

# **PROMISING PRACTICES**

## **JANUARY 20, 2018 – JUNE 30, 2018**

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*This report highlights many of the promising practices in Health Centers that received operational site visits during January 20, 2018 through June 30, 2018.*

# Table of Contents

<b>EXECUTIVE SUMMARY OF PROMISING PRACTICES.....</b>	<b>5</b>
HISTORY OF HEALTH CENTERS.....	5
WHY THERE IS A PARTICULAR FOCUS ON SPECIAL POPULATIONS .....	5
HOW PROMISING PRACTICES ARE IDENTIFIED .....	5
WHY SHARING PROMISING PRACTICES IS IMPORTANT .....	6
<b>PROMISING PRACTICES .....</b>	<b>7</b>
<b>CALIFORNIA.....</b>	<b>8</b>
<i>Grantee: Lifelong Medical Care (LMC), Berkeley, CA (CH, PH).....</i>	<i>8</i>
Management and Finance, Patient Scheduling Appointments: .....	8
Clinical Services, Care Transitions: .....	8
<i>Grantee: Tulare Community Health Clinic (TCHC), Tulare, CA (MH, CH).....</i>	<i>8</i>
Clinical Services, Provider Scans:.....	8
Clinical Services, Substitute for Migratory and Seasonal Agricultural Workers: .....	9
<i>Grantee: Share Our Selves Corporation (SOS), Costa Mesa, CA (CH, HCH).....</i>	<i>10</i>
Clinical Services, Mailroom for Patients without Addresses: .....	10
<i>Grantee: McCloud Healthcare Clinic, Inc. (MHC), McCloud, CA (CH).....</i>	<i>11</i>
Management and Finance, Rearranging Health Center Schedules: .....	11
<b>COLORADO.....</b>	<b>11</b>
<i>Grantee: Metro Community Provider Network (MCPN), Englewood, CO (CH, HCH).....</i>	<i>11</i>
Clinical Services, Screening, Brief Intervention & Referral to Treatment:.....	11
Clinical Services, Oral Health: .....	12
<b>CONNECTICUT.....</b>	<b>13</b>
<i>Grantee: Norwalk Community Health Center, Inc. (NCHC), Norwalk, CT (CH, PH, HCH).....</i>	<i>13</i>
Clinical Services, Case Management: .....	13
<b>FLORIDA.....</b>	<b>13</b>

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<i>Grantee: Citrus Health Network, Inc. (CHN), Hialeah, FL (CH)</i> .....	13
Clinical Services, Chronic Condition Management: .....	13
<b>ILLINOIS</b> .....	14
<i>Grantee: Erie Family Health Center, Inc. (EFHC), Chicago, IL (CH)</i> .....	14
Management and Finance, <i>Clinic Telephones</i> : .....	14
<b>MASSACHUSETTS</b> .....	15
<i>Grantee: South End Community Health Center (SECHC), Boston, MA (PH)</i> .....	15
Clinical Services, Chronic Disease Management: .....	15
Clinical Services, <i>Peer Review</i> : .....	16
<i>Grantee: Dothouse Health, Inc. (Dothouse), Dorchester, MA (CH)</i> .....	16
Clinical Services, Hypertension Management: .....	16
<i>Grantee: East Boston Neighborhood Health Center (EBNHC), Boston, MA (CH)</i> .....	17
Management and Finance, <i>Project Management</i> : .....	17
<b>MARYLAND</b> .....	18
<i>Grantee: Choptank Community Health System, Inc. (CCHS), Denton, MD (MH, CH)</i> .....	18
Clinical Services, <i>Oral Health</i> : .....	18
Clinical Services, <i>Case Management</i> : .....	18
<b>NEBRASKA</b> .....	19
<i>Grantee: Charles Drew Health Center, Inc. (CDHC), Omaha, NE (CH, HCH)</i> .....	19
Clinical Services, <i>School-Based Screening</i> : .....	19
<b>NEW JERSEY</b> .....	20
<i>Grantee: Zufall Health Center, Inc. (ZHC), Dover, NJ (CH, PH, HCH)</i> .....	20
Clinical Services, Childhood Diabetes: .....	20
<i>Grantee: North Hudson Community Action Corporation (NHCAC), Union City, NJ (CH)</i> .....	22

Clinical Services, Diabetes: .....	22
<b>OHIO</b> .....	<b>22</b>
<i>Grantee: Health Partners of Western Ohio (HPWO), Lima, OH (MH, CH)</i> .....	22
<i>Grantee: Signature Health, Inc. (SH), Willoughby, OH (CH)</i> .....	23
<b>OKLAHOMA</b> .....	<b>24</b>
<i>Grantee: Morton Comprehensive Health Services (MCHS), Tulsa, OK (CH, HCH)</i> .....	24
<b>OREGON</b> .....	<b>25</b>
<i>Grantee: Lane County (Lane County), Eugene, OR (MH, CH, HCH)</i> .....	25
<b>PENNSYLVANIA</b> .....	<b>25</b>
<i>Grantee: Wayne Memorial Community Health Centers (WMCHC), Honesdale, PA (CH)</i> .....	25
<b>TEXAS</b> .....	<b>26</b>
<i>Grantee: People’s Community Clinic (CHD), Austin, TX (CH)</i> .....	26
<b>ACRONYMS</b> .....	<b>28</b>
<b>PROMISING PRACTICES BY AREA OF OPERATION, TYPE, SUB-TYPE, STATE, AND GRANTEE</b> .....	<b>31</b>

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# Executive Summary of Promising Practices

## History of Health Centers

Health centers are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services. For over 50 years, Health Centers (HCs) have provided high-quality preventive and primary health care to patients, regardless of their ability to pay.

Today, the Health Resources and Services Administration (HRSA) funds nearly 1400 HCs, operate approximately 12,000 service delivery sites in every U.S. state, District of Columbia (DC), Puerto Rico, the Virgin Islands, and the Pacific Basin; these HCs employ nearly 220,000 staff who provide care for nearly 27 million patients. One in 12 people in the United States (U.S.) relies on a HRSA-funded HC for medical care.

For millions of people across the country, including some of the most vulnerable individuals and families, HCs are the essential medical home where they find services that promote health, diagnose and treat disease and disability, and help them cope with environmental challenges that put them at risk.

## Why There is a Particular Focus on Special Populations

Health Centers not only provide care for the medically underserved, uninsured and under-insured, but special populations as well. These include persons experiencing homelessness, migratory and seasonal farmworkers and their families, public housing residents, and other special populations. The special populations, as compared to other groups, experience: 1) greater health disparities, 2) greater lack of availability of health professionals, 3) greater inability to access health services, and 4) greater inability to pay for health services. These groups consequently can experience more negative consequences of illness and premature death than other groups.

## How Promising Practices are Identified

The Promising Practices in this document were identified by consultants on health center Operational Site Visits (OSVs). Consultants used the following criteria to determine the promising practices in this report:

- Indicators of a positive/effective health interventions that are replicable
- Continuous quality improvement
- Strong quantitative and qualitative data showing positive outcomes

These promising practices fall into the general categories of governance, clinical services, and management and finance. The promising practices identified are generally in-scope, but some are out-of-scope practices that are supportive of the Health Center.

