being performed.

Grantee: **Community Health Partners, Inc. (CHP)**
Livingston, Montana (CHC/MHC)

Clinical Services, *Training:* CHP has an innovative partnership with a group called Learning Partners. Housed in another section of the same building as the Livingston Clinic, this group provides learning opportunities to CHP patients. There is high school equivalency offered as well as literacy education on all levels. Health and parenting education is available. One of the most interesting services is the visit with a parent educator, which takes place early in every woman's pregnancy. This way, it is reinforced that learning to be a good parent is as important as learning about the pregnancy itself. From that point, there are many opportunities to learn effective parenting. This group has a representative on the QA/QI committee who is an integral part of staff and other team meetings.

Management and Finance, *Information Sharing:* For three and a half years, CHP has been providing "welcome visits" to its new patients. This visit is scheduled to occur on the same day as a new patient's first visit to the health center. The process was first implemented at the Livingston Medical Clinic, where the resource and support coordinator developed the process. It has now been expanded to all of CHP's medical and dental clinics. The visit helps orient new patients to CHP's sliding fee scale discount process and supportive services, both in the clinic and in the community. During the visit, CHP staff assist new patients with the new patient packet, which includes a patient demographic form, notice of HIPAA rights, consent to treatment form, and the sliding fee form.

NEW JERSEY

Grantee: **Zufall Health Center, Inc. (ZHC)**
Dover, New Jersey (CHC/MHC/HO/PH)

Clinical Services, *Targeted Populations:* ZHC has established a component of its health center to focus on the medical, dental, and behavioral health services for its special populations, i.e., the office of outreach and special populations (OOSP). OOSP has identified the homeless, public housing residents, farm workers, and veterans as special populations within the service area. In the past, the health center put an emphasis on the developmentally disabled in their community, and OOSP has initiated activities to target outreach to an increasing Latino population, primarily from South America. The OOSP director and its staff serve as internal subject matter experts for the center and external liaisons to the community on those populations. They continually work to secure partnerships and sponsors to provide medical and dental services and enabling services to clients at the local sites or via the mobile van. Efforts to strengthen partnerships with the Veterans Clinics and to improve the services provided to local veterans have been highlighted by local newspapers and local legislators.

The OOSP works with homeless shelters to compile information to identify issues and for scheduling. ZHC has established the mobile van outreach team, which includes the CEO, to meet weekly to discuss issues and activities twice each month. The OOSP coordinates transportation for farm workers to get needed services in a timely manner. ZHC has also incorporated a new enrollment form and provided additional training to encounter staff to identify clients at enrollment from their special populations. The OOSP staff and health center providers continually strive to improve the patient navigation through many services. In addition, the mobile van schedules regular events to provide services to veterans at certain locations. With the assistance of AmeriCorps, ZHC has implemented special projects to work with seniors, pre-schools, and Head Start programs. AmeriCorps staff members have implemented an intergenerational program in which they work with seniors and pre-school children. With the implementation of the Affordable Care Act (ACA), the OOSP provides counseling on the availability of services and implementation of the new health care law, ensuring those populations have a PCMH.

Grantee: **Lakewood Resource and Referral Center, Inc. (LRRC)**
Lakewood, New Jersey (CHC)

Clinical Services, *Technological Assistance in Providing Care:* LRRC received a grant from the Nicholson Foundation to establish an integrated behavioral program in adult medicine using technological assistance from Cobalt Therapeutics. Based on the Cherokee Health model of integration, the practice locates behavioral health staff in the medical department to conduct brief

interventions (15 to 30 minutes) for common patient problems. The innovation is the adjunct use of technology to assist cognitive behavioral therapy (CBT) in this setting. LRRC is piloting a program with Cobalt Therapeutics using a tailor-made screening and intervention computer-based program that is patient driven. Upon check-in, all new sick visit patients and all well visit patients receive an iPad that lists screening questions for the five concerns most noted by LRRC's clinicians: insomnia, anxiety, depression, substance abuse, and obsessive-compulsive disorder. The results of the screenings are sent to the provider with risk level noted, as well as clinical suggestions based on risk. The provider can review these results and immediately introduce the patient to the behavioral health clinician if indicated. The behavioral health staff can opt to provide a brief intervention or to assist the patient through the computer module set up in a private room. The module is linked with the screening form and is compliant with privacy laws. Patients have unique CBT plans, and LRRC staff have been able to modify therapeutic suggestions to conform to the cultural preferences of the population. The screenings and the CBT modules are available in English and Spanish and delivered in audio and print format. Patients have assignments they can access from home to complete more modules and give feedback on therapeutic interventions attempted. Providers can monitor the patients' progress on the modules. Provider and patient satisfaction is high. The modules are useful when the wait time is long or when the patient is not ready for a face-to-face intervention. The off-site portion allows continuity of care and documented self-management.

Clinical Services*, Oral Health Care:* A dentist is stationed in pediatrics every Wednesday. Children ages 6 months to 18 years with well checks will have an oral health exam conducted by a dentist. Fluoride varnish application by nurses and oral health education are components of the program. Oral health needs are documented and periodic checks updated.

Grantee: **Newark Community Health Centers, Inc. (NCHC)**
Newark, New Jersey (CHC)

Clinical Services*, Assigned Clinical Measures:* The CMO of NCHC has implemented a process that assigns each of the clinical measures to one of the providers. That provider is responsible for the tracking and development of QI activities designed to improve the performance on the individual clinical performance measures. Not only does this encourage continuous monitoring, it also engages the provider staff in the QI process and helps their understanding of the process and the overall importance of outcomes measures in patient care.

NEW YORK

Grantee: **Middletown Community Health Center, Inc. (MCHC)**
Middletown, New York (CHC)

Governance, *Monitoring Operations:* The annual MCHC 330 Program Requirements Matrix is a tool to assist the board in oversight of the 19 FQHC program requirements. The matrix is a month-by-month list of the various requirements, the responsible party, when a requirement was met (vote held), and what was accomplished for compliance (e.g., 2014 Needs Assessment, Update 2014 organizational chart, policies and procedure reviewed/updated, 2014 Sliding Fee, 2015 QI/QA Plan, review of organizational data reporting systems, 2014/5 budget period progress report and annual budget, 2013 CEO performance review, review of Notice of Grant Awards, ongoing staff reports).

Management and Finance, *Real Estate and Property:* MCHC works closely with various community leaders/residents to identify existing facilities to update as clinical space. Recent acquisitions include a former hospital, a former office facility, and a soon-to-be renovated historic train station. MCHC's management also works with local businesses to purchase, at significantly reduced rates, furniture and equipment.

Clinical Services, *Information Sharing:* A MCHC pediatrician hosts a weekly radio program and several MCHC providers provide timely articles in a local newspaper.

Grantee: **Charles B. Wang Community Health Center, Inc. (CBW)**
New York, New York (CHC)

Management and Finance, *Monitoring Operations:* CBW adopted a comprehensive strategic plan in 2012 and, subsequently, has systematically focused on addressing the strategic priorities outlined in the plan. Utilization of a strategic planning dashboard at the monthly board meetings to gauge the implementation and completion of the strategic plan is a best practice that assists the organization in measuring and evaluating its effectiveness.

Grantee: **Syracuse Community Health Center, Inc. (SCHC)**
Syracuse, New York (CHC)

Management and Finance, *Sliding Fee Scale:* SCHC has a self-declaration policy for its sliding fee discount program whereby a patient can qualify for a discount on the first visit, even though full documentation is not readily available to prove eligibility. Rather, eligibility for the sliding fee discount on the first visit is based on a patient's self-declaration of the number of members in the household and their household income. This policy is most helpful for patients

who walk-in for care, thereby removing the barrier to care for new patients first seeking care, particularly in the walk-in clinics operated by the grantee. Patients qualifying for the sliding fee discount, based on self-declaration for the first visit, are required to provide documentation for future visits to continue to receive the discount. Patients receive a letter within five days providing information on the documentation needed to continue eligibility for the sliding fee discount.

