Promising Practices July 2018 – December 2018

This report highlights many of the promising practices in Health Centers that received operational site visits during July 2018 through December 2018.

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Executive Summary of Promising Practices

July 2018 – December 2018

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 of services, increased cost savings, and improved performance and health outcomes and reduced health disparities.

Highlights of Promising Practices from July 2018 through December 2018

HCs continued to demonstrate leadership in the health care field during the period July 2018 through December 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 318 Operational Site Visits (OSVs) of HCs on behalf of the Bureau of Primary Health Care (BPHC) during the second half of calendar year (CY) 2018, they cited 36 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 OSVs from July 2018 through December 2018. The type of promising practice is identified as clinical services, governance, or management and finance. A sub-type is also identified in a chart at the end of the report, as follows:

Health Education

Quality Improvement

Managing Chronic Conditions

Safe Work Environment

Specialty Care

Customer Service

Managing Chronic Conditions

Behavioral Health

Health Center Finance

Problem Resolution

Transportation

Oral Health

In addition, the chart at the end of the report states the kind(s) of funding received by the HC, as follows: CH for Community Health Center, MH for Migrant Health Center, HO for Health Care for the Homeless, and PH for Public Housing.

Also, a list of commonly used acronyms is at the end of the report.

Examples of Promising Practices

The following are some highlights of the commendable work of HCs in the areas of clinical services, governance and management & finance:

CLINICAL SERVICES

Clinicas de Salud del Pueblo (CDSDP) –Brawley, CA– *Telehealth Program Manager*:

CDSDP is located in one of the most remote and rural areas of California. There is a limited number of specialists in the region, few of whom will accept Medi-Cal (Medicaid) or serve uninsured patients. A lot of specialty care is located more than two hours away and, during inclement weather, roads may be closed, limiting access to needed specialty care.

In July 2015, the health center received a foundation grant and hired its first Telehealth Program Manager. CDSDP developed and implemented a strategic telehealth plan and ensured its sustainability by integrating telehealth within the center's core clinical services. CDSDP initially focused on three areas, including retinal screening for diabetic patients, psychiatric services, and dermatology. Key factors in CDSDP's success include: 1) dedicated staff assigned to develop and implement programs; 2) clinical leadership and commitment to utilize technology as part of care options; 3) telehealth integration into existing protocols; 4) financial incentives aligned to support telehealth; and 5) new in 2017, monitoring key performance indicators (KPI) to ensure program sustainability. The Telehealth Department was placed under the leadership of the CMO, who serves as the clinical champion. Today the Telehealth Department is supported by 6 FTE spread over 10 sites.

Within three months of hiring dedicated telehealth staff and revising the clinical work flow, CDSDP increased the number of patients receiving retinal screens by more than 300 percent. In 2016, CDSDP received an award from the California Telehealth Network for its retinal screening program. The health center has completed more than 2,500 retinal screens in 2018. Timely retinal screening contributes to the center's HEDIS measures, resulting in increased revenue from health plans on a regular basis. Also, CDSDP provided more than 3,500 telepsychiatry visits in Spanish and English for both children and adults. The health center has generated more than $648,000 in charges for telepsychiatry. Since 2016, more than 500 dermatology consults have been conducted as well. By adding telehealth services, CDSDP has been able to increase the Prospective Payment System (PPS) rate at some of its sites.

GOVERNANCE

Marillac Clinic, Inc. (Marillac) –Grand Junction, CO– *Board Self-Evaluation*:

While not a new safety net clinic but as a newly funded health center, the Board of Directors was expressing frustration over the length of meetings, receiving either too much or not enough information, and lack of alignment of work across the Board and its the committees. The board room was not comfortable and conducive to its work.