## Why Sharing Promising Practices is Important

Given the immediate need for quality health care services to be provided efficiently, and with effective governance, it is critical that practices that have been shown to work well be shared expeditiously throughout the nation, in Puerto Rico, and in the U.S. Territories. By sharing these promising practices in writing, HCs have the opportunity to learn from others they would not ordinarily encounter because they are in areas distant from them.

Identification and implementation of promising practices can provide health centers with significant, long-term benefits including, but not limited to, improved quality and quantity of services, increased cost savings, and improved performance and health outcomes.

# Promising Practices

HCs continued to demonstrate leadership in the health care field during the period January 20, 2018, through June 30, 2018. In addition to solid performance relative to HC requirements, several HCs have a promising practice in one or more particular area of operations (e.g., clinical services, governance, management and finance). When experts in these areas of operations conducted 252 Operational Site Visits (OSVs) of HCs on behalf of the Bureau of Primary Health Care (BPHC) during the first half of calendar year (CY) 2018, they cited 21 HCs with a promising practice in at least one 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 HCs that received operational site visits from January 20, 2018, through June 30, 2018. The type of promising practice is identified as clinical services, governance, or management and finance. A sub-type is also identified as follows:

- Behavioral health
- Board training
- Hospital-related
- Miscellaneous
- Oral health
- Out-of-scope
- Pain management
- Patient cycle time
- Pharmaceutical
- Quality improvement
- Shared medical appointments
- Sliding Fee Scale
- Website

The promising practices of HCs 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 HC, the categories of funding from BPHC are designated by the following abbreviations: Community Health Center (CH), Migratory and seasonal agricultural Health Center (MH), Healthcare for the Homeless (HO) and Public Housing (PH).

Additional resources at the end of this report include a list of commonly used acronyms, and a chart listing the promising practices by area of operation, type, sub-type, grantee, state, and special population funding status

## CALIFORNIA

### **Grantee: Lifelong Medical Care (LMC), Berkeley, CA (CH, PH)**

#### **Management and Finance, Patient Scheduling Appointments:**

To establish more efficient access to care, LMC began an Open Access pilot in 2017 at two of LMC's largest sites. This involves scheduling according to patient time and date preference, rather than visit type and provider schedule; only scheduling out 14 days to reduce no-shows; reducing the types of visits to simplify scheduling; and monitoring panel size and utilization to ensure timely access.

Successful outcomes so far include improved Third Next Available Appointment from 21 - 30 days to two - six days; decreased no-show rate from 25-30% to 10-20%; improved patient, staff, and provider satisfaction; and improved productivity as evidenced by a new operational dashboard that allows for easy daily monitoring of utilization.

#### **Clinical Services, Care Transitions:**

To coordinate services and improve patient outcomes following hospital discharge, LMC developed the Community-Based Care Transitions (CBCT) Program in partnership with a local hospital in 2012.

The program targets utilizers of hospital and emergency services and features a timely "warm hand-off" between the hospital and LMC's Care Transitions Registered Nurse (RN), who provides a bridge back to primary care and other community-based services.

An evaluation of hospital data for patients touched by the CBCT program in 2016 revealed a 32% increase in primary care physician follow-up within 30 days of admission; 17% decrease in Emergency Department (ED) visits; and 17% decrease in hospital re-admissions. In 2017, LMC provided over 5,000 CBCT encounters, and scheduled over 3,000 follow-up appointments to promote linkage back to primary care. This new targeted and timely service resulted in 1,443 kept primary care appointments (a rate of 46%) following hospital discharge.

### **Grantee: Tulare Community Health Clinic (TCHC), Tulare, CA (MH, CH)**

#### **Clinical Services, Provider Scans:**

All health centers have the issue of ensuring confidentiality of patient health information. Having computers in the exam rooms increases the likelihood of compromise of this privacy. Typically, the effort is to set the computer to automatically log out, or to train the clinicians to close out the screen, even if they are just temporarily stepping out of the room. . TCHC uses an Identification (ID) scan, which uses fingerprint biometrics for the clinicians to sign in to their laptops in the exam rooms. If a provider is on a computer in one room, closes that screen and moves to another room, with a finger touch the screen opens where the provider left off. This allows for smooth transition from location to location, seamless communication and completion of clinical documentation, and protection of information in each room from which the individual logs out with just a touch of the finger. Implementation of this process has improved effectiveness, efficiencies, and security of the clinical data management by all providers functioning within the organization's walls. The occurrences of breach of protocol (not maintaining Protected Health Information (PHI) by omission, lack of adherence to procedures to close out the Electronic Health Record (EHR) and block patient access to such data have decreased, and compliance with the process is facilitated by the fact that one cannot log in to another screen without first logging out of the prior screen.

### **Clinical Services, Substitute for Migratory and Seasonal Agricultural Workers:**

A good proportion of the clinic's patient population is comprised of migratory and seasonal agricultural workers, and a good proportion of the clinical and general staff have actually served as migratory and seasonal agricultural workers in their lives, including the Chief Executive Officer (CEO). The organization is aware of the fact that, if a worker comes off the line, someone else is standing nearby ready to permanently take their place. This was identified as one of the limiting factors with respect to ensuring that patients come for their primary/preventive care and follow-up on urgent care or hospitalizations.

So that migratory and seasonal agricultural patients can obtain clinical care during the time of office hours and while specialty care is available on site at the health center, staff members literally tap in for a given worker, and work the fields in their place while that individual goes to their clinic location to receive medical services. Any staff member experienced in agricultural processes may volunteer to serve in this capacity on a pro re nata (PRN) basis. This is a hugely innovative and impressively humble manner in which to serve the patients of highest need. The organization has had a significant increase in migratory and seasonal agricultural workers. The outreach team has facilitated this growth with the involvement of Promotoras, free door-to-door shuttle transportation of the migratory and seasonal agricultural workers to the clinic (straight from the farms to the clinic, too), bilingual drivers, chronic care educational sessions in English and in Spanish, walks with the doctor (bilingual), and extensive dental services including oral surgery, etc. There was a 37% increase in service to this population between 2014 and 2016.

## **Grantee: Share Our Selves Corporation (SOS), Costa Mesa, CA (CH, HCH)**

### **Clinical Services, Mailroom for Patients without Addresses:**

SOS has a long standing history of integrated care that motivates it to investigate, collect data, and validate the value of a coordinated care agency. It is in that establishing principle that keeps the mission true and focused on providing a comprehensive practice that includes addressing the Social Determinants of Health (SDOH). SOS has provided direct social services to those in need mostly through private financial support and contributions. Though SDOH continues to build momentum in standardization, data collecting, and clinical health outcomes, etc. the practice/delivery of service remains largely unfunded, not universally structured for reimbursement, and dependent on private funding.

In order to continue the strides made in advancing best practices of SDOH and Clinical integration, it needed to continue to create methods of sustainability. To do so, in May of 2016 the SOS Foundation was formed.

Comprised of 12 members of the Orange County community, the role of the Foundation at SOS will be to provide clarity, accountability, and strategic support and focus, related to the definition, execution, and implementation of current and long-range fundraising goals and objectives.

By developing a Charitable Foundation, SOS will be better able to strategically program the organization for successful growth, while maintaining the integrity, purpose, and meaning of its programs and services.