NORTH CAROLINA

Grantee: **Roanoke Chowan Community Health Center Inc., (RCCHC)**
Ahoskie, North Carolina (CHC/MHC)

Management and Finance, *Co-location of Services:* RCCHC has a unique arrangement with the East Carolina School of Dentistry. Through a joint agreement, the two organizations built facilities that are located next to each other. There is a common walkway between the two facilities that allows for ease of access to and from the health center and dental facilities. Through the dental program, residents of the community are able to have affordable access to a wide variety of dental services. RCCHC has an agreement to pay for the dental services of its patients based on a sliding fee scale. In return, the dental school receives the volume and diversity of patients to provide its dental students with the variety of cases necessary to fulfill the requirements of their training. This arrangement is a win-win for both organizations and the community.

Governance, *Prospective Board Members:* The RCCHC board of directors mentoring program begins with potential members from the community being appointed as non-board/community members. RCCHC's objective is to keep members of the community informed of the health center activities and to prepare a pool of individuals interested in serving on the board. Once the RCCHC board identifies community members voicing an interest in being on the board, these members participate in RCCHC board committees, board meetings, and in other activities sponsored by the health center. The community members are presented with information about the health center before they are elected to fill board positions as incumbents' terms end. RCCHC currently has six community members participating in their board mentoring program. In addition to attending board meetings, each of the community members is assigned to the following board committees: finance, quality improvement, and development/planning. As board vacancies occur, the RCCHC board has a pool of knowledgeable community members ready to fully participate in board activities. They learn the workings of various committees and are able to determine how to best use their individual strengths and experiences on selected committees. They are provided the opportunity to become knowledgeable about health center policy and operations early in the mentoring process. As a result, new board members who are mentored by RCCHC's current board members begin their terms in office better prepared to participate in

decision- and policy-making issues earlier than most board members who have not been exposed to such programs.

Grantee: **Lincoln Community Health Center, Inc. (LCHC)**
Durham, North Carolina (CHC/HO)

Clinical Services, *State-of-the-Art Pharmacy:* LCHC has a state-of-the-art pharmacy at its main location. The pharmacy has received many citations as being a "best practice" in the field. The staff have published several articles in multiple peer reviewed journals on the subject of pharmacies in Community Health Centers. The pharmacy conducts customer and physician user surveys to evaluate the services that are rendered and how to improve these services. Medication safety is a very high priority. Medication errors have been reduced by use of barcoding and changes in prescription labelling, and e-prescribing is a seamless, routine process. As a promising practice, the staff have initiated benchmarking pharmacy performance measures on a state-wide basis. LCHC's pharmacy has also initiated a "think tank," which is a collaboration with four pharmacy groups across North Carolina to discuss pharmacy measures. The LCHC pharmacy has been recognized with four HRSA awards for patient safety, clinical pharmacy service improvement, life-saving patient safety, and health outcomes management.

Grantee: **Gaston Family Health Services, Inc. (GFHS)**
Gastonia, North Carolina (CHC)

Management and Finance, *Paying for Service Programs:* GFHS has partnered with local health care providers to expand services in a unique and effective manner. The health center raised $2,500 each from 65 out of the 70 dentists in the service area to fund the establishment of an effective dental program.

Management and Finance, *Paying for Service Programs:* GFHS established a vision health program through donations by local optometrists. Optometrists volunteer to treat health center patients at the health center while offering glasses with prescription lenses for $25, by having the volunteer optometrists donate the lenses and frames for the glasses. Expansion to include vision care services allows uninsured clients to be able to read and find employment.

Management and Finance, *Thorough Insurance Coverage Reviews:* GFHS has vibrant patient assistance programs. Management has instituted a process of re-certifying patients' eligibility for the programs every six months. The process has been amended to cover all of the patient assistance program requirements in an all-inclusive process. This enables patients to be kept up-to-date with all of the programs for which they qualify.

Management and Finance, *Real Estate and Equipment:* GFHS has averaged 20% growth annually since 2006 by expanding sites and services. The organization has tried to ensure its

success by developing and applying a systematic model of expansion that involves a conservative approach to forecasting the financial performance in the start-up phases and requiring the local community to invest in the health center's success through local financial commitments.

Management and Finance, *Document Management System:* GFHS has a document management system (DMS). This is an intranet system used to house and keep track of documents important to the operations and governance of GFHS. The DMS contains several years of policies, procedures, corporate compliance, QI, audits, contracts, leases, marketing materials, and UDS. The accessibility is username and password protected for staff and board members. During the OSV, temporary permission, via secured username and password, was granted to the consultants who went on the site visit. The DMS is easy to navigate as it is organized into categories with subheadings. Documents are further organized by name, approved date (if applicable), and a description. The DMS is a historical/archival and practical interface where important documents can be stored, accessed, and monitored. The DMS adds efficiency by allowing staff and board members to log-on and access or log-on and search for documents relevant to their roles and responsibilities quickly. In order for an organization to succeed, all employees should understand and work toward common goals, and the DMS facilitates this.

Grantee: **NC Department of Health and Human Services**
North Carolina Farmworker Health Program (NCFHP)
Raleigh, North Carolina (MHC)

Management and Finance, *Electronic Health Record:* The statewide, population-focused service delivery model of NCFHP creates unique data management challenges. In order to monitor utilization and quality, NCFHP supported the development of FHASES (Farmworker Health Administration System and Electronic Services), a customized, certified electronic health record. It is used to capture all of the enabling, medical, dental, vision, and behavioral health services for which the program pays and allows for monitoring the provision of services at all sites. Although it is not used as a medical record for primary care services, patient information and encounters are recorded to be used in combination with site records in completing the UDS report and medical chart audits at each site.

OHIO

Grantee: **Columbus Neighborhood Health Center (CNHS)**
Columbus, Ohio (CHC/HO/PH)

Management and Finance, *Monitoring Operations:* The CNHS corporate scorecard was developed to provide the executive staff and CNHS board with information about the spectrum

of activities conducted by the organization to support delivery of high quality services to patients. Areas reflected in the scorecard include: operations, QI, IT, EHR, facilities, HR, development and grants, finance, and marketing. A total of 105 measures are tracked. By incorporating metrics for all areas of activity in the organization, the scorecard raises awareness of the organization's progress and ensures that data are used to drive decision making. The scorecard is compiled by the administrative team with data submitted from each site, all programs, and all administrative departments. It is reviewed monthly by the executive team and presented quarterly to the CNHS board of directors. The corporate scorecard figures prominently in both the board and executive team's strategic planning efforts.

Clinical Services*, Information Sharing:* CNHS, in collaboration with the Central Ohio Diabetes Association (CODA), offers the following classes to help its diabetic patients manage their disease:

1. Diabetes Self-Management Education Classes (four classes, two hours each) is a complete diabetes education series covering a wide range of topics to help patients understand diabetes and how to manage the disease.
2. Diabetes Introduction Class (one class, two hours in length); this class is designed for newly-diagnosed diabetic patients, their families and friends, and anyone interested in learning more about diabetes. The class offers a general overview of diabetes.
3. Nutrition for Diabetes Class (one class, two hours in length); this class focuses on healthy nutrition for a person with diabetes. The class includes information about the effects of food on blood glucose (sugar), carbohydrate (carb) counting, and portion sizes.

Grantee: **HealthSource of Ohio, Inc. (HSO)**
Milford, Ohio (CHC)

Management and Finance*, Provider Incentive Plans:* HSO's staff and provider incentive plans take a broad-based and collaborative approach. The staff bonus and the provider withhold are based on a combination of productivity measures, quality measures, and overall organizational achievement. Staff and providers are held to the same measures to make sure everyone is working toward the same goals, rather than being in competition with each other. Staff members are eligible for a bonus every six months. Providers have a salary withhold that is earned back in quarterly installments.