Leadership instituted a simple but routine board self-evaluation tool that is completed at the conclusion of every monthly meeting. The evaluations are completed anonymously and collected by the Board Assistant. The evaluations are aggregated into a summary report within 24 hours and sent to the Executive Committee of the board. The CEO additionally responds to the Executive Committee with her observations and, as appropriate, recommendations. The Executive Committee uses the regular feedback to monitor the development of agendas, distribution of information, organization and assignment of committee work, and the board meeting room environment.

The upside to this practice is its simple but meaningful impact. Feedback is constant. The requirement is simple but requires discipline of staff and the board members. It does require the commitment of a health center staff person, in this health center's case the Board Assistant, who is the minute taker. She collects and tabulates the evaluations into a summary report. The whole process requires perhaps up to an hour per month.

The efficiency and effectiveness of the board and committee meetings have improved significantly. Board members feel they are being heard and their input is valued. Consumer members especially feel that their participation is contributing to the decision-making of the governing board. Feedback is rapid and constant. Feedback is constantly monitored and measurable, i.e. length of meetings, board packets, adherence to the agenda, and the Board Chair's performance in facilitating the meeting. The information is clear and concise.

MANAGEMENT AND FINANCE

Alliance Medical Center, Inc. (Alliance) –Healdsburg, CA– *Texting Patients*:

Alliance was looking for a tool that would allow the health center to communicate with its patients on an ongoing basis (outreach messages, health education calls, reminders, surveys, etc.) in a manner in which patients would relate and respond. The patients did not respond to mail or daytime calling efforts and the health center did not have staff to make calls in the evening hours.

Alliance identified that the majority of its patient base had smart phones, and texting was their primary mode of communication. They would not answer a call, but they would answer a text. The patients were surveyed and responded that they would be predisposed to receiving and responding to test messages. The next step was to find a texting program/service with a bilingual evidence-based health education program. The tool also had to have the ability to send surveys, alerts, reminders, and embedded links. The texts would not have PHI and needed to be HIPPA-compliant. The tool needed to be easy to use, support staff, and require no additional IT hardware. The health center found a 501(c)3 nonprofit that empowers health organizations with mobile technologies to improve health literacy and self-health management while fostering more efficient care delivery. That organization focuses on patient engagement, providing ongoing evidence-based health education, with reporting/dashboards to track effectiveness of messages.

Alliance started with the non-profit's Health Education Programs. Alliance ran the Type 2 Diabetes Program for 25 weeks with 283 patients, obtaining a 19 percent response rate, 77 percent user retention, and 35 percent users activated. Hypertension was run for 20 weeks with 673 participants and a 24 percent response rate, 75 percent user retention, and 35 percent of users activated. Alliance is now working on an evaluation to see if measures improved in the uncontrolled patients selected. The tool was also used to survey patients to see if they would be interested in acupuncture services and included a question asking if they knew what acupuncture is. Alliance had an 18 percent response rate (968) compared to a usual 1 percent response to mail with 10 times the cost; 62 percent of responses were in English, 38 percent were in Spanish. Based on the information from the surveys, Alliance is adding acupuncture to its service offerings. The tool has been used to advertise flu clinics, focused recall efforts, wellness classes, and to send reminders.

The tool is easy to implement. It does not require any special training of staff to send their educational material or create their own messages. The dashboards are easy to understand. It is easy for patients to opt-out if they wish. The cost is reasonable, with tiered pricing based on number of texts sent per month. The tool can integrate with most Electronic Health Records (EHRs).

Promising Practices

July 2018 – December 2018

The following 12 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), Migrant Health Center (MH), 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.

CALIFORNIA

Grantee: **San Joaquin, County of (San Joaquin)**
                     Stockton, CA (N/A)

Clinical Services, *Congestive Heart Failure Intervention*:

Hospitalists at the hospital affiliated with the site noted high utilization of Emergency Department (ED) and inpatient services by patients with congestive heart failure. Previous efforts by the hospital to establish a specialty service for these patients had been unsuccessful. The site decided to develop a comprehensive program to address the needs of the approximately 1,400 patients with a diagnosis of congestive heart failure.