As a result of its fundraising efforts, it continues to sustain and extend its work in Social Services offering direct, integrative, and stabilizing services that include:

Financial Assistance	Officer of the Day
On-Site Partner Services	Transportation
Linkages to Resources	SOS Mobile Liaison
Eligibility Assistance	Stabilizing Services
Food Pantry	Case Management
Seasonal Programs	Multi-Disciplinary Team

## **Grantee: McCloud Healthcare Clinic, Inc. (MHC), McCloud, CA (CH)**

### **Management and Finance, Rearranging Health Center Schedules:**

The health center wanted to determine whether extending its hours of service for both regular medical appointments (follow-up, medication refills, dental, etc.) and immediate care (sprains, difficulty breathing, injuries, etc.) would be a patient satisfier for its current patients, as well as provide a service, urgent care, that is not available in the community.

Before permanently implementing essentially a new service (urgent care) and extended hours, the health center decided to do a Plan-Do-Study-Act (PDSA) for seven weeks. It wanted to see if current patients would take advantage of the extended hours and how responsive the community would be to the clinic offering urgent care services. The PDSA ran from January 4, 2016, to February 19, 2016. The hours were 5 p.m. - 7 p.m., Monday through Thursday, and were for both medical and dental services. It also looked at opening an hour early for dental on select days. Depending on the day of the week, there were one or two providers seeing patients at each site during extended hours. It was decided that, if the clinic were to proceed with extending its hours, staff needed to study the impact on patient appointment times, provider workload, visit reason, and certain patient demographics (age, insurance).

The results were as follows: 1) Medical appointments increased overall by 17%; dental appointments increased overall by 14%; the two combined increased overall appointments by 16%. 2) Most appointment slots were filled up to 6:45 p.m., when a significant number of the patients were seen between 5 - 6:15 p.m. 3) Both clinic locations experienced a significant number of walk-in (immediate care) patients out of the total patients seen during the test period. (Clinic A=64%; Clinic B=41%). The larger site (Clinic B) saw most of the scheduled appointments.

## **COLORADO**

### **Grantee: Metro Community Provider Network (MCPN), Englewood, CO (CH, HCH)**

#### **Clinical Services, Screening, Brief Intervention & Referral to Treatment:**

It has been a challenge to increase behavioral health assessments and, where needed, referrals to behavioral health services throughout MCPN health centers. The decision was to have patients complete the Screening, Brief Intervention & Referral to Treatment (SBIRT) questionnaire on laptops in the waiting room.

The SBIRT technology project workflow states that the patient checks in with the front desk staff, the front desk staff provides the patient a unique one-time-use PIN, and the patient is directed to complete the SBIRT on a laptop in the waiting room. If the patient answers “yes” to

any of the questions on the laptop, the patient is asked to complete secondary screens, depending on what questions they answered as “yes.” Secondary screens include the Patient Health Questionnaire-9 (PHQ9), AUDIT, Drug Abuse Screening Test-10 (DAST 10), and Nicotine Questionnaire. Once the patient electronically submits the completed survey all results are loaded into the EHR within 30 seconds. The Medical Assistant (MA) and/or provider can review the completed screens before the patient is brought to the exam room and arrange the appropriate follow-up, such as, having the Behavioral Health Provider (BHP) meet with the patient during the current visit and/or making a follow-up appointment with the patient for another day. . This has had a positive impact on the number of patient no-shows for behavioral health visits. Due to the SBIRT Technology Project, MCPN has seen the following results: 1) At the end of 2014, MCPN had a total penetration rate of 7% into Behavioral Health Department (BHD); by the end of 2017, the total penetration rate into Behavioral Health (BH) increased to 14.9%, the highest in the history of the organization. 2) There was a 69% increase in PHQ9s completed since the SBIRT Project went live in the second half of 2017. 3) Quarter 1 2018 data shows: 75% of the patients who complete the PHQ9 on the laptops are screening positive for mild depression and 46% are screening positive for moderate depression; 16% of the patients are screening positive for possible problems with alcohol and 16% are screening positive for possible problems with drugs. 4) The utilization of substance use screening tools has increased by nearly 100%. 5) Increased productivity for BHPs from six patients/day to 10.5 patients/day.

### **Clinical Services, *Oral Health:***

Dental caries is the most common chronic childhood disease; 39.7% of Colorado kindergarteners have already experienced tooth decay. By third grade, 55.2% of Colorado children have experienced tooth decay. A total of 7.8 million school hours are lost annually in Colorado due to acute dental pain. Children who reported having recent tooth pain were four times more likely to have a low grade point average (GPA), below the median GPA of 2.8, when compared to children who had not had dental pain. “Overall, first molars with sealants had a 62% less risk of developing a new carious lesion. Even partially lost sealants reduced the risk of developing new caries by 66% compared with no sealants.” – Journal of the American Dental Association (JADA) April 2017. Providing sealants in school programs to 1,000 children would prevent 485 fillings and 1.59 disability-adjusted life-years. School-based sealant programs save society money and remain cost-effective across a wide range of reasonable values.

Utilizing best practices, outlined by the Association of State and Territorial Dental Directors (ASTDD) and Centers for Disease Control and Prevention (CDC), MCPN has built a relationship with several school districts and Head Start programs to implement a School-Based Dental Program. Partners include: Jeffco Public Schools, Jefferson County Head Start, and Lakewood Head Start. For the Head Start programs, dental screenings, caries risk assessments, and fluoride varnish treatment three times per year are provided for all students who sign up for the program (over a 95% participation rate). MCPN and Head Start case workers then coordinate referrals back into MCPN health centers for comprehensive dental care. The program with Jeffco Public

Schools provides dental screenings, caries risk assessments, and fluoride varnish treatments to elementary and middle school students at all but one Title I school. Following the dental screenings, MCPN coordinates follow-up and referral back into the MCPN clinics for comprehensive dental care and sealants.

There are a total of 87 elementary schools in Jeffco Public Schools. Of those schools, 25 are Title 1 schools, with a total student population of 8,247. MCPN currently provides screening in 20 of the 25 Title 1 schools, representing a total student population of 6,895. The program also provides screenings in seven Head Start programs in the county. During the 2016-2017 school year, the following outcomes were recorded: 1) MCPN provided 2,307 dental screenings (a penetration rate of approximately 30%); 2) 758 students were seen on the dental truck for dental sealants; 3) 716 first molar sealants were placed and 67 second molar sealants were placed; 4) Approximately 20% of the students seen through the Oral Health Screening Program have also been connected to medical services at MCPN.

## CONNECTICUT

### **Grantee: Norwalk Community Health Center, Inc. (NCHC), Norwalk, CT (CH, PH, HCH)**

#### **Clinical Services, Case Management:**

NCHC recognizes that some patients are high-risk and high-cost users of the medical system, particularly as evidenced by frequent use of the emergency room (ER).

NCHC initiated the WeCare program by identifying a high risk cohort of patients using a hybrid of metrics, including diagnoses, social determinants of health, hospital utilization, and provider referral. These patients received enhanced Patient-Centered Medical Home-driven services, including extended time during provider visits, focused patient education about how to access care outside of working hours (including local urgent care centers that could be utilized rather than the ER), and enhanced case management from the WeCare team. The team also collaborates with multiple community agencies.

The 32 patients initially included in the program had 482 ED visits in the year October 2015 to September 2016. During the intervention year (October 2016 to September 2017), the number of ER visits fell to 213. This is a 55.81% reduction for this utilizer cohort.