Grantee: **Ohio North East Health Systems, Inc. (ONEHS)**
Youngstown, Ohio (CHC)

Management and Finance*, Credentialing and Privileging:* ONEHS utilizes its outsourced payroll vendor to track information such as credentialing and privileging. Most major payroll systems have similar functions. ONEHS's system can be used to track any item with an expiration date. The system is set to email a reminder to the principal and the human resource

manager who tracks credentialing. A reminder can be sent for each credentialing item. Parameters can be set for any length of time chosen for email reminders sent out prior to the expiration of the item; which individuals receive the reminder can also be customized.

OKLAHOMA

Grantee: **Northeastern Oklahoma Community Health Center (NEOCHC)**
Hulbert, Oklahoma (CHC)

Clinical Services, *Co-location of Services:* NEOCHC has entered into a collaborative relationship with a behavioral health service provider to lease space at the health center whereby a licensed clinical social worker (LCSW) will be available for patients at each site location. This provides easy access to behavioral health services for patients and allows for collaboration with the LCSW for provider staff, thereby increasing the integration of comprehensive care.

Grantee: **East Central Oklahoma Family Health Center, Inc. (ECOFHC)**
Wetumka, Oklahoma (CHC)

Management and Finance, *Comprehensive Transportation Services:* ECOFHC successfully collaborated with the local area transit system, county commissioner, city council, and a local hospital to establish the area's first public transportation system. Buses and vans transport residents throughout the target area for both personal reasons and appointments at the health center sites. Patients can also access this on-demand transportation for appointments to health care centers as far away as Tulsa, Oklahoma.

OREGON

Grantee: **Columbia River Community Health Services (CRCHS)**
Boardman, Oregon (CHC/MHC)

Clinical Services, *Ensuring Up-to-Date Immunizations:* CRCHS has made a unique combination of practices by combining its free sports physicals for junior and senior high school students with immunization screening and renewal. With a large migrant and immigrant population, this has been a fruitful idea that has increased the percentage of immunizations in 2011 - 2013 by 160.51% on the CRCHS UDS trend report.

Grantee: **Multnomah County Health Department**
Portland, Oregon (CHC/HO)

Clinical Services, *Discreet Communication Method:* At the school-based health centers, students are offered a set of small laminated cards at the front desk that are pre-printed with possible chief complaints. This provides a discreet method for a patient to communicate a presenting problem when other students are within hearing distance.

PENNSYLVANIA

Grantee: **Public Health Management Corporation (PHMC)**
Philadelphia, Pennsylvania (HO/PH)

Clinical Services, *Co-location of Services:* PHMC has been able to integrate mental/behavioral health services with primary care services. These services are provided at each of the five permanent clinic locations and are provided by psychiatric nurse practitioners and licensed clinical social workers. All services use the same chart to record their information so that medical information is available to the behavioral health providers, and the behavioral health information is available to medical providers, to assure appropriate medications and treatments for each patient.

Grantee: **Squirrel Hill Health Center (SHHC)**
Pittsburgh, Pennsylvania (CHC)

Management and Finance, *Regular Sharing of Promising Practices and Lessons Learned:* SHHC achieved PCMH Level 3 recognition after extensive collaborations with five other area health centers over a three-year period, as members of the Safety Net Medical Home Initiative. The project was a national demonstration project of Commonwealth Fund and Qualis, run locally by the Pittsburgh Regional Health Initiative (PRHI) of the Jewish Healthcare Foundation.

Management and Finance, *Payment Plan Policy:* SHHC has a payment plan policy for patients who have outstanding balances. The budget agreement plan provides for payments for up to 12 months on outstanding balances. This policy helps patients pay for care received, particularly higher-cost medical and dental services.

SOUTH CAROLINA

Grantee: **HopeHealth, Inc. (HH)**
Florence, South Carolina (CHC)

Clinical Services, *Peer Review:* HH performs peer reviews on a regular basis. The health center has developed a process whereby a rotating team of providers is assigned to perform the reviews quarterly. The team meets to review each chart. They utilize the EMR system to review the medical records on a large computer screen. Each team member is allowed to provide additional comments and recommendations to those made by the primary reviewer. The results are summarized and the medical officer, who oversees the peer review program, meets individually with each of the providers who were reviewed. If necessary, a corrective action plan is developed and followed-up.

SOUTH DAKOTA

Grantee: **Horizon Health Care, Inc. (HHC)**
Howard, South Dakota (CHC)

Management and Finance, *Cultural Competence:* HHC's cultural proficiency initiative developed a "universal encounter" model that promotes a consumer-oriented response to the patient that transcends cultural barriers. It operates on the premise that no assumptions may be made in an encounter with the patient and that each encounter provides an opportunity for staff members to elicit the patient's point of view. This approach promotes a reliance on the patient's cues and perspectives, thereby increasing trust and involvement in the health care encounter. All staff members participate in annual cultural competency training, with content emphasizing respect for and incorporation into treatment of cultural traditions and values.

Clinical Services, *Telemedicine:* HHC utilizes video conferencing technology for telemedicine and distance learning. This technology allows live, interactive video connections among HHC's widely-scattered clinics and health care specialists in larger health systems within the state. The telecommunications systems connect all of the site locations and allow for the provision of telemedicine services, including behavioral health, specialty, and health education services for all patients served by the grantee. The system also supports management and clinical collaboration, serving to increase quality and more effective and efficient use of health center resources.

Grantee: **City of Sioux Falls Health Department**
dba Falls Community Health (FCH)
Sioux Falls, South Dakota (CHC/HO)

Clinical Services, *Pap Tests:* FCH instituted an initiative called "Add a Pap" which encourages each provider to offer Pap tests to eligible women, even if the visit is only for acute care. FCH reported a significant increase in the number of Pap tests being performed by the providers. The results of this initiative are being reported out monthly to the care teams. In addition, FCH is orienting and training residents in the Center for Family Medicine (CFM) residency program on the need to screen using Pap tests.

TENNESSEE

Grantee: **Mercy Health System (MHS)**
Franklin, Tennessee (CHC)

Clinical Services, *Mental Health Services:* MHS provides a model for integrated continuum comprehensive mental health services to primary care patients. The integrated services include: family, individual, and group counseling; psychiatry; and social service case management. Using a team approach, the protocol has two paths: a) strengthening skill-building strategies to cope with disorders (e.g., ADHD), and b) decreasing cognitive distortions (e.g., depression and anxiety). Primary care referrals to behavioral health at MHS have reduced no-show rates between 5% and 15% in comparison to national averages in non-integrated programs that have 45% to 75% no-shows.

TEXAS

Grantee: **Stephen F. Austin Community Health Center, Inc. (SFACHC)**
Alvin, Texas (CHC)

Clinical Services, *Care Coordination:* In the past, SFACHC had experienced challenges with communication and coordination. The executive and junior management teams discussed the issues and developed care coordinators to focus on specific areas of the health system including: a) population management, b) OB/GYN, c) laboratory, d) Patient-Centered Medical Home, e) non-clinical services, and f) behavioral health. Starting in June 2014, the care coordinators began meeting twice each month with an agenda based on the business meeting. Each meeting is focused on a care coordination area. The meetings allow a more useful discussion of issues and allow more focus on specific work.

The care coordination team ensures the follow-through with the hospitalization, referral to a specialist, identified population management, and tracking for all outside referral services. Different care coordinators are responsible for checking every morning for new admissions and following through with the providers to ensure referrals or follow-up appointments are complete. This process exists at both clinics and allows care coordinators to function more efficiently and to be better informed about other areas in the health system.

Grantee: **Health Center of Southeast Texas (HCST)**
Cleveland, Texas (CHC)

Clinical Services*, Technological Assistance in Providing Care:* A revolving video loop on health education topics is installed on a screen for viewing by health center patients in the waiting room. The information on the video is periodically updated.

Clinical Services*, Real Property and Equipment:* HCST used a Susan B. Komen Breast Cancer Foundation grant to install a special procedure room and necessary equipment. HCST now offers scheduled mammograms to health center patients.

Management and Finance*, Technological Assistance in Providing Care:* The health center has installed a super generator strong enough to withstand effects of any hurricane; it is kept in an outside metal cage, runs on natural gas or propane liquid, and offers enough power supply for other community needs in case of a natural disaster.