The Heart Failure Intervention Program is a multidisciplinary team approach to improving quality of life and reducing the cost of care for these patients. A specialized clinic held on two half-days a week is embedded in the primary care outpatient clinics and is staffed by a physician, pharmacist, nurse, dietician, medical assistant and, recently added, palliative care. Patients are referred to

this clinic as part of hospital discharge planning, and the appointment is usually made within three to seven days of discharge. Patients are also referred to care management, which provides assistance with accessing community resources and self-management tools (such as blood pressure cuffs, exercise bands, and personal scales), and health coaching.

Between September 2017 and August 2018, 105 enrolled in the program. These patients experienced a 40 percent decrease in ED visits, 63 percent decrease in hospital admissions, and, when admitted, had a 54 percent shorter stay. Estimated cost savings is $364,900 for the time period.

The keys to replicability are effective communication systems between the hospital and the center; written agreements describing the roles of both organizations, especially the process of referring patients to the center; and a clinical champion with an interest in cardiology. The champion does not need to be board-certified in cardiology. Medication management is a critical component of the program, so clinical pharmacist involvement is very helpful. Care management is critical.

Grantee: **University of California, Irvine (UCI)**
Irvine, CA (CH)

Clinical Services, *Shared Medical Visits*:

Shared Medical Visits (SMV) are a clinically effective way to engage and empower patients to better manage chronic health conditions and adopt healthy lifestyle changes. Bringing together a group of patients at a community health center with a health provider and a health educator who acts as a group facilitator, SMVs provide patients with direct clinical treatment, group education, one-on-one coaching, and a "safe space" for interactive peer support and the development of effective problem-solving tools.

UCI has offered SMVs since 2013, addressing standard diabetic and weight management recommendations, as well as broader foundational health and wellness topics including healthy diet, exercise and activity, approaches to stress management and mind/body relaxation techniques, and healthy sleep. Key staff members in SMVs include clinicians, medical assistants, administrative support staff, and health educators. Groups meet 1.5 to 2.5 hours and the intervals between meetings are appropriately tailored to the group itself (for example, weekly, bimonthly, or quarterly). Groups meet in a location where vital signs may be taken, access to medical records may be accessed, and an area where patients feel safe to express their needs

and concerns regarding their medical condition(s). Due to time constraints, one-on-one patient and provider visits during SMVs are limited to one acute complaint, and no more than 20 minutes. This allows for the patient to continue to participate in class discussion. If the patient has more concerns, an appointment is scheduled before leaving the SMV for the patient to see his/her Primary Care Provider (PCP) or next available provider for follow-up.

In 2017, there were 143 SMV sessions serving 1,218 patients. Diabetes management demonstrated 66.7 percent maintained or improved HbA1c and 20.5 percent improved HbA1c.

Grantee: **Clinicas de Salud del Pueblo, Inc. (CDSDP)**
                       Brawley, CA (MH, CH. HCH)

Clinical Services, *Telehealth Program Manager*:

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provided more than 3,500 telepsychiatry visits in Spanish and English for both children and adults. The health center has generated more than $648,000 in charges for telepsychiatry. Since 2016, more than 500 dermatology consults have been conducted as well. By adding telehealth services, CDSDP has been able to increase the Prospective Payment System (PPS) rate at some of its sites.