## FLORIDA

### **Grantee: Citrus Health Network, Inc. (CHN), Hialeah, FL (CH)**

#### **Clinical Services, Chronic Condition Management:**

More than 2.4 million people have diabetes and more than 5.8 million have prediabetes in Florida. Diabetes, a life-long disease, can affect anyone, but some groups are disproportionately more affected than others, such as Hispanics/Latinos and people with low income. CHN faces many challenges because of the complex populations it serves; for example, 80% are Hispanics/Latinos and 97% of patients are at or below 200% of poverty. In addition, 50% of the CHN population have a psychiatric or behavioral disorder; this is a high-risk population for poor control of their diabetes. Individuals with poorly managed and controlled diabetes may develop serious complications that can lead to disability and work loss, which can potentially reduce their overall quality of life. Diabetes can also place an individual at an increased risk of developing other chronic diseases, such as hypoglycemia, hypertension, dyslipidemia, cardiovascular disease, heart attack, stroke, blindness, and kidney failure.

CHN has a comprehensive program focused on the management of chronic conditions, particularly diabetes for adults and children. The program is designed to ensure regular check-ups, preventive screenings, regular doctors' home visits, physical exams, and treatments. The CHN program takes a multidisciplinary approach to integrate primary care, behavioral health, nutrition, and care coordination between CHN and specialists, such as endocrinologists. This program is very comprehensive and includes behavioral assessment. Parents with children who have diabetes take the Expanded Food & Nutrition Education Program (EFNEP,) a free, hands-on nutrition education program for limited-resource parents and other adult caregivers who have primary responsibility for feeding children. EFNEP teaches participants how to stretch their food dollars, eat nutritious meals, and improve their overall health. At the end of the nine lessons, participants receive a certificate from the University of Florida.

As a result of the diabetes control program, only 7% of CHN patients have a diagnosis of diabetes based on Uniform Data System (UDS) data, although the population served is a high-risk population for pre-diabetes and diabetes; neuropsychological evaluation is available to all diabetes patients, including gestational diabetes and Type I diabetes; and there is early detection of diabetes in adults and children due to the program to screen all patients for diabetes. In addition, CHN has a lower percentage of uncontrolled patients with diabetes compared to the state of Florida and the nation.

## ILLINOIS

### **Grantee: Erie Family Health Center, Inc. (EFHC), Chicago, IL (CH)**

#### **Management and Finance, *Clinic Telephones:***

EFHC was experiencing a high volume of: 1) Missed calls within its phone system; 2) Patient dissatisfaction with the phone system; and 3) Patient dissatisfaction with not being able to see their assigned provider. To address this issue, EFHC implemented a state-of-the-art call center. The integrated call center improves scheduling, triage, referrals, and medical records.

EFHC's call center provides real-time oversight of: 1) The number of dropped calls; 2) How long a patient is waiting on the phone for service; and 3) A system that supports the phone technician to align the patient with their provider.

EFHC has been able to track the results of its new system both qualitatively and quantitatively. This is done through tracking: 1) Number of dropped calls – the industry standard is 10-15%, whereas EFHC's rate is 5-10%; 2) Patient surveys – demonstrate increased satisfaction with the phone system and responsiveness, from 77% to 86% patient satisfaction; and 3) Schedule with an assigned provider – EFHC reports a significant increase in its ability to schedule a patient with their assigned provider.

## MASSACHUSETTS

### **Grantee: South End Community Health Center (SECHC), Boston, MA (PH)**

#### **Clinical Services, Chronic Disease Management:**

SECHC was inspired by the Quality Improvement (QI) team efforts at PCMH locations, like the Cambridge Health Alliance, and Protected Department Meeting Time Structures at sites like the Codman Square Health Center. Hence, "Work it out Wednesdays" was envisioned, a weekly forum for cross-discipline, cross-department collaboration and learning. The structure was launched in March 2017 after the UDS submissions and review of key clinical and administrative processes.

SECHC blocks routine appointments every Wednesday morning from 8:00 a.m. - 9:15 a.m. to allow the clinical (nurses, medical assistants, providers, integrated behavioral health therapists, etc.) and non-clinical (community health workers, practice managers, etc.) teams time to contribute and learn within work groups. Small QI working groups (30 min): Focus is on process (i.e., walk-in flow) or clinical measures (i.e., diabetic foot exams). The team membership and QI projects change quarterly to ensure representation within (i.e., nurses only) and across (i.e., mixed group) disciplines. Larger Groups (40 min): Meet together across and/or by department or discipline to review data, progress, identify new challenges, participate in morbidity and mortality rounds, conduct peer review, define new QI Projects for the next quarter, or attend topic-specific trainings.

This QI structure was set with guiding principles drawn from Learning Organization Models and, therefore, encourages participation; sharing of best practices; and open discussions about errors, near-misses and opportunities to improve as a system. The sessions are facilitated by QI facilitators from the QI Team (nurse, navigator, and physician) who are paired with clinical coaches (medical assistant, nurses) who volunteer to co-facilitate. Because of the teamwork and concerted efforts, outcomes at the one-year mark showed measurable improvements in most clinical performance measures.

## **Clinical Services, Peer Review:**

SECHC's Peer Review Program is designed to facilitate sharing of best practices and encourage practice improvement based on clinical guidelines and experience. With a QI Facilitator present, providers meet to review charts using two different approaches. The peer review program at SECHC is designed to facilitate sharing of best practices, a culture of learning, and encourage practice improvement based on clinical guidelines and experience. While individual peer review is routinely practiced at health centers, the group peer review approach is innovative and aimed at improving electronic health record documentation.

SECHC peer review is accomplished using the following approaches. Individual Peer Review: Using a list generated by Information Technology (IT), providers periodically review two to three charts and document findings. The QI Team identifies trends and shares results with each provider whose work is reviewed. Collectively, providers share what they have discovered and hear about trends noted by the QI Team. Group Peer Review: To improve and optimize the use of existing EHR tools, the QI facilitator looks at new or underutilized features and starts the session by highlighting an EHR tool using a randomly selected case. The group then discusses the documentation, shares suggested approaches, and providers take turns demonstrating their use of the EHR. This approach allows providers to have their full note, their clinical processes, or their results management reviewed by the provider group.

The outcome of the collaborative, well-designed approach to peer review is promotion of uniformity in practice style and treatment approaches, as well as maximizing the use of electronic health record technology to facilitate accurate documentation of patient care, resulting in useful reports of clinical outcomes.

## **Grantee: Dothouse Health, Inc. (Dothouse), Dorchester, MA (CH)**

### **Clinical Services, Hypertension Management:**

White coat syndrome, an increase in blood pressure (BP) when visiting the provider, masked hypertension, and poor technique may produce inaccurate office-based BP readings and lead to over-diagnosis and over-treatment with antihypertensive agents. National and international hypertension guidelines recommend using home BP monitoring in conjunction with office readings for hypertension diagnostic and/or treatment evaluation.

Patients with uncontrolled hypertension, despite medication therapy or having elevated blood pressure readings in the clinic without a diagnosis of hypertension, were referred to the clinic's home BP monitor loaner program, facilitated by a clinical pharmacist. For at least five days, patients recorded three consecutive BP readings in the morning and the evening. At a scheduled follow-up office visit with the clinical pharmacist, the patient returned the monitor with the completed log sheet. The clinical pharmacist facilitated standardized documentation for efficient

evaluation.