Clinical Services*, Real Property and Equipment:* HCST focused on addressing property needs to improve care, such as through the following:

1. An office was built for the clinic manager; the office has large windows in both directions for her to be available for operational support for both work flow areas – the front office and the rear six patient treatment rooms.
2. For computer needs of any provider, a PC is set up and ready to sign prescription orders with finger-to-screen contact.
3. A special behavioral health patient treatment room was installed in the health center.

Grantee: **Barrio Comprehensive Family Health Care Center, Inc. (BCFHCC)**
San Antonio, Texas (CHC/PH)

Clinical Services*, Colorectal Screening:* BCFHCC's colorectal cancer screening program is an effective approach to increasing the number of individuals screened for colorectal cancer. Involvement of all clinical support staff and case managers in identifying patients needing this screening is an appropriate approach. The health center developed a comprehensive protocol that outlines standardized documentation of this screening test in the EHR.

Management and Finance, *Training:* BCFHCC has established a 12-month leadership college in collaboration with the University of Texas San Antonio. This capacity-building initiative provides up to 15 employees the opportunity to learn about the principles of management, supervision, the importance of documentation, and more each year. Working in three teams of five, the employees work on a capstone project that innovates or problem-solves or improves a critical issue at the health center.

Grantee: **El Centro del Barrio, Inc., dba CentroMed CHC (CMCHC)**
San Antonio, Texas (CHC/HO)

Clinical Services, *Quality of Care:* The entire staff of CMCHC is engaged in continuous improvement. All changes are measured and analyzed for success or limitation with clear metrics. This practice far exceeds that of most centers. For example, new providers have a formal orientation and then start at a graduated pace to see patients. Their EHR quality is monitored as they advance in the scheduling. They are not scheduled more fully until chart accuracy and comprehensiveness are at goal. This includes such things as clinical measures work and chart completion times. New providers are thus adept at quality by the time they are fully oriented. Another example is the monitoring of patients who are turned away without being seen. All such encounters are monitored to assess access and needs. Currently, only three to four patients are turned away daily, and the reasons are that their need is outside of scope (such as orthopedic or other specialty). Peer review happens monthly and is based on 25 charts per provider with all providers participating. Peer review results are included as part of provider evaluations. All staff members are able to identify areas that are being engaged for improvement and use of rapid cycle change is widespread.

VERMONT

Grantee: **Springfield Medical Care Systems, Inc. (SMCS)**
Springfield, Vermont (CHC)

Clinical Services, *Information Sharing*: All seven of SMCS's sites have prominent patient information placards that state, "Need a Ride? Have you Tried?" followed by a number of local transportation options. Eligibility for each option is highlighted. Local bus routes to the site are also displayed. Patients are encouraged to seek case management if these transportation suggestions do not solve their issues.

Clinical Services, *Quality of Care*: The providers in the emergency department of the hospital joined the providers in the seven clinic sites to develop uniform protocols for the management of common conditions seen in both places. This effort made use of the skills and training of all types of providers and reduced misinformation and multiple treatments of the same problem.

Providers are happy with the outcome and note that quality of care, patient safety, and provider satisfaction are all improved by this accomplishment.

Clinical Services, *Quality of Care*: Patients are seen within three days of hospital discharge. Discharge planning is communicated with the community health team at SMCS and with the provider of record. The community care team member ensures that things such as transportation, medication access, and housing needs are addressed before the patient follows up regarding his/her medical needs with the provider. Records are shared between the hospital and the clinic, despite the use of different IT vendors. The center has lowered its hospital readmission rate, and it is now the lowest in the state of Vermont.

VIRGINIA

Grantee: **Harrisonburg Community Health Center, Inc. (HCHC)**
Harrisonburg, Virginia (CHC)

Clinical Services, *Performance Improvement:* Patients waiting to be seen by a provider, as well as those leaving after being seen, are given an opportunity to provide satisfaction data and feedback. There is a computer kiosk located in the waiting room where patients can directly and privately enter this information. Patient feedback has increased and is more specific, which has aided the overall performance improvement activities at HCHC.

Grantee: **Daily Planet (DP)**
Richmond, Virginia (HO/PH)

Clinical Services, *Integrated Services:* The DP homeless program has integrated behavioral health into the clinical department and vice versa, and this has proven advantageous in maintaining the homeless population in care and has enhanced compliance with treatment.

WASHINGTON STATE

Grantee: **Peninsula Community Health Services (PCHS)**
Bremerton, Washington (CHC)

Management and Finance, *Performance Improvement Approach:* PCHS has a cleverly-designed comprehensive dashboard that displays selected key performance indicators with charts or graphs for visual display of performance trends on a monthly, quarterly, or semi-annual basis. This dashboard is shared widely on a regular basis among board and staff, and displays

improvement trends in a clear and simple visual format. More detailed dashboards with additional metrics are prepared and distributed within each program area and each site.

Grantee: **Colville Confederated Tribes (CCT)**
Inchelium, Washington (CHC)

Clinical Services*, Model Pain Management Program:* The assistant medical director of CCT participates in the Project Echo Chronic Pain in Primary Care program through the University of Washington. This program provides interactive consultations for clinicians. Through these efforts, the number of patients on narcotics for pain control has been significantly reduced.

Grantee: **Columbia Basin Health Association (CBHA)**
Othello, Washington (CHC/MHC)

Management and Finance*, Information Sharing:* CBHA uses technology throughout the organization for patient information, management information and marketing purposes. Although many health centers are embarking on the use of technology, CBHA has achieved and can demonstrate how technology improves communications between providers and patients, between management and staff, and information sharing with the public, including the following:

1. CBHA uses a system to capture data directly from its EHR system for reporting purposes. The system capturing information from the other system is a web-based quality measurement and improvement platform that measures and monitors performance on key clinical, operational, and financial metrics at all levels.
2. The HR Information System (HRIS) allows HR professionals and other managers to instantly access both prospective and current employee documents and information directly from within the HRIS. The "electronic" HR system provides files and information on recruitment and selection, employee onboarding, employee file management, policies and procedures, and employee separation.
3. Colorful reader boards at each CBHA site draw the attention of pedestrians and individuals in cars and buses to messages regarding available appointments for health and dental services, upcoming community events, and messages of interest.

In addition to traditional marketing concepts, CBHA uses social media to reach various members residing in its target areas. The use of video messages on YouTube to reach patients of all ages is informative, ingenious, and entertaining.

Clinical Services*, Access to Medications:* CBHA is able to deliver and mail needed medications to patients who have limited transportation. Patients are able to access medications using "drive through" windows at CBHA pharmacies.

Grantee: **HealthPoint**
Renton, Washington (CHC)

Management and Finance, *Paying Vendors Via Credit Card:* HealthPoint has developed a system of paying vendors via credit card payment. The credit card company then reimburses HealthPoint the sum of 1.44% of the total amount of charges, which has resulted in a return of $78,000 to HealthPoint in the most recent two-year period.

Clinical Services, *Training:* HealthPoint has participated in Lean training programs through the Virginia Mason Institute. The institute offers the "Virginia Mason Production System," a management method for health care organizations to improve quality and patient safety by eliminating waste and increasing value to patients. Some of these tools (focus on clinician wait times, well-stocked examination rooms, and a "Dental Assistant Skill Task Alignment" board) were evidenced during visits to the Midway and SeaTac sites.

Grantee: **International Community Health Services (ICHS)**
Seattle, Washington (CHC)

Management and Finance, *Model Contract Management Policy:* ICHS has a contract management policy that ensures appropriate consideration and planning prior to execution of all written contracts and compliance with all required terms, and provides for sufficient monitoring of specific performance of all parties to the agreements. There is also a contract and review and routing form that is completed on all new contracts and upon renewal for existing contracts to ensure compliance with regulations of the organization and to ensure that the contract is the best fit in accordance to the strategic direction of ICHS.