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Grantee: **Alliance Medical Center, Inc. (Alliance)**
                     Healdsburg, CA (CH)

Management and Finance, *Texting Patients*:

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ILLINOIS

Grantee: **PCC Community Wellness Center (PCC)**
                                     Oak Park, IL (CH)

Clinical Services, *Opioid and Substance Abuse*:

The epicenter of Illinois's opioid epidemic is in PCC's service area, where opioid hospitalizations account for nearly one-quarter of Illinois hospitalizations. Interstate 290 is referred to as the "Heroin Highway" due to the concentration of trafficking, making the West Side the U.S.'s largest open-air drug market. PCC's population of opioid-dependent patients is ten times the national average of 0.3 percent. Racial and ethnic health disparities compound the effects of Opioid Use Disorder (OUD). As the opioid epidemic has intensified, the center sees the continued need for prevention and treatment. According to Healthy Chicago's Epidemiology Report October 2017, opioid overdose-related deaths increased 74 percent from 2015 to 2016, in part, due to the increased access to fentanyl. An adulterant to heroin, fentanyl increases the risk of overdose. Also, fentanyl-related overdose deaths are highest among non-Hispanic African-Americans. Located in Chicago's West Side, a large percentage of PCC's patients are African-American.

In 2014, PCC implemented the chemical dependency treatment program. Using a team-based approach, including medical, behavioral health, and care management, PCC provides direct access to substance use treatment services, including medication-assisted treatment. The Chemical Dependency Clinic (CDC) is open to adults (18 or older) and pregnant women. In collaboration with West Suburban Medical Center, and with the help of PCC care coordinators embedded at the Medical Center, high utilizers of the ER, and inpatient admissions are targeted. PCC has an internal hub-and-spoke model. Patients receive medical and behavioral health evaluations, medication induction, and stabilization at the hub, the Chemical Dependency Clinic.

Once stabilized, treatment is integrated into primary care at a continuity clinic, PCC's spokes, making SUD treatment part of chronic disease management. This model allows a patient to receive care depending on the severity of need.

PCC's Chemical Dependency Clinic can be implemented in other health centers. In order to do so, a financially sustainable model, based on integrated behavioral health and primary care providers, must be developed. Initial funding is necessary to support the financial liability associated with provider salaries without established patient panel revenue. Additionally, funding is necessary to support the salaries of staff who provide care management activities, which are essential components of effective treatment provision.

Since 2014, PCC has provided treatment to 711 individuals on the West Side of Chicago and western suburbs. PCC's primary quantitative measure is treatment engagement and retention. Research indicates an average retention rate of 20-25 percent at 30 days post-treatment initiation. Since implementing programming in 2014, PCC has a 55 percent continuous engagement. Additionally, PCC has a 78 percent continuous engagement for the first six months of the calendar year 2018. PCC performs quarterly peer reviews, with analysis of each provider's adherence to quality clinical performance measures. Medical and behavioral health providers are reviewed by a provider with a chemical dependency specialty. Each quarter, the analysis is assembled by the Behavioral Health Manager, Chemical Dependency Medical Clinic Coordinator, and Medical Director of Performance Improvement. Results are analyzed, and individual feedback is provided. Results are shared with individual providers, while aggregate results are shared with the provider group as a whole.

MASSACHUSETTS

Grantee: **Community Health Connections, Inc. (CHC)**
Fitchburg, MA (CH, PHPC, HCH)

Clinical Services, *Opioid and Substance Abuse*:

In 2016, CHC noted during Morbidity and Mortality (M&M) reviews that there was a dramatic rise in deaths in CHC's young patients (20- to 30-year-olds) related to drug overdoses. At the same time, the CDC identified the rise in narcotic use and associated deaths nationally as an epidemic. (www.cdc.gov/drugoverdose/epidemic/index.html). The health center wanted to improve the way opioids were prescribed through the development of a Chronic, Non-Malignant, Pain

Management Protocol for Adults. The protocol ensures that patients have effective pain management while reducing the number of opioid prescriptions that could be misused or contribute to overdose.

Under the direction of the CMO and the quality team at CHC, a focus group was convened to review evidence based guidelines and develop a Chronic Pain Management Protocol. The goal was to provide guidance and tools that standardized provider prescribing practices of narcotics for chronic pain management. The protocol was completed in March 2016.