Over the first year of the program, 75 patients were referred for either medication management evaluation (n=41) or hypertension diagnosis confirmation (n=34). For medication management referred patients, roughly half (n=20) had some clinical action taken and roughly half (n=21) had no action taken. Of the 34 patients referred for hypertension diagnosis confirmation, 23 (68%) had home BP readings averaging less than 135/85 mmHg, resulting in no formal diagnosis of hypertension and no medication prescribed. This was particularly pronounced in those patients with an office BP goal of <150/90 mmHg, a relatively older group. This data suggests that integrating home BP monitoring with office-based hypertension management is clinically important and may have a substantial impact on the accuracy of diagnosis and the appropriateness of medication use.

## **Grantee: East Boston Neighborhood Health Center (EBNHC), Boston, MA (CH)**

### **Management and Finance, *Project Management:***

In 2014-2015, senior staff at EBNHC identified several issues with project completion within the organization. It was noted that projects were not being completed in a timely fashion, “scope creep” was a frequent occurrence, in that a project would start with one goal and then have others added, to the point that the original goal was not being met. The IT Department was being completely overwhelmed with requests for data to assist with the project completion. There was no process in place to prioritize projects, and valuable resources were being used for projects that were of a lower priority, and higher priority projects weren’t getting completed.

EBNHC developed a Project Management Department to improve the process. A Project Manager was hired and provided training in project management, and she also has trained other staff within the organization in the process. A project steering committee was developed and began meeting regularly in mid-year 2016. An organizational definition of “a project” was developed, a priority scoring system developed, and use of a specific project management methodology was identified and implemented to standardize the process across the organization. All departments were trained in the process and system that had been developed. Currently, the committee meets two times a month. The Chief Information Officer (CIO) chairs the committee, and the Chief Executive Officer (CEO) attends/participates in the committee. Proposed projects are discussed, and if the project is approved to continue, it is scored using the priority system. A color-coded system is used to track status toward completion, and this is presented to the committee on a regular basis.

Quantitative results of the project include the development of a scoring system for assessing the merits of a proposed project, and a process for tracking the total number of projects, the number of projects completed, and the strategic goal that is addressed through each project. The staff reported being able to complete more complex projects, in a more timely manner, and with efficient/effective use of resources.

## MARYLAND

### **Grantee: Choptank Community Health System, Inc. (CCHS), Denton, MD (MH, CH)**

#### **Clinical Services, *Oral Health:***

A need for oral health services for pregnant women was recognized by CCHS providers, as well as other perinatal care providers in the community. Research evidence supports the association between good oral health and good pregnancy outcomes.

The program created a reliable and systematic referral process, whereby prenatal patients can have access to much needed dental care throughout their pregnancy and have their first dental visit start when they begin prenatal care. This process also allows for the dental providers to educate the patients regarding their child's dental health and needs in hopes of lowering the caries risk of these children by getting them into the dentist early and providing oral hygiene instruction and nutritional counseling at a very young age.

During the initial pilot phase of the program (February-June 2017), 39 pregnant women were referred internally and received oral health screening. Of those, most received fluoride varnishes, additional prophylaxis, and returned for additional services.

#### **Clinical Services, *Case Management:***

Many of the CCHS patients were using the ED for care, rather than coming into the health center. This was having an impact on CCHS's unique patient count as well as the center's ability to contain costs with its largest Medicaid Managed Care Organization (Priority Partners).

Approximately 25% of the patient population belongs to the Priority Partners MCO. CCHS has an Memorandum of Understanding (MOU) with Priority Partners and an incentive to reduce unnecessary ED use. In 2015, CCHS's ED usage was 1,051 ED visits per 1,000 members. This was double or triple the rate of the other Federally Qualified Health Centers (FQHCs) in CCHS's Maryland cohort.

CCHS began receiving daily Event Notification Services (ENS) reports from the state health information exchange (CRISP) that listed the center's patients who had been discharged from the ED the day before from any hospital in Maryland or Delaware. The ED visit of each patient was reviewed by a care coordinator and a continuity plan was created – a call to the patient, a follow-up appointment, or a referral to a community service provider. In addition, a collaborative was formed with the local hospital and Priority Partners to identify the shared patients who were frequent users of the ED. The collaborative consisted of Choptank Care Coordinators, Hospital Transitions Nurses, Priority Partners Case Managers, and social workers from both the hospital and Priority Partners, as well as administrative staff from all entities. One goal was to redirect patients to the health center before they made the decision to go to the ED.

By the end of 2017, CCHS's rate of ED usage for its Priority Partners patients had been reduced to 363 ED visits per 1,000 members. This represented a cost avoidance to Priority Partners of over \$1M for the calendar year. CCHS has also developed close relationships with the care coordination and ED staff at local hospitals, and they understand the CCHS processes and mission. This has improved the overall care of patients in the community. CCHS's unique patient volume also increased by approximately 1,500 patients from 2015 to 2017.

## NEBRASKA

### **Grantee: Charles Drew Health Center, Inc. (CDHC), Omaha, NE (CH, HCH)**

#### **Clinical Services, Health Education:**

Binary, gender-exclusive language at the health center excluded Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) "Sexual Orientation and Gender Identity" (SOGI) communities, and did not address the health disparities addressed in this community. The center developed a health education curriculum aimed at adolescents with a section focused on LGBTQ and SOGI youth. It used guiding principles of a non-judgmental and inclusive philosophy. It is an eight-part curriculum that increases sexual health knowledge and healthy adolescent relationships. All sessions use inclusive language and medically-accurate terminology.

The current measures are qualitative. Quantitative data are being collected and pending. Community groups previously uncomfortable with this topic opened up when presented with the curriculum in a respectful and comprehensive nature. New opportunities to serve those without access developed as a result of the curriculum use. This included: human growth and development classes at high schools, faith-based organizations, homeless and street-dependent youth, after-school programs, and gay-straight alliances at schools. Because of this work, "See, Test and Treat," a national cancer screening event, updated its eligibility criteria to be transgender inclusive.

#### **Clinical Services, School-Based Screening:**

An adolescent risk assessment tool, "Rapid Assessment for Adolescent Preventive Services-Public Health" (RAAPS-PH) administered at a school-based health center revealed that 25% of the students who completed the screening were food insecure. One-third of the school students took the screening test. Food insecurity is a social determinate of health (SDOH) that affects learning, sleep, obesity, depression, and other diseases.

The school-based health center staff wrote a grant to implement a food pantry that is stocked through the local food bank. The food pantry is operated by students and continues to be facilitated with the help of the school-based center staff. There is also a snack cupboard in the school clinic from which students can get a snack – no questions asked.

In one year, the food insecurity of the school decreased from 25% to 17% among those surveyed.

## **NEW JERSEY**

### **Grantee: Zufall Health Center, Inc. (ZHC), Dover, NJ (CH, PH, HCH)**

#### **Clinical Services, Childhood Diabetes:**

According to the National Survey of Children's Health 2011-12, nearly one out of four (24.7%) of New Jersey children ages 10-17 are overweight or obese. The CDC reports that obesity more than doubled in children and quadrupled in teens in the past 30 years. Local Community Health Needs Assessments in 2013 show that the rate of physical inactivity is nearly double among Hispanics as compared to non-Hispanic children. Latino children who are overweight or obese have high risk of developing diabetes and insulin resistance (2010 Profiles of Latino Health). At Zufall Health Center, located in northwest New Jersey and serving a large Hispanic population, a 40% rate of pediatric overweight and obesity underscores the need to address generational patterns. Initially funded with a Community Access to Child Health (CATCH) grant, a program with the AAP, Andale (Spanish for Go!) was launched in 2013 as a culturally competent exercise and nutrition program for overweight and obese Latino school-age children.