Management and Finance, *Information Sharing:* ICHS has a comprehensive performance dashboard/report card that displays selected key performance indicators with charts or graphs for visual display of performance trends on a monthly, quarterly, or semi-annual basis. These indicators correspond to the five categories that also serve as the framework for the organization's strategic plan: infrastructure, customer service, human investment, sustainability, and quality (clinical). This dashboard/report card is shared widely on a regular basis among board and staff, and displays improvement trends in a clear and simple visual format.

Governance, *Minutes:* ICHS's board decision form is completed and attached to the minutes to highlight discussions on complicated/complex actions taken on a particular issue/agenda item.

Clinical Services, *Interpretation Services:* ICHS provides a video interpretation service that allows for online, real time interpretation through a contract. A live, medically-trained interpreter is available throughout the medical or dental visit as needed. At present, 11 languages are available through this unique video service, with additional languages becoming available. This

is a unique innovation that offers significant promise and savings for health centers that struggle to provide multilingual services.

Grantee: **Metropolitan Development Council (MDC)**
Tacoma, Washington (HO)

Clinical Services, *Co-location of Services:* MDC has co-location of the hygiene center and the medical clinic. Program staff members encourage unstably housed or homeless individuals who use the hygiene center for showers and/or laundry to receive medical care while they are at the medical clinic site. The hygiene center serves as a conduit for channeling clients into medical care.

Grantee: **Yakima Valley Farmworkers Clinic (YVFWC)**
Toppenish, Washington (CHC/MHC)

Management and Finance, *Thorough Insurance Coverage Reviews:* YVFWC has an excellent process for assuring that all patients who are qualified receive health insurance. YVFWC reviews every uninsured patient visit to assure that no insurance coverage is available to that patient. Since January of 2014, staff members have enrolled more than 41,000 patients into either Medicaid or other third-party health insurance plans.

Management and Finance, *IT Support:* YVFWC has an excellent information technology department. It has two generators capable of running the servers for six days. There are have four levels of support for staff based on the severity of the issue. There is a help desk system whereby technicians respond to staff's day-to-day software questions: tier one for equipment issues; tier two for more complicated issues that require greater expertise; and tier three, which is for software enhancements.

Clinical Services, *Chronic Disease Management:* The "Tomando Control de su Salud" (Chronic Disease Self-Management Program) was recognized as a best practice by Stanford University. This program helps health center patients manage their chronic diseases.

Clinical Services, *Information Sharing:* Through the Amigas Program, promotoras provide education on cervical cancer screening and encourage Latina patients to come in and be tested. The Amigas Program was recognized as a best practice by the Centers for Disease Control.

WEST VIRGINIA

Grantee: **Community Health Systems, Inc., dba Accesshealth**
Beckley, West Virginia (CHC)

Management and Finance, *Teaching Health Center Initiatives:* Accesshealth was awarded an ACA Teaching Health Center grant in 2010 for a 12-person family practice residency. The grantee has integrated the training of the residents into the health center and community for long-term recruitment and retention of primary care physicians into the program, community, and region.

Grantee: **Valley Health System, Inc. (VHS)**
Huntington, West Virginia (CHC/HO)

Management and Finance, *Branding:* VHS has focused on branding that utilizes the name "Valley Health" with a logo and high-quality print brochures with detailed information on the services provided. The new, state-of-the art architecture and 24,000-square-foot facilities at East Huntington enhance the brand.

Clinical Services, *Warm Hand-Off for Services:* VHS has a successful integration of primary medical care with behavioral care and dental care with a "warm hand-off" where patients are personally escorted and introduced to the referred in-house clinic. This has increased utilization of the referred services.

Clinical Services, *Chronic Disease Management:* The chronic disease management program has been effective with diabetic patients; a team consisting of a physician, WIC dietitian, pharmacist, psychologist, and nurse intervene with appointed patients in the EHR database with HgA1c greater than 9. This program will be evaluated for effectiveness with the consideration of centering group appointments as the next step.

Clinical Services, *Impact of Medical School and Teaching Hospital Relationships:* VHS has a strong relationship with a medical school (Marshall University/the Joan C. Edwards School of Medicine) and teaching hospital. This facilitates recruitment of the top talent from the residency training programs to VHS. The retention of staff is also effective at VHS where staff turnover is low.

Clinical Services, *Opioid Addition:* VHS has a program for opioid addiction (POA) to address the epidemic of opioid addiction in the state and region. The program is designed in house to promote recovery and independence.

Grantee: **Community Care of West Virginia (CCWV)**
Rock Cave, West Virginia (CHC)

Clinical Services*, Residency Compensation Program:* CCWV has developed an innovative strategy to address recruitment and retention issues. The center, together with local residency programs, has developed a residency compensation program. The program offers a monthly payment to residents ($1,000/month), throughout their residency training. At the conclusion of their residency, they agree to provide CCWV three years of post-residency services. This promising program provides the organization a steady flow of providers who are familiar with and committed to continued service to CCWV, and is analogous to national "grow-your-own" programs.

Grantee: **The New River Health Association, Inc. (NRHA)**
Scarbro, West Virginia (CHC)

Clinical Services*, Communication Center Covering Multiple Sites:* NRHA maintains a well-established network of nine school-based primary care clinics that also offer mental health services, and are located in several school districts. Parent and teacher satisfaction with this service is very high.

A well-organized large communication center has been established that is staffed by a nurse and eight full-time phone secretaries trained to respond to all types of phone calls pertinent to all 16 service sites, including nine school-based health centers spread out over several counties. Instant and reliable clinical and operational communication links reduce misunderstandings, delays, and errors, and increase staff and patient satisfaction.

Governance*, Prospective Board Members:* NRHA has established an advisory board. The primary purpose of the advisory board is to identify and assist in the training and preparation of replacement members to the board of directors. This has served the organization well in quickly filling vacant positions with more knowledgeable new board members.

Grantee: **WomenCare, Inc., dba FamilyCare HealthCenter**
Scott Depot, West Virginia (CHC)

Clinical Services*, Group Appointments:* FamilyCare HealthCenter is using an innovative, evidence-based model of maternity care in which women meet in a group with their primary maternity care provider 10 times throughout the pregnancy. The group prenatal visits combine education, support, and standard prenatal health assessments. Participants report high satisfaction with the model of care and some retain relationships with other parents through the postpartum period and into parenting.

FamilyCare HealthCenter compiled the FamilyCare Obstetrics and Gynecological Clinical Guidelines 2013 in order to facilitate uniform, evidence-based care for women's health and perinatal services offered by the grantee. Expectations are defined regarding operations of the Birth Center and content of the attractive publication includes formulary drugs for categories of care (infections, intrapartum, postpartum and gynecology). A signature page attests to clinician review and acceptance of the OB/GYN Guidelines 2013.

WISCONSIN

Grantee: **Primary Connection Health Care, Inc.**
dba Bridge Community Health Clinic (aka Bridge Clinic)
Wausau, Wisconsin (CHC)

Clinical Services, *Wheelchair Lift Operatory Suite:* Bridge Clinic's dental department offers an innovative, state-of-the-art service for wheelchair-bound patients. There is a wheelchair lift operatory suite that allows dental staff to provide patient care in the best ergonomic positions possible. The lift allows wheelchair patients to back into the tilting deck and recline to a comfortable position for both patient and provider. The lift is ideal for dentistry, podiatry, physical therapy, wound treatment, and many other medical uses.

U.S. TERRITORIES

Grantee: **Ministry of Health and Environment**
Ebeye Community Health Center (ECHC)
Ebeye, Republic of Marshall Islands (CHC)

Clinical Services, *Diabetic Care:* ECHC's diabetes comprehensive care program is a great example of not only providing excellent comprehensive clinical care for diabetic patients in the health center, but also "moving out of the health center" to address the more important social determinants of health. ECHC utilizes an electronic registry to enroll all of its diabetic patients so that the grantee is able to closely monitor the clinical measures, and therefore have the ability to institute interventions when measures do not achieve the desired goals.