The protocol begins with a thorough assessment of pain and includes an objective pain assessment tool that is completed by the patient. Initial treatment starts with non-narcotic pain relievers that can be combined with non-pharmacologic therapies such as exercise, stress reduction, yoga, massage, and cognitive behavioral therapy among others.

If a non-narcotic treatment is not successful an opioid risk assessment is performed to help in determining whether the patient is at an increased risk for opioid abuse. The protocol requires that narcotic prescribers also query the Massachusetts Prescription Monitoring Program (MA online PMP) and asks the provider to consider a baseline urine drug test. Prescribers who are not pain specialists are not to prescribe in excess of 100 milligrams of morphine equivalent per day without a documented consultation with a pain specialist.

The provider and the patient execute a contract for pain management that sets clear treatment goals and helps frame realistic expectations. Goals are revaluated on a regular basis and based on the patient's profile visits will be more frequent for those at high risk of abuse. Patients undergo regular urine screenings and are asked to bring their prescription medications with them to each visit and are subject to random pill counts. Specific guidance is provided regarding how to handle any contract violations including what to do if the prescribed drug is not found in the patient's urine and guidance if a non-prescription narcotic is found. Any patient who repeatedly violates their contract may be removed from the narcotic prescription program or even from the facility. Resumption of therapy after suspension requires review and concurrence by the CMO and/or an ad hoc pain management team consisting of at least one other physician.

The protocol also provides guidance for the prescribing of the opioid antagonist naloxone (Narcan) as well as guidelines for how to taper patients off of narcotics when they are no longer needed for pain management. Additional guidance is provided for patients with chronic pain who are also receiving psychiatric medication management. Medical providers collaborate with the patient's behavioral health providers to determine the best treatment plan for the patient.

Since the adoption of the pain management protocol the use of narcotics for chronic pain management has dramatically decreased. In March of 2016, the number of narcotic scripts written was 392 and in March 2018 the number was down to 270. New providers have minimal number of patients on narcotics for chronic pain management. Long-term providers who may have existing patients on chronic narcotics, are working in collaboration with their patients to taper their dose or even stop narcotics altogether while still effectively managing patients' pain.

Utilizing the protocol allows an organization to be standardized and consistent in its approach to chronic pain management and chronic narcotic prescribing. CHC has found this to be so successful that it is adopting the same model to develop and implement a protocol for benzodiazepine prescribing.

Any health center wishing to learn more about the protocol, how it was developed and how it has been implemented at CHC is welcome to contact Lucille Songer, RN, MS, Chief Quality & Compliance Officer at lsonger@chcfhc.org.

Grantee: **Harbor Health Services (HHSI)**
                       Mattapan, MA (CH)

Management and Finance, *Single Intranet Tool*:

HHSI is a diverse and complex organization with eight locations spread out over 100 miles from Boston to Provincetown. There were multiple systems for managing policies, protocols, and projects, including an unused intranet, network drives, paper files, and email. To operate more efficiently, HHSI needed a better tool to communicate and coordinate work across locations and departments.

HHSI selected a new tool for its intranet and successfully launched it in two months. Success depended on ensuring that the new system was easy to use, had leadership buy-in, and was able to get widespread adoption. The key success factors tracked were: 1) the characteristics of the system chosen; 2) achieving successful and sustained engagement of the staff; and 3) critical initial content and functionality for the launch. Features include easy access to policies, a platform for sharing clinical best practices, project management/team collaboration tools, and a communication platform. The engagement of staff was achieved through the inclusion of all sites and departments in the launch and post-launch teams, and initially highlighting the social aspects of the platform. The post-launch team was expanded to include representatives from every

department, which now ensures that all departments have a plan for content growth and training on the ways to use it for project management and team collaboration.

