Baton Rouge Primary Care Collaborative, Inc.
Doctors Committed to Wellness and Disease Prevention

Strategic Planning Retreat

April 26, 2013 (Updates in RED thru 2014)

Hilton Garden Inn, Baton Rouge, LA

Board Members

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Martha Forbes, Vice Chairperson
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James Forbes, Parliamentarian
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Stacie Bland, Assoc. Medical Director
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Donna Smith, MA
Domonique Harris, MA
Christie Gwinn, FDC
Arletha Jack, FDC
Joyce Boatner, Billing/Office Mgr.
Mildred Roberts, Business Office Mgr.
Lynne Medley-Long,

Stakeholders

Jonathan Chapman, LA Primary Care Association
Gwendolyn Laury, Louisiana Health Care Connections
Stephanie Decker, Charter Health Care

Introductions

Ms. Lynne Medley-Long, CEO of Baton Rouge Primary Care Collaborative began the planning session with welcome, personal comments, and exercise.

Organizational Overview/Purpose of Strategic Planning

Mr. Jonathan Chapman, Executive Director of the Louisiana Primary Care Association, made brief comments regarding the association and need and intentions for the planning session.

History of Organization

Ms. Long presented materials on the history of BRPCC and provided a general organizational status along with a visual of the BRPCC Descriptive Model.

Mission, Vision and Value Statements

Mr. Chapman led the group through a review of the organization's mission and vision statements that included an overview of the survey results and word exercise. After discussing the current statements the group decided that the mission and vision statements were somewhat accurate but some revisions were appropriate at this time.

MISSION STATEMENT:
To increase access to high quality comprehensive primary and preventative health care services for the underserved population of East Baton Rouge Parish and the surrounding areas regardless of ability to pay.

POSSIBLE MISSION STATEMENT:
Baton Rouge Primary Care Collaborative will be a primary community medical healthcare facility serving the Greater Baton Rouge metropolitan area with a continuing commitment to the Homeless Population

VISION STATEMENT:
By 2012, Baton Rouge Primary Care Collaborative (BRPCC) will be the premiere community medical healthcare facility serving both the North Baton Rouge community and the Homeless populations of metropolitan Baton Rouge by providing an active role in addressing public health issues to achieve sustainable, high quality, and affordable health care.

POSSIBLE VISION STATEMENT
Baton Rouge Primary Care Collaborative will be a comprehensive, high quality community health center serving each patient with care and compassion.

Environmental Assessment

Both Ms. Long and Mr. Chapman spoke on a significant amount of diverse information regarding the local, state and national health care environments as well as provided an organizational context for planning discussions.

Stakeholder Presentations

Ms. Gwen Laury, of Louisiana Healthcare Connections, presented information on various quality measures and operations including Patient Centered Medical Home (PCMH).

While there was no representative from the Department of Health and Hospitals, as a former employee Mr. Chapman briefly addressed the information and initiatives included in their provided

slides. Topics included Health Professional Shortage Areas (HPSA), Public Health System, and Behavioral Health Service Integration.

Strategic Priorities

As part of an effort to tie much of the day's information together, Mr. Chapman briefly referenced the survey results regarding Strengths, Weaknesses, Opportunities and Threats (SWOT) before instructing the participants to separate into four smaller groups (policy, marketplace, clinical programs and services and operations) to discuss, identify and prioritize strategic actions they would like the health center to implement over the next three years.

After 45 minutes, Mr. Chapman reconvened the participants and collected their priorities one group at a time. The results were as follows:

1. Policy
    a. Advocacy
        i. Promote and generate awareness of BRPCC
        ii. Address physical (transportation) accessibility to BRPCC
    b. Negotiations and Policy Compliance
        i. Board identify focus for next six months to prepare for January 2014 and its Health Care changes.

The *Center* has worked diligently over the past year to increase access and vigorously promote awareness of services available for the underserved as a result of the massive changes occurring within the charity care system. Early in 2013, the Public Relations and Education Board Committee developed a Public Relations and Marketing Plan and attended marketing seminars hosted by local television stations in the area in an effort to increase the *Center's* visibility in the community as neighboring facilities began to close. As a result of this plan, the *Center* developed new marketing materials (brochures, flyers, and give-aways) as well as created a company website, which included the development of an "Patient Portal" where patients can make appointments, check lab results, obtain copies of medical records and communicate directly with their Primary Care Provider. www.brpcc.org.

In addition, The *Center* invested in a massive television advertisement campaign which is contracted to run from March, 2013 to March, 2014. An investment of $30,000.00 was made by the *Center* to improve visibility, awareness and access to services for the uninsured. This investment has been extremely valuable and beneficial with regard to reassuring the community in the throes of loosing services and providers but also had residual benefits of assisting the *Center* in its first steps to "re-brand" and improve its image and reputation in the community given the financial challenges it had faced. The *Center* has become more visible and competitive in the local community. One of the television Ads appears on the Center's website.