Grantee: **Camuy Health Services, Inc. (CHSI)**
Camuy, Puerto Rico

Clinical Services, *Information Sharing:* Since June 2013, CHSI has hosted a weekly 45-minute long radio program to educate and engage the local community. This may contribute to

improved health literacy and self-management among community members and patients, as well as encourage new patients to seek care at the center.

Grantee: **Corporación de Servicios de Salud y Medicina Avanzada, Inc. (COSSMA)**
Cidra, Puerto Rico (CHC/MHC)

Management and Finance, *Information Sharing:* To keep all employees informed of COSSMA's programmatic and financial status, and to foster camaraderie among employees, the grantee developed and implemented an annual Día de Los Logros (Accomplishments Day) Initiative. This consists of an annual meeting of COSSMA employees, management, and board members to present and celebrate corporate accomplishments. Employees of all disciplines can learn about health center medical, dental, and biosocial productivity; results of chronic conditions case management; and progress in health care indicators. Employees also receive information about the financial status of the organization as well as other accomplishments. After the information is shared, employees can network and listen to an inspirational speaker.

Clinical Services, *Information Sharing:* COSSMA has a well-developed and active multidisciplinary academic partnership program that annually provides approximately 200 students from medical, dental, ophthalmology, psychology, nursing, and social worker programs with the opportunity to learn about Community Health Centers. The program appears to be good for recruiting medical, dental, behavioral, and other allied health care professionals to the Community Health Center program.

Grantee: **Centro de Servicios Primarios de Salud, Inc. (CSPS)**
Florida, Puerto Rico (CHC)

Clinical Services, *Targeted Home Visit Program:* CSPS has a well-organized and active home visit program targeting individuals who have mobility or other health issues that prevent them from coming in to the center. Nurses visit patients' homes for lab draws, and a general practice doctor provides a follow-up visit. This practice decreases the no-show rate, ensures that patients do not forgo needed care, and is sensitive to the specific needs of this community.

Governance, *Monitoring Operations:* CSPS has developed an annual work plan for the board of directors by month that outlines all of the responsibility the board has in that specific month in order to ensure that they are compliant with the 19 BPHC Health Center Program requirements.

Grantee: **HPM Foundation, Inc. (HPM)**
San Juan, Puerto Rico (CHC)

Clinical Services, *Dental Care:* Patient care at HPM is delivered from a whole-person perspective and is well-coordinated, evidence-based, and tailored to the physical, educational,

and social needs of each particular patient. HPM has recently become the dental home for the community's Head Start program. A dental resident provides on-site services one day per week, and will soon expand to two days per week. In addition, the resident has created an educational video on pediatric oral health that will be shared with other health centers through the Primary Care Association (PCA).

Clinical Services, *Polypharmacy Management:* Primary care providers (PCPs) refer patients to the on-site pharmacist for polypharmacy management, identification of barriers to adherence, collaborative action plan development, and general education and support. The pharmacist reviews relevant information, such as clinical history and labs, and writes a detailed report with recommendations for the PCP.

Clinical Services, *Asthma Program:* HPM's pediatric asthma program is in partnership with the School of Public Health through funding from Merck. The program coordinator works with a team of community health workers and health center staff to promote behavioral change, provide education and resources, and assess/troubleshoot contributing environmental factors in patients' homes.

Clinical Services, *Maternal and Infant Health:* The health center's maternal and infant health home visit program is administered by the Bureau of Maternal Child Health. Expectant mothers who are classified as high-risk receive an alcohol, drug, and smoking assessment with interventions as indicated; a post-partum depression screen with follow-up monitoring; and education about newborn care. Services are also coordinated with dental and social work services. The ages and stages questionnaire is used to monitor the child's development through age two.

Clinical Services, *Information Sharing:* Health promotion/education is offered at the main site, at the schools, and through collaborative agreements at community events. Areas of attention include bullying prevention, sexual abuse prevention for children through the use of puppets, violence prevention for women and families, smoking cessation referrals, nutrition, oral health education for mothers and children, and sexually transmitted disease/contraception education.

Clinical Services, *Environmental Services:* Environmental services, known as Alcance Comunitario, were recognized at a regional conference as a 330 best practice. HPM, in collaboration with the Icahn School of Medicine at Mount Sinai and others and members of the community (including an HPM board member), are evaluating the environmental conditions of the neighborhood with particular attention on the impact of waste discharge in the waterways that surround the residential areas. Informal analysis of prevalence of disease appears to demonstrate an increase in the number of children affected by disabilities.

ACRONYMS

Acronym	Meaning
ACA	Affordable Care Act
ADA	American Dental Association
BMI	Body Mass Index
BMCH	Bureau of Maternal and Child Health
BPHC	Bureau of Primary Health Care
CPR	Cardiopulmonary Resuscitation
CDC	Centers for Disease Control and Prevention
CNM	Certified Nurse Midwife
CSD	Central Southeast Division
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CMO	Chief Medical Officer
COO	Chief Operating Officer
CBT	Cognitive Behavioral Therapy
CHCs	Community Health Centers
DMS	Document Management System
EDDA	Expanded Duties Dental Assistant
EHR	Electronic Health Record

EMR	Electronic Medical Record
ER	Emergency Room
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GEM	Gestational Diabetes Mellitus
FTEs	Full Time Equivalents
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HCH	Health Care for the Homeless
HR	Human Resources
HRIS	Human Resources Information Systems
IT	Information Technology
LEEP	Loop Electrosurgical Excision Procedure
LVN	Licensed Vocational Nurse
MA	Medical Assistant
MOA	Memorandum of Agreement
NCD	North Central Division
NED	Northeast Division
OB	Obstetrical
OB/GYN	Obstetrician/Gynecologist
OPPD	Office of Policy Program Development

OSV	Operational Site Visit
PCA	Primary Care Association
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PI/QA	Performance Improvement/Quality Assurance
PDSA	Plan, Do, Study, Act
PI	Process Improvement
PCA	Primary Care Association
PCP	Primary Care Physician
PR	Program Requirement
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Program
RN	Registered Nurse
SSDI	Social Security Disability Income
SWD	Southwest Division
SSI	Supplemental Security Income
STFM	Society of the Teachers of Family Medicine
TA	Technical Assistance
UDS	Uniform Data System

PROMISING PRACTICES: October 2013 – September 2014

Category	Type	State	Grantee
Clinical Services	Quality Program Plan, Do, Study, Act Studies	Alabama	Bayou La Batre Area Health Development Board, Inc.
Clinical Services	Credentialing/ Privileging Processes	Alaska	Yukon-Kuskokwim Health Corporation
Clinical Services	Employee Health Tracking System	Alaska	Yukon-Kuskokwim Health Corporation
Clinical Services	Self-Management of Diabetes	Arkansas	Healthy Connections, Inc.
Clinical Services	Mental Health Screening Tool Pilot	California	Northeast Community Clinic, Inc.
Clinical Services	Ensuring Up-to-Date Immunizations	California	El Proyecto del Barrio
Clinical Services	Obesity Prevention Program	California	Andersonville Valley Health Center, Inc.
Clinical Services	Sharing Staff with Other Organizations	California	Andersonville Valley Health Center, Inc.
Clinical Services	Increased Dental Services Access Through Schools	California	Borrego Community Health Foundation
Clinical Services	Model Pain Management Program	California	CommuniCare Health Centers, Inc.
Clinical Services	Warm Hand-Off for Dental Care	California	CommuniCare Health Centers, Inc.
Clinical Services	Care for Pregnant Women with Diabetes	California	CommuniCare Health Centers, Inc.
Clinical Services	Model Tracking Policy/Procedure for Specialty Referrals	California	South County Community Health Center, Inc.