The new intranet saves staff and leaders time, makes HHSI more efficient overall and brings a new level of transparency to operations. Two thousand pages of information have been created and organized in the eight months since implementation. Every employee uses it daily (all web browsers are set to open it as the home page), to stay informed about HHSI news, learn a procedure, share a clinical guideline, or manage a project. Some examples of the use of the intranet include cross-team organizational quality improvement (QI), which achieves significantly better diabetes control through shared best practices and feedback among team members supported by the system. In policy and guideline management, over 200 policies were revised and implemented in a user-friendly manner; in project management, team communication and best practices were improved. Every department has a page to communicate important protocols, team news, and performance metrics. HHSI has better communication through an improved employee experience through a common platform for communication.

MICHIGAN

Grantee: **Northwest Michigan Health Services, Inc. (NMHS)**
                                 Traverse City, MI (MH, CH)

Management and Finance, *Kiosk Patient Check-In*:

One of NMHS's sites is located in a rural area and physically co-located with other community social service agencies. When walking into the building, there is one waiting room, with three different windows for patients to go to. The first window to the left is NMHS, the second window is the local health department's Women, Infants and Children (WIC) program, and the third window is the local behavioral health agency. If a patient walks in the door, it can be very confusing as to which way to go and where to check in for the appointment.

To alleviate the stress of patients not knowing where to go once they enter the door, NMHS uses a kiosk system. Before the patient's appointment, patients are telephoned, and the kiosk is explained. Signage is clearly placed, and the kiosks are visible as soon as you walk in. The patient inputs their last name and first initial, which prompts the kiosk to ask the purpose of their visit. Choices are medical, dental, behavioral health, or other. Once completed, the kiosk prompts each of the staff members at the windows to check their schedule and then call the patient to the

appropriate window. This notification is on the back end, which minimizes patient disruption. Even though NMHS's patient population is older, along with migrant and seasonal farm workers, there are no challenges with using the kiosk. The information on the kiosk is in English and Spanish. There is also a sign that states, "If you haven't been called up within 15 minutes, please come to the NMHS window."

NMHS uses patient surveys to determine whether this method of check-in works for patients. Of the majority of patients served, qualitative data presented noted that patients feel that this method of check-in is easier for them and easier to understand.

This clinical workflow can be replicated in all health centers. Costs associated with this workflow would be the cost of the kiosk and the interface to communicate with the Electronic Health Record (EHR). After the initial cost, there are no additional costs.

NORTH CAROLINA

Grantee: **Piedmont Health Services, Inc. (PHS)**
Carrboro, NC (CH)

Clinical Services, *Medical Student Project Manager*:

The challenge for PHS is how to best integrate medical students into the quality improvement architecture of the organization. Too often in the past, medical students completed assigned projects during their rotations, but the findings were not transmitted to the larger organization for a lasting benefit to patient care.

PHS has assigned a centralized project manager to the medical student training effort. This individual helps incoming medical students understand the mission of the agency, the key health disparities faced by the community, organizational quality priorities, and available project data sources. The CMO, manager, and local site clinical staff strive to ensure that the student project selections are highly relevant to the patient populations served. The project manager also works to establish continuity between exiting and entering students. Moreover, a project may be started by one set of medical students and continued by a new set of entering students. All project results are shared at a PHS quality meeting at the end of every trimester. Medical students use a research poster presentation to describe their PDSA cycle, the data they collected,

and whether the PDSA was judged to be successful.. All project results are centrally stored and accessible.

The quality projects of all third-year medical students are evaluated by the UNC School of Medicine faculty competitively, and awards are made in each trimester block. Thus far, PHS-placed medical students have won top honors in each block, and PHS continues to be a popular destination for training. In all cases, process improvements are being used to improve the quality of care.