Three program components include: enhanced well child visits that focus on children ages 2-18 with an increased risk for diabetes, such as overweight or obese; family history of diabetes; and skin discoloration and/or lab abnormalities. Themed group visits for high-risk children (overweight or obese 7- to 11-year-olds) and their families provide peer support, reduce isolation, reinforce dietary modifications, and enhance activity levels. Group visits are structured with culturally relevant themes for maximum impact. Activities include "stations" for time-limited, hands-on health education. Physicians, Clinical pharmacists, nutritionists, dental hygienists and behavioral health specialists attend group visits, which are held monthly for four months, and are repeated throughout the year. Structured physical exercise is led by an experienced exercise trainer and includes cardio and resistance exercises modified to each patient's fitness level and ability. This takes place twice a week for four months.

Program materials include a detailed agenda for the monthly themed group visits, handouts to parents on each themed topic, including how to build positive self-esteem in children and how to deal with peer pressure, testimonial on weight loss benefits, parenting and food, emotional eating, managing hunger, triggers, and others. The physician reviews the definitions of overweight and obesity, and the conditions associated with them including diabetes and elevated blood pressure, and reviews the health plate (My Plate, 5, 2, 1, 0 (5 veggies or fruit per day, 2 hours or less of screen time, 1 hour of physical activity, 0 sugary drinks)). The nutrition section is the most popular for parents and includes snack list recommendations, reading food labels, the benefits of drinking water, and how the family meal influences eating and weight habits in

children, to name a few. Self-reporting tools on behaviors observed by the participants and families are used to gauge program effectiveness.

To date, participants have shown improved activity levels, improved nutritional knowledge, and have adopted behavioral changes. They express enhanced sense of support, enhanced self-confidence and self-esteem, and reduced stress from supportive group and peer experiences. During year one of the project, a small study was conducted over a six-month period, and there was statistically significant improvement in Body Mass Index (BMI) percentage from a baseline of 93% to a final measurement of 83% (Z-score p value = .0002 and BMI% p value = .0015).

### **Clinical Services, Oral Health:**

Integration of medical and dental services has long been a challenge, as both disciplines historically operate in silos. Nonetheless, the benefits of integration and potential harm to the patient if not established may have significant consequences. Medication reconciliation and promptly updating changes to the patient's health status could impact care. Sharing important health-related information among medical and dental providers is critical to providing safe and quality care. Additionally, being able to coordinate preventive treatments, such as fluoride varnish, during both medical and dental visits, improves access to effective preventive services. Through integration, medical and dental providers are able to coordinate fluoride varnish applications at proper intervals to optimize a child's oral and physical health. Care to pregnant women coordinated during their prenatal visit increases dental access and reduces periodontal disease.

Zufall Health Center has established medical/dental collaborations focused on key patient services. The use of a fully-integrated electronic records system has allowed the center to incorporate activities addressing oral health whenever possible to improve outcomes for vulnerable populations. The health center identified different areas where it could apply quality improvement processes. These include the pediatric well child visit, group visits, the prenatal program, and the Ryan White HIV/AIDS Program. Interdisciplinary teams were trained to work together to identify high-risk individuals and provide them with targeted education, screenings, and preventive services, as well as referrals with a warm handoff into dental care. Protocols and trainings have been developed to teach pediatricians and family physicians how to apply fluoride in the pediatric setting. Guidelines are reviewed with provider staff on dental care of pediatric, prenatal, and people living with HIV (PLWH) patients. The process is data-driven, with the team tracking relevant measures such as risk assessments, risk status, referrals, appointments made, incidence of new caries, and dental sealant application, among others.

Knowing the patient's risk status is a critical step to providing risk-based care. Zufall regularly conducts caries risk assessments for all dental patients. Zufall's data show that 95% of dental patients received a caries risk assessment in 2017. Additionally, patients are engaged in a conversation about risk factors and protective behaviors by family physicians, pediatricians, medical assistants, case managers, and patient navigators during medical and case management visits. The prenatal care team provided oral health education to 100% of the pregnant women

they interacted with and increased the rate of pregnant women receiving dental care from 14% in 2014 to 95% in 2017. Similarly, the Ryan White team increased access to dental care for PLWH from 37% in 2016 to 59% in 2017. As a result of dental/medical integration, the pediatric team has reduced new caries rates among children from 77% in 2014 to 30% in 2017.

## **Grantee: North Hudson Community Action Corporation (NHCAC), Union City, NJ (CH)**

### **Clinical Services, Diabetes:**

The health center needs to improve the overall health status of patients diagnosed with diabetes and control blood sugar levels of known diabetics, as well as improve the number of diabetic patients who obtain required screenings to control diabetes: 1) HgbA1c testing at least twice a year; 2) retinal exam annually; 3) LDL annually; 4) Blood pressure screening at least twice a year; 5) flu vaccine annually; and 6) Microalbumin screen annually. The center needs to increase the number of patients with diabetes who have self-management goals.

The health center, through its quality program initiative, developed specific smart forms (clinical pathways) that included diabetes self-management goals, diabetic foot exams, chart prep questions with standard fields, and a diabetic risk assessment tool for patients not diagnosed with diabetes. Also, the center initiated team-based care, consisting of a provider, nurse case manager, nutritionist, health educator, certified diabetic educator, podiatrist, ophthalmologist, and a dedicated health coach. Group education classes were scheduled both in English and Spanish that included chair exercises, meal planning, carbohydrate counting, reading food labels, My Plate demonstrations, and cooking demonstrations. They added a retrievable field for medication compliance to the electronic health record, developed bilingual diabetic educational tools and made them available through the ED, clearly defined the data collection needs and outcomes, and standardized quality measure monitoring.

Diabetic foot exams increased from 0% to 97%. Diabetic Risk Assessment increased from 0 assessments to 5,082 assessments in 2016. Medication compliance increased from 0% to 82%. Self-Management Goals increased from 0% to 100%. The Hgba1c average decreased below 9% is 19%. The health center expanded in-house podiatry and cardiology services to multiple sites and developed regular sessions with an APN, who is a Certified Diabetic Educator.