Through connections made by the *Center's* Board Chairperson, Southern University School of Business was approached and has agreed to provide technical support on a planning an Annual Gala event for the *Center* which will be open to the public. Volunteer from Delta Sigma have also been approached and have agreed to serve on a

planning committee for this community event. It is anticipated that an Annual Gala will be held in 2014.

During the year, the Center also developed a new "community" Newsletter (Community Caring). The Newsletter format used is intended not only communicate important activities of the *Center,* but also to place names and faces on the many dedicated staff member serving to carry out the mission of the *Center.* The Newsletter also indicates and attempts to educate patients and staff on the amount of change occurring in the healthcare industry currently, and expected over the next year. A Newsletter format was selected to provide "bite-sized" relevant information in large amounts to ensure the Center's patients stay on top of all of the changes and reform activities.

As the implementation of the Sequestration laws and the ACA began over the past year, including recent news issued by the National Association of Community Health Centers (NACHC), the need to fix the Health Center funding cliff gets more urgent, advocacy within the *Center* has will become more important to overcome the challenges and take advantage of the opportunities. Board members of the *Center* have attended Louisiana Governance Academy seminars hosted by Louisiana Primary Care Association (LPCA) on the importance of advocacy to FQHCs, building a Culture of Advocacy; legal issues of advocacy, lobbying, and v voter registration and understanding the legislative process. The *Center's* Board Chairperson has been one of the most active board members in these endeavors.

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2. Clinical Programs
    a. PCMH – Care Coordination
        i. Both sites certified at Level 3 PCMG
        ii. Follow up Referrals
        iii. Establish relationships with other providers and medical facilities
        iv. Integrate Mental and Behavioral Health
            1. Expand provider types/specialties
            2. Screening Patients for Issues
            3. In-house referrals
            4. Acknowledgement of Patient's specific Spiritual preferences (cultural, ethnicity, etc)

Because of the **high prevalence rate of diabete and Heart Disease** among the Center's patient population, the Center has been engaged in a HRSA-funded regional collaborative to implement a best practices model of chronic care disease management for all 500+ of its diabetic patients. The project created a Health Centered Controlled Network (HCCN) and is called the Accelerating Clinical Quality through Health Information Technology (ACQ-HIT) project. This specially funded HRSA project is a partnership involving the Louisiana Public Health Institute (LPHI), Crescent City Beacon Community (CCBC), the Louisiana Primary Care Association (LPCA) and 16 FQHCs (including BRPCC). The projects aim is provide Technical Assistance in Quality Improvement and to harmonize, align & use Clinical Quality Measures (CQM) within the existing electronic medical records (SuccessEHS) shared by all participating FQHC . This project will also seek to provide a platform for CQM validation, future information exchange and sharing of Best Practice to ensure compliance with the HI-TECH Act as well as transfer the BEST PRACTICES of the noted Crescent City Beacon Community project which began in New Orleans and is spreading

throughout the state of Louisiana.

Over the past year, the Quality Assurance Committee has, among other things:

- Reviewed and improved protocols for its Coordination of Care (**Referral Tracking**)
- Created a **Referral Coordinator** (PS) devoted solely to Referral Coordination
- **Hospital Admitting Privileges and Continuity of Care** – MOU with OLOL for diagnostic testing/specialty services and Contract with Dr. Jonathan Roberts for hospital admissions (7/2013 and 1/2014 respectively)
- Revised Standing orders to include Population Management (Diabetics and Hypertensive patients) and follow up monitoring system.
- Increased same day appointments and reduced no show rates and waiting times by implementing CQI principles and PDS cycles.
- Initiated a pain management campaign to better protect patient safety.
- Evaluated the use of the PHQ2 and PHQ9 questionnaire to more consistently screen for adult depression along with implementing a host of other evidence-based practice guidelines Including Accountable Care Organization (ACO) quality measures monitoring (including patient safety measures, such as avoidable ER visits) in anticipation of additional ACA Health Care law changes and quality of care expectations.
- (ACQ-HIT) project focus on DM and HTN outcome improvements. The Center's has been fully compliant with submitting quarterly reports (by site location) on Diabetes and HTN CQMs and participate in CQI training and Learning Sessions with LPHI to improve data collection, validation and measure reporting and BEST PRACTICE learning and sharing.

BATON ROUGE PRIMARY CARE COLLA

HCCN/Louisiana Public Health Institute - CVD, Diabetes and Opiod Clinical Outcome Measures

03/01/2013 to 02/28/2014

Provider	SB		CH		RG		RS		TOTAL		HRSA Health Plan	
Diabetes - Management and Control	Patients	%	Patients	%	Patients	%	Patients	%	Patients	%	2013 Reported	2014 Goal
Total Diabetic