NEW YORK

Grantee: **Ezras Choilim Health Center, Inc. (ECHC)**
                         Monroe, NY (CH)

Clinical Services, *C-Section Rate Reduction*:

In the United States, the rate of C-sections being performed as opposed to vaginal deliveries had significantly increased in the past couple of decades. According to the National Center for Health Statistics, in 2012, the total number of births was 3,952,841 in the United States, and the C-section birth rate remained at a stable 32.8 percent since 2010. The concern over this rate is due in part to the fact that 32.8 percent is approximately twice the World Health lOrganization's recommended rate of 15 percent. ECHC has a large obstetrical practice, which has grown significantly over the past four years and continues to grow. The center was concerned with rising C-section rates nationally and launched a campaign to reduce the center's rate. Since 2012, ECHC has maintained a rate of less than 4 percent for C-section births. Additionally, despite delivering over 1,000 babies, the center has had no malpractice claims. Each of these statistics is astounding considering the national statistical norms.

ECHC has a very supportive environment. Each doctor has three nurses assigned to work with him/her, one of whom serves as a scribe, allowing the provider to focus only on the patient's needs. Additionally, EAHC assigns two registered nurses to manage incoming phone calls. ECHC also has care managers who work side-by-side with providers to monitor all "high-touch" patients. ECHC's obstetricians staff the hospital 24/7 for incoming deliveries. Women know the provider who will deliver them, as opposed to the utilization of hospitalists. The center stays with women throughout the labor and delivery process, ensuring a high level of support and quality

care. ECHC supports its physicians by allowing them a day off following a 24-hour rotation. This ensures that the team is focused on the current patients, and not on the next day's busy schedule. Finally, there is no financial incentive for a doctor to deliver the patient; all providers are salaried and get paid biweekly, regardless of patient volume.

ECHC monitors obstetric outcomes on a regular basis, not only for C-section rates but also for adverse events and/or "near misses." The center is wholly committed to a high-quality, safe birth experience. ECHC's efforts have resulted in extremely good outcomes for mothers and babies, including a C-section rate that is less than 4 percent, significantly lower than national average.

ECHC believes its model can be successfully replicated elsewhere. Being responsive to patient needs, both cultural and social, helps the provider set expectations for delivery outcomes. Additionally, supporting providers in care provision results in improved outcomes.

PENNSYLVANIA

Grantee: **North Penn Comprehensive Health Services, Inc. (NPCHS)**
                     Lancaster, PA (CH)

Management and Finance, *Patient Safety*:

From March 2017 through July 2018, there were four documented patient falls at the health center, and the health center QI team recognized they had to implement changes to assure this trend did not continue.

A plan was developed and rolled out to staff that involved every team member – from the front line clerical staff, clinical staff, and providers – to provide a safe hand-off through every stage of the appointment by keeping patients safe during the health center visit. If a patient is identified as a high risk for fall, a notation is placed on the encounter and a message is sent to the nurse, who provides a safe hand-off. Clinical staff assist the patient to the exam room and identify this patient as high risk for fall to the provider by attaching a notation to the outside of the exam room door. This alerts the provider and any other staff caring for the patient that there is a high risk for fall, so the team can assist the patient from stop to stop during their visit.

With the initiation of the program, there has been a decline in patient falls from four in 15 months, to zero in the three months since the approach was initiated. Notation/fall safety has been added as a standing agenda item on monthly safety and health center meetings.

VIRGINIA

Grantee: **St. Charles Health Council, Inc. (SCHC)**
                    Jonesville, VA (CH)

Governance, *Board Membership***:**

SCHC has 11 primary care clinics spread across seven counties. Although all clinics are located in rural areas, there are significant differences among sites because of relative proximity to larger towns and degree of isolation because of terrain and local community customs. Thus, ensuring adequate and appropriate board member representation was a challenge.

SCHC began as a single clinic and then added locations over time. As a result, these additional sites had their own local boards. In an effort to respect existing local boards, while also meeting the needs of the growing overall organization, Stone Mountain decided to utilize a tiered approach. Local boards maintain oversight of their individual clinic(s) and elect representatives to participate on an overarching board that has oversight over the entire organization. Local boards have a pool of their own candidates from which to select, in the event that an elected member is unable or unwilling to continue serving on the overarching board. This approach meets the individual community needs while also allowing the organization to meet HRSA requirements regarding board composition.