Category	Type	State	Grantee
Clinical Services	Group Appointments	California	University of California, Irvine
Clinical Services	On-Site Specialty Care	California	Antelope Valley Community Clinic
Clinical Services	Prescription Medication Abuse Program	California	Antelope Valley Community Clinic
Clinical Services	Mental Health Program	California	Antelope Valley Community Clinic
Clinical Services	Obesity Program for Children and Their Families	California	QueensCare Health Centers
Clinical Services	Pediatric Asthma Program	California	QueensCare Health Centers
Clinical Services	Translation of Health Education Documents	California	Asian Health Services
Clinical Services	Mental Health Screening Tool	California	Asian Health Services
Clinical Services	Gynecological Interventions without Hospital Day Surgeries or Overnight Stays	California	LaClinica De La Raza, Inc.
Clinical Services	Using Data to Manage Diabetes and Hypertension	California	LaClinica De La Raza, Inc.
Clinical Services	Services to Facilitate Patients Showing at Appointments	California	San Francisco Community Clinic Consortium
Clinical Services	Access for Patients with Acute Concerns	California	Santa Rosa Community Health Center, Inc.
Clinical Services	Continuity of Care Between Inpatient and Outpatient Settings	California	Santa Rosa Community Health Center, Inc.
Clinical Services	Emergency Room/Hospital Care Reduction Program	California	Santa Rosa Community Health Center, Inc.

Category	Type	State	Grantee
Clinical Services	Information Sharing	California	Santa Rosa Community Health Center, Inc.
Clinical Services	Decreasing Pediatric Obesity	California	Santa Rosa Community Health Center, Inc.
Clinical Services	Information Sharing	California	Santa Rosa Community Health Center, Inc.
Clinical Services	Information Sharing	California	Vista Community Clinic
Clinical Services	Real Time Monitoring of Patient Flow	California	East Valley Community Health Center
Clinical Services	Interpretation Services	Colorado	Peak Vista Community Health Centers
Clinical Services	Expanded Duties for Lower Cost Staff	Colorado	Sunrise Community Health
Clinical Services	Patient Consultation Services	Colorado	Sunrise Community Health
Clinical Services	Co-Location of Services	Connecticut	Cornell Scott Hill Health Center
Clinical Services	Quality of Care	Florida	Health Care District of Palm Beach County
Clinical Services	Information Sharing	Florida	Rural Health Network Monroe County
Clinical Services	Scribe Program	Florida	Miami Beach Community Health Center
Clinical Services	Participation in Research to Improve Health Outcomes	Georgia	Community Health Care Systems, Inc.
Clinical Services	Four-Question Oral Health Screening	Illinois	Aunt Martha's Youth Service Center, Inc.

Category	Type	State	Grantee
Clinical Services	Electronic Health Records	Iowa	People's Community Health Clinic, Inc.
Clinical Services	Quality of Care	Maine	Katahdin Valley Health Center
Clinical Services	Continuum of Care	Maine	York County Community Action Corporation
Clinical Services	Telemedicine	Maine	Islands Community Medical Services, Inc.
Clinical Services	After Hours Call System	Maryland	Health Care for the Homeless
Clinical Services	Therapeutic Children's Summer Program	Maryland	Three Lower Counties Community Services, Inc.
Clinical Services	Information Sharing	Maryland	Community Clinic, Inc.
Clinical Services	Pet Policy	Massachusetts	Community Health Connections, Inc.
Clinical Services	Suboxone Clinic	Massachusetts	Community Health Connections, Inc.
Clinical Services	Suboxone Clinic	Massachusetts	Duffy Health Center, Inc.
Clinical Services	Colorectal Screenings	Massachusetts	Duffy Health Center, Inc.
Clinical Services	Housing First Model	Massachusetts	Community Healthlink, Inc.
Clinical Services	Team Care Model	Massachusetts	Community Healthlink, Inc.
Clinical Services	Dental Lab Services	Massachusetts	Edward M. Kennedy Community Health Center, Inc.
Clinical Services	Emotional Health of Staff	Massachusetts	Edward M. Kennedy Community Health Center, Inc.
Clinical Services	Diabetes and Obesity	Michigan	Sterling Area Health Center

Category	Type	State	Grantee
Clinical Services	Referrals by Medical Assistants	Minnesota	Cedar Riverside People's Center
Clinical Services	After Hours Shelter Phone Number Cheat Sheet	Minnesota	Hennepin County Community Health Department, Hennepin County Health Care for the Homeless Project
Clinical Services	Group Appointments	Mississippi	Center for Family Health
Clinical Services	Patient Assistance Program	Mississippi	Claiborne County Family Health Center
Clinical Services	Group Appointments	Montana	Yellowstone City & County Health Department
Clinical Services	Polypharmacy	Montana	Yellowstone City & County Health Department
Clinical Services	Training	Montana	Community Health Partners, Inc.
Clinical Services	Targeted Populations	New Jersey	Zufall Health Center, Inc.
Clinical Services	Technological Assistance in Providing Care	New Jersey	Lakewood Resource and Referral Center, Inc.
Clinical Services	Oral Health Care	New Jersey	Lakewood Resource and Referral Center, Inc.
Clinical Services	Assigned Clinical Measures	New Jersey	Newark Community Health Centers, Inc.
Clinical Services	Information Sharing	New York	Middletown Community Health Center, Inc.
Clinical Services	State-of-the-Art Pharmacy	North Carolina	Lincoln Community Health Center, Inc.
Clinical Services	Information Sharing	Ohio	Columbus Neighborhood Health Center

Category	Type	State	Grantee
Clinical Services	Co-Location of Services	Oklahoma	Northeastern Oklahoma Community Health Center
Clinical Services	Ensuring Up-to-Date Immunizations	Oregon	Columbia River Community Health Services
Clinical Services	Discreet Communication Method	Oregon	Multnomah County Health Department
Clinical Services	Co-Location of Services	Pennsylvania	Public Health Management Corporation
Clinical Services	Peer Review	South Carolina	HopeHealth, Inc.
Clinical Services	Telemedicine	South Dakota	Horizon Health Care, Inc.
Clinical Services	Pap Tests	South Dakota	City of Sioux Falls Health Department
Clinical Services	Mental Health Services	Tennessee	Mercy Health System
Clinical Services	Care Coordination	Texas	Stephen F. Austin Community Health Center, Inc.
Clinical Services	Technological Assistance in Providing Care	Texas	Health Center of Southeast Texas
Clinical Services	Real Property and Equipment	Texas	Health Center of Southeast Texas
Clinical Services	Colorectal Screening	Texas	Barrio Comprehensive Family Health Care Center, Inc.
Clinical Services	Quality of Care	Texas	El Centro del Barrio, Inc. dba CentroMed CHC
Clinical Services	Information Sharing	Vermont	Springfield Medical Care Systems, Inc.
Clinical Services	Quality of Care	Vermont	Springfield Medical Care Systems, Inc.

Category	Type	State	Grantee
Clinical Services	Quality of Care	Vermont	Springfield Medical Care Systems, Inc.
Clinical Services	Performance Improvement	Virginia	Harrisonburg Community Health Center, Inc.
Clinical Services	Integrated Services	Virginia	Harrisonburg Community Health Center, Inc.
Clinical Services	Model Pain Management Program	Washington State	Colville Confederated Tribes
Clinical Services	Access to Medications	Washington State	Columbia Basin Health Association
Clinical Services	Training	Washington State	HealthPoint
Clinical Services	Interpretation Services	Washington State	International Community Health Services
Clinical Services	Co-Location of Services	Washington State	Metropolitan Development Council
Clinical Services	Chronic Disease Management	Washington State	Yakima Valley Farmworkers Clinic
Clinical Services	Information Sharing	Washington State	Yakima Valley Farmworkers Clinic
Clinical Services	Warm Hand-Off for Services	West Virginia	Valley Health Systems, Inc.
Clinical Services	Chronic Disease Management	West Virginia	Valley Health Systems, Inc.
Clinical Services	Impact of Medical School and Teaching Hospital Relationships	West Virginia	Valley Health Systems, Inc.
Clinical Services	Opioid Addiction Services	West Virginia	Valley Health Systems, Inc.
Clinical Services	Residency Compensation Program	West Virginia	Community Care of West Virginia