## **OHIO**

### **Grantee: Health Partners of Western Ohio (HPWO), Lima, OH (MH, CH)**

#### **Clinical Services, Pre-Diabetes Screening:**

In 2017, HPWO began participation in a pilot project established by the Ohio Department of Health and the Ohio Primary Care Association (PCA). The focus of the project was to implement pre-diabetes screening within CHC clinics. A standardized screening tool from the American Diabetes Association was used, with a modification to screen all patients 18 years of age and older. Most screening recommendations currently recommend routine screening be started at 40-45 years of age. HPWO utilized one clinic for the development of the process and workflow. This process was developed during the summer of 2017 and started in the fall. As the process was implemented and results were monitored, a significant number of patients were being identified at risk for developing diabetes (defined as a score of 5 or higher on the screening tool). There were also patients diagnosed with pre-diabetes and several diagnosed with diabetes. Due to the high numbers of patients who were being identified at one health center site, HPWO made a decision to implement this process at all the health center sites. Training/education was completed in late 2017 (October/November). The clinical work flow developed is as follows: if the patient scores 5 or higher on the screening tool, a hemoglobin A1c (HgbA1c) is completed. If the HgbA1c is between 5.7% -6.4%, the patient is identified as pre-diabetic. If the HgbA1c is greater than 6.5%, the patient is diagnosed with diabetes. HPWO also decided to pilot a Diabetes Prevention Program for these patients. After exploration of the possibilities of utilizing an external Diabetes Prevention Program, HPWO made the decision to develop an internal Diabetes Prevention Program. This program is currently in place in the original pilot health center site and discussions are ongoing related to expanding this program within the organization. Data gathered for the last three months of 2017 showed that 1,900 patients screened during the last three months of 2017 were identified as being at risk for developing diabetes (score of 5 or higher on the screening tool). In addition, 208 patients were identified as pre-diabetic (HgbA1c between 5.7% and 6.4%), and approximately 20 patients were diagnosed with diabetes (Hgb A1c 6.5% or higher). HPWO also implemented alerts/notifications in the EHR to remind the teams to screen patients and implemented alerts to complete annual testing if the patient was at risk. Workflows/responsibilities for each team member have also been identified, with all team members empowered to complete these tasks whenever a patient is at the health center. Written guidelines and flowcharts are used at all sites.

## **Grantee: Signature Health, Inc. (SH), Willoughby, OH (CH)**

### **Clinical Services, Child Courtesy Drop Area:**

Signature Health started as a mental health center serving children and adults with mental health illness and substance use disorders. In 1994, the organization was challenged with high no-show rates. Also, during appointments, parents' attention was diverted to attending to children's needs, posing communication challenges between staff and patients, and poor patient adherence. Signature Health created a supervised center, Kid Zone, where parents or guardians can sign in one or more children, for no more than three hours, while parents attend medical or mental health individual or group appointments, either for themselves or for other children. The center is not a child care center, but rather a courtesy drop area that is supervised and provides books and toys

for children to entertain themselves. The Kid Zone has the capacity for 10 children at one time. Only toilet trained children between the ages of 3-12 years old are admitted into the Kid Zone, and only when parents or guardians are in the building. Parents need to present with photo identification when signing children into to the Kid Zone. At sign in, parents/guardians receive a pager, Kid Zone policies and guidelines, and are instructed to return to the Kid Zone if their pager is activated to attend the needs of their children.

Quantitative data was not available; however, according to the Chief Operational Officer, implementation of the Kid Zone at the Willoughby clinic has decreased the no-show rate, enhanced patient and provider communication, and improved both patient and staff satisfaction.

## OKLAHOMA

### **Grantee: Morton Comprehensive Health Services (MCHS), Tulsa, OK (CH, HCH)**

#### **Management and Finance, Transportation Services:**

The city of Tulsa does not have a formal transportation system in place for its residents, and this creates a barrier to care for patients to get to medical and social services appointments. MCHS, along with other community-minded organizations, identified a lack of transportation for patients to get to referrals and keep follow-up appointments, especially for the low-income/uninsured population. Identifying factors were: large volume of patient appointment cancellation, rescheduling, non-adherence to medication regimen, as well as no follow-up appointment due to lack of transportation and means to support getting to medical/dental/social services.

Along with the City of Tulsa and other partners, they were able to implement a 14-bus transportation system that is accessible by Morton low-income patients. MCHS identifies low-income patients within its system, and then offers the transportation opportunity to them get to and from medical and social services appointments. This system has been able to expand due to more community support; a local natural gas company donated a fill-up station, as well as an additional transportation bus.

Morton has offered 36,155 rides to 18,077 riders, and all buses are lift-equipped. MCHS receives a Community Development Block Grant (CDBG) for \$21,649.00 to help support the program, funding from United Way, and other funding streams that believe in the program. The Morton bus system has software called Route Match to help efficiently track, manage, and collect relevant data to help continuously improve. Outcomes are better, including patient adherence to medical appointments, less stress on patients trying to identify a costly transportation method, reducing the no-show rate for referrals, and increasing follow-up for patients back to MCHS.

## OREGON

### **Grantee: Lane County (Lane County), Eugene, OR (MH, CH, HCH)**

#### **Clinical Services, Opioid and Substance Abuse:**

Prescription opioid overdose is a public health concern for the United States. Americans are dying at the rate of 175 a day from opioid overdoses. Oregon has the second highest rate of opioid prescribing in the country, and struggles to control, or even slow, opioid abuse. A study in 2016 from CDC put the annual cost of prescription opioid overdose, abuse, and dependence at \$78.5 billion, including direct health care costs, lost productivity, and costs to the criminal justice system. The federal Department of Health and Human Services (DHHS) numbers show Lane and Linn counties in Oregon are still in the top seven in the state for drug poisoning deaths per 100,000 people.

The health center has established a multidisciplinary approach to reduce the use of opiates for non-malignant pain and improving safety for those medications in 2017, including the adoption of the recent CDC Chronic Pain Guidelines into their policies in response to the opioid crisis among their service populations. The policy targets reduction of total opioid use, measured in Morphine Equivalent Doses, by working with pharmacists and providers and increasing use of Naloxone for overdoses to prevent mortality. In addition, the center works on limiting the supply of excess prescription opioids for acute and chronic pain among its clinicians; decreasing the demand for prescription opioids through the promotion of nonpharmacologic pain management strategies such as exercise, acupuncture, mindfulness, yoga and warm salt water therapy; raising patient awareness of the risks of opioid misuse, addiction, and overdose; and controlling medication registry and oversight.

The health center was able to achieve a 40% reduction in the total number of patients on opiates in only six months. Education about alternative and complementary medicine to reduce high doses of opiates was offered to all patients. Naloxone prescribing among 50% of patients >50 MED and 75% of patients on >90 MED 137 patients were served in the first two months of operating the Alternative Medicine Pain Care Clinic. A total of 20 scholarships were provided for warm salt movement therapy at Tamarack Pool in the first two months. More integrated behavioral health providers are assisting in coaching. A communication team assists in developing and disseminating patient education tools.

## PENNSYLVANIA

### **Grantee: Wayne Memorial Community Health Centers (WMCHC), Honesdale, PA (CH)**

## **Clinical Services, Opioid and Substance Abuse:**

The health center recognized the increasing incidence of opioid addiction in its service area, which was further complicated by a lack of treatment options, especially for patients on Medicaid and those with no insurance.

The health center piloted a VIVITROL program in its behavioral health department. Unlike opioid substitute medications, VIVITROL is a non-addictive, once-monthly treatment that works by blocking the “high” that opioids induce. The treatment is used in conjunction with counseling. The health center started with 149 patients in the program; 87 patients remained for three months, and there was a 57.7% adherence rate; 54 patients stayed in the program for six months, and there was a 36.2% adherence rate; 26 patients stayed in the program for a year and there was a 17.4% adherence rate. For comparative purposes, the national adherence rate in Food and Drug Administration (FDA)-approved National Institutes of Health (NIH) studies was 10.5% at six months.

## **TEXAS**

### **Grantee: People’s Community Clinic (CHD), Austin, TX (CH)**

#### **Management and Finance, Workforce Training:**

With over 200 staff serving five sites, ensuring that all new staff receive an adequate on-boarding experience and orientation, as well as ensuring that all staff receive required annual training, e.g., Health Insurance Portability and Accountability Act (HIPAA) and Occupational Safety and Health Administration (OSHA) requirements, is a challenge. Some of the challenges are: new staff come on at different times throughout the year and, thus, training must be provided throughout the year; if training is presented “live,” it requires that clinical services be suspended or limited during that time period; tracking of all non-electronic training requires dedicated staff and time to ensure that the reporting is complete and accurate.