The local boards have been able to recruit and retain members who are representative of, and knowledgeable about, their communities. The overarching board has had a healthy mix of members who bring a long-term approach and memory of past cycles of events, along with newer members who are willing to ask questions in order to understand the history, as well as identify changes in the environment. Board member satisfaction remains high at both local and overarching levels. The health center lost two long-term board members, including the board chair, within three months in 2013, and lost an additional three board members within a two-month period during 2017. Because of SCHC's ability to tap into the local board's pool of trained and highly committed members, the board ensured continuity of governance.

ACRONYMS

Acronym	Meaning
BPHC	Bureau of Primary Health Care
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CEU	Continuing Education Units
CH	Community Health
CME	Continuing Medical Education
CMO	Chief Medical Officer
COO	Chief Operating Officer
CS	Central Southeast Division
CY	Calendar Year
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Services
FTE	Full-Time Equivalent
HC	Health Center
HEDIS	Healthcare Effectiveness Data Information Set
HIE	Health Information Exchange

HIPAA	Health Insurance Portability and Accountability Act
HO	Health Care for the Homeless
HRSA	Health Resources and Services Administration
KPI	Key Performance Indicator
MA	Medical Assistant
MAT	Medicine Assisted Therapy
MH	Migrant Health
NADA	National Acupuncture Detoxification Association
NCD	North Central Division
NCHS	National Center for Health Statistics
NED	Northeast Division
NMD	North Midwest Division
NWD	Northwest Division
OPPD	Office of Policy Program Development
OSV	Operational Site Visit
OUD	Opioid Use Disorder
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PDSA	Plan, Do, Study, Act
PH	Public Housing
PI	Process Improvement

PPS	Prospective Payment System
QA	Quality Assurance
QI	Quality Improvement
RD	Registered Dietician
RN	Registered Nurse
SED	Southeast Division
SMV	Shared Medical Visits
SWD	Southwest Division
UDS	Uniform Data System
WIC	Women, Infants and Children

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

Area of Operations	Type	Sub-Type	State	Grantee	Special Populations
Clinical Services	Congestive Heart Failure Intervention	Quality Improvement	California	San Joaquin, County of	N/A
Clinical Services	Shared Medical Visits	Managing Chronic Conditions	California	University of California, Irvine	CH
Clinical Services	Telehealth Program Manager	Specialty Care	California	Clinicas de Salud del Pueblo, Inc.	MH, CH, HCH
Clinical Services	Opioid and Substance Abuse	Behavioral Health	Illinois	PCC Community Wellness Center	CH
Clinical Services	Opioid and Substance Abuse	Behavioral Health	Massachusetts	Community Health Connections, Inc.	CH, PHPC, HCH
Clinical Services	Medical Student Project Manager	Quality Improvement	North Carolina	Piedmont Health Services, Inc.	CH
Clinical Services	C-Section Rate Reduction	Quality Improvement	New York	Ezras Choilim Health Center, Inc.	CH
Management and Finance	Texting Patients	Quality Improvement	California	Alliance Medical Center, Inc.	CH
Management and Finance	Staff Training	Customer Service	California	Clinicas de Salud del Pueblo, Inc.	MH, CH, HCH
Management and Finance	Intranet	Quality Improvement	Massachusetts	Harbor Health Services	CH
Management and Finance	Kiosk Patient Check-In	Customer Service	Michigan	Northwest Michigan Health Services, Inc.	MH, CH

Area of Operations	Type	Sub-Type	State	Grantee	Special Populations
Management and Finance	Patient Safety	Quality Improvement	Pennsylvania	North Penn Comprehensive Health Services, Inc.	CH
Governance	Board Membership	N/A	Virgnia	St. Charles Health Council, Inc. (SCHC)	N/A