Category	Type	State	Grantee
Clinical Services	Communication Center Covering Multiple Sites	West Virginia	The New River Health Association, Inc.
Clinical Services	Group Appointments	West Virginia	WomenCare, Inc. dba FamilyCare Health Center
Clinical Services	Wheelchair Lift Operatory Suite	Wisconsin	Primary Connection Health Care, Inc. dba Bridge Community Health Clinic
Clinical Services	Diabetic Care	U.S. Territories	Ministry of Health and Environment, Ebeye Community Health Center
Clinical Services	Information Sharing	U.S. Territories	Camuy Health Services, Inc.
Clinical Services	Information Sharing	U.S. Territories	Corporación de Servicios de Salud y Medicina Avanzada, Inc.
Clinical Services	Targeted Home Visit Program	U.S. Territories	Centro de Servicios Primarios de Salud, Inc.
Clinical Services	Dental Care	U.S. Territories	HPM Foundation, Inc.
Clinical Services	Polypharmacy Management	U.S. Territories	HPM Foundation, Inc.
Clinical Services	Asthma Program	U.S. Territories	HPM Foundation, Inc.
Clinical Services	Maternal and Infant Health	U.S. Territories	HPM Foundation, Inc.
Clinical Services	Information Sharing	U.S. Territories	HPM Foundation, Inc.
Clinical Services	Environmental Services	U.S. Territories	HPM Foundation, Inc.
Governance	Information Sharing	Arizona	Ajo Community Health Center

Category	Type	State	Grantee
Governance	Consumer Participation on Board	California	Mendocino Coast Clinics, Inc.
Governance	Participation in Patient Leadership Council	California	Asian Health Services
Governance	Board Manual	Indiana	HealthNet, Inc.
Governance	Information Sharing	Maine	York County Community Action Corporation
Governance	Advisory Board	Massachusetts	Community HealthLink, Inc.
Governance	Training	Massachusetts	Edward M. Kennedy Community Health Center, Inc.
Governance	Participation	Massachusetts	Edward M. Kennedy Community Health Center, Inc.
Governance	Prospective Board Members	Mississippi	Center for Family Health
Governance	Agenda/Minutes	Montana	Yellowstone City and County Health Department
Governance	Monitoring Operations	New York	Middletown Community Health Center, Inc.
Governance	Prospective Board Members	North Carolina	Roanoke Chowan Community Health Center, Inc.
Governance	Minutes	Washington	HealthPoint
Governance	Prospective Board Members	West Virginia	The New River Health Association, Inc.
Governance	Monitoring Operations	U.S. Territories	Centro de Servicios Primarios de Salud, Inc.
Management and Finance	Including QA/PI in New Employee Orientation	Alaska	Sunshine Community Health Center, Inc.

Category	Type	State	Grantee
Management and Finance	Teaching Health Center Initiatives	California	Clinica Sierra Vista
Management and Finance	Enrollment of Homeless Individuals in Benefits Programs	California	CommuniCare Health Centers, Inc.
Management and Finance	Game Show Format for Training	California	Asian Health Services
Management and Finance	Agreement for Access to Specialty Services and Inpatient Care	California	La Clinica De La Raza, Inc.
Management and Finance	iPad Use by Outreach Workers	California	Community Health Alliance of Pasadena
Management and Finance	Facilitating Close-Out of Encounter Forms/Timely Billing	California	La Maestra Family Clinic
Management and Finance	Monitoring Deliverables from Subcontractors	California	San Francisco Community Clinic Consortium
Management and Finance	Facilitating Close-Out of Encounter Forms/Timely Billing	California	Vista Community Clinic
Management and Finance	Corporate Compliance and Ethics	Colorado	Southwest Colorado Mental Health Center, Inc.
Management and Finance	Information Sharing	Connecticut	Community Health Services, Inc.
Management and Finance	Training Workshops	Connecticut	Cornell Scott Hill Health Center
Management and Finance	Model Contract Template	Delaware	Westside Family Healthcare, Inc.
Management and Finance	Medical Answering Service Coupled with Internal Call Center	Georgia	Southside Medical Center, Inc.

Category	Type	State	Grantee
Management and Finance	Teleconferencing System	Illinois	Community Health Partnership of Illinois
Management and Finance	Use of Electronic Records	Indiana	Jane Pauley Community Health Center, Inc.
Management and Finance	Services to Facilitate Patients Showing at Appointments	Iowa	Community Health Care, Inc.
Management and Finance	Interpretation Services	Iowa	People's Community Health Clinic, Inc.
Management and Finance	Services to Facilitate Patients Showing at Appointments	Iowa	People's Community Health Clinic, Inc.
Management and Finance	New Employee Orientation/Competencies Process	Louisiana	St. Thomas Community Health Center, Inc.
Management and Finance	Revenue Generation	Louisiana	Primary Health Services Center
Management and Finance	Performance Improvement Approach	Massachusetts	Codman Square Health Center
Management and Finance	Interpretation Services	Massachusetts	Lowell Community Health Center
Management and Finance	Monitoring Operations	Massachusetts	Lowell Community Health Center
Management and Finance	Comprehensive Transportation Services	Michigan	Health Delivery, Inc.
Management and Finance	Policies	Montana	Lincoln County Community Health Center
Management and Finance	Information Sharing	Montana	Community Health Partners
Management and Finance	Real Estate and Property	New York	Middletown Community Health Center, Inc.

Category	Type	State	Grantee
Management and Finance	Monitoring Operations	New York	Charles B. Wang Community Health Center, Inc.
Management and Finance	Sliding Fee Scale	New York	Syracuse Community Health Center, Inc.
Management and Finance	Co-Location of Services	North Carolina	Roanoke Chowan Community Health Center, Inc.
Management and Finance	Paying for Service Programs	North Carolina	Gaston Family Health Services
Management and Finance	Paying for Service Programs	North Carolina	Gaston Family Health Services
Management and Finance	Thorough Insurance Coverage Reviews	North Carolina	Gaston Family Health Services
Management and Finance	Real Estate an Equipment	North Carolina	Gaston Family Health Services
Management and Finance	Document Management System	North Carolina	Gaston Family Health Services
Management and Finance	Electronic Health Record	North Carolina	North Carolina Department of Health and Human Services
Management and Finance	Monitoring Operations	Ohio	Columbus Neighborhood Health Center
Management and Finance	Provider Incentive Plans	Ohio	HealthSource of Ohio, Inc.
Management and Finance	Credentialing and Privileging	Ohio	Ohio North East Health Systems, Inc.
Management and Finance	Comprehensive Transportation Services	Oklahoma	East Central Oklahoma Family Health Center, Inc.
Management and Finance	Regular Sharing of Promising Practices and Lessons Learned	Pennsylvania	Squirrel Hill Health Center
Management and Finance	Payment Plan Policy	Pennsylvania	Squirrel Hill Health Center

Category	Type	State	Grantee
Management and Finance	Cultural Competence	South Dakota	Horizon Health Care, Inc.
Management and Finance	Technological Assistance in Providing Care	Texas	Health Center of Southeast Texas
Management and Finance	Training	Texas	Barrio Comprehensive Family Health Care Center, Inc.
Management and Finance	Performance Improvement Approach	Washington State	Peninsula Community Health Services
Management and Finance	Information Sharing	Washington State	Columbia Basin Health Association
Management and Finance	Paying Vendors Via Credit Card	Washington State	HealthPoint
Management and Finance	Model Contract Management Policy	Washington State	International Community Health Services
Management and Finance	Information Sharing	Washington State	International Community Health Services
Management and Finance	Thorough Insurance Coverage Reviews	Washington State	Yakima Valley Farmworkers Clinic
Management and Finance	IT Support	Washington State	Yakima Valley Farmworkers Clinic
Management and Finance	Teaching Health Center Initiatives	West Virginia	Community Health Systems, Inc. dba Accesshealth
Management and Finance	Branding	West Virginia	Valley Health Systems, Inc.
Management and Finance	Information Sharing	U.S. Territories	Corporación de Servicios de Salud y Medicina Avanzada, Inc.