Eight months ago, the health center hired a full-time Training Specialist. She completed a needs assessment to identify skills needed and gaps in learning, and she met with managers to determine their greatest challenges. In response, and with the assistance of staff subject matter experts, she developed e-learning modules for both new staff and all staff. For all staff, the modules include: HIPAA, OSHA, blood-borne pathogens, cultural humility, health literate communication, human trafficking awareness, sexual abuse reporting, and building a respectful workforce. As part of the new employee orientation, the modules include: FQHC, PCMH, Title X, HIV training, accounts payable, and going green at PCC. In addition to the e-learning, other changes were made to the training and orientation process for new employees. First, all new employees begin on a Monday so they have a cohort to work with. To acquaint themselves with a large facility, a scavenger hunt is part of the orientation.

The e-learning modules are recognized as being applicable to the health center. Other health centers have purchased similar modules, but they often have a hospital-focus or large, private practice focus. The e-learning is completed during downtime and, thus, does not affect clinic flow or require schedules to be blocked (which reduces available patient time). An example of this is that HIPAA 2018 was launched three weeks ago and already 44% of staff have completed the training – all during downtime. Compliance reminders are sent automatically via email, and all tracking is done electronically, thus significantly reducing time spent by supervisors to complete these tasks. Given that this program is less than six months old, more results will be evaluated once one year of the program has been completed.

# ACRONYMS

<u>Acronym</u>	<u>Meaning</u>
ASTDD	Association of State and Territorial Dental Directors
BHD	Behavioral Health Department
BHP	Behavioral Health Provider
BMI	Body Mass Index
BP	Blood Pressure
BPHC	Bureau of Primary Health Care
CY	Calendar Year
CDC	Centers for Disease Control and Prevention
CS	Central Southeast Division
CO	Chief Executive Officer
CMO	Chief Medical Officer
CDBG	Community Development Block Grant
CHC	Community Health Center
CIO	Chief Information Officer
DC	District of Columbia
DHHS	Department of Health and Human Services
ED	Emergency Department
EFNER	Expanded Food & Nutrition Education Program
EHR	Electronic Health Record
ENS	Event Notification Services
ER	Emergency Room
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center

GPA	Grade Point Average
HC	Health Center
HIPAA	Health Insurance Portability and Accountability Act
HO	Health Care for the Homeless
HRSA	Health Resources and Services Administration
ID	Identification
IT	Information Technology
JADA	Journal of the American Dental Association
LGBTQ	Lesbian, Gay, Bi-Sexual, Transgender and Queer
MA	Medical Assistant
MH	Migratory and seasonal agricultural Health
MHC	Migratory and seasonal agricultural Health Center
MOU	Memorandum of Understanding
MSAW	Migratory and Seasonal Agricultural Workers
NCD	North Central Division
NED	Northeast Division
NIH	National Institutes of Health
OPPD	Office of Policy Program Development
OSHA	Occupational Safety and Health Administration
OSV	Operational Site Visit
PCA	Primary Care Association
PCMH	Patient-Centered Medical Home
PDSA	Plan, Do, Study, Act
PH	Public Housing
PHI	Protected Health Information
PHQ9	Patient Health Questionnaire-9
QI	Quality Improvement
RAAPS-PH	Rapid Assessment for Adolescent Preventive Services – Public Health
RN	Registered Nurse
SBIRT	Screening, Brief Intervention & Referral to Treatment
SDOH	Social Determinant of Health
SED	Southeast Division

U.S. United States SOGI  
Sexual Orientation and Gender  
Identity  
SWD Southwest Division  
UDS Uniform Data System

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# Promising Practices by Area of Operation, Type, Sub-Type, State, and Grantee

Area of Operations	Type	Sub-Type	State	Grantee	Special Populations
Clinical Services	Care Transitions	Hospital-Related	California	Lifelong Medical Care	CH, PH
Clinical Services	Provider Scans	Quality Improvement	California	Tulare Community Health Clinic	MH, CH
Clinical Services	Substitute for Migratory and Seasonal Agricultural Workers	Miscellaneous	California	Tulare Community Health Clinic	MH, CH
Clinical Services	Mailroom for Patients without Addresses	Miscellaneous	California	Share Our Selves Corporation	CH, HCH
Clinical Services	Screening, Brief Intervention & Referral to Treatment	Behavioral Health	Colorado	Metro Community Provider Network	CH, HCH
Clinical Services	Oral Health	Oral Health	Colorado	Metro Community Provider Network	CH, HCH
Clinical Services	Case Management	Hospital-Related	Connecticut	Norwalk Community Health Center, Inc.	CH, HCH
Clinical Services	Chronic Condition Management	Quality Improvement	Florida	Citrus Health Network, Inc.	CH
Clinical Services	Oral Health	Oral Health	Maryland	Choptank Community Health System, Inc.	MH, CH
Clinical Services	Case Management	Hospital-Related	Maryland	Choptank Community Health System, Inc.	MH, CH

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Clinical Services	Chronic Disease Management	Quality Improvement	Massachusetts	South End Community Health Center	PH
Clinical Services	Peer Review	Quality Improvement	Massachusetts	South End Community Health Center	PH
Clinical Services	Hypertension Management	Quality Improvement	Massachusetts	Dothouse Health, Inc.	CH
Clinical Services	Health Education	Miscellaneous	Nebraska	Charles Drew Health Center, Inc.	CH, HCH
Clinical Services	School-Based Screening	Miscellaneous	Nebraska	Charles Drew Health Center, Inc.	CH, HCH
Clinical Services	Childhood Diabetes	Quality Improvement	New Jersey	Zufall Health Center, Inc.	CH, PH, HCH
Clinical Services	Oral Health	Oral Health	New Jersey	Zufall Health Center, Inc	CH, PH, HCH
Clinical Services	Diabetes	Miscellaneous	New Jersey	North Hudson Community Action Corporation	CH
Clinical Services	Pre-Diabetes Screening	Miscellaneous	Ohio	Health Partners of Western Ohio	MH, CH
Clinical Services	Child Courtesy Drop Area	Miscellaneous	Ohio	Signature Health, Inc.	CH
Clinical Services	Opioid and Substance Abuse	Pain Management	Oregon	Lane County	MH, CH, HCH
Clinical Services	Opioid and Substance Abuse	Pain Management	Pennsylvania	Wayne Memorial Community Health Centers	CH
Management and Finance	Patient Scheduling Appointments	Quality Improvement	California	Lifelong Medical Care	PH
Management and Finance	Rearranging Health Center Schedules	Miscellaneous	California	McCloud Healthcare Clinic, Inc.	MHC, CH

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Management and Finance	Clinic Telephones	Miscellaneous	Illinois	Erie Family Health Center, Inc.	CH
Management and Finance	Project Management	Quality Improvement	Massachusetts	East Boston Neighborhood Health Center	CH
Management and Finance	Transportation Services	Miscellaneous	Oklahoma	Morton Comprehensive Health Services	CH, HCH
Management and Finance	Workforce Training	Quality Improvement	Texas	People's Community Clinic	CH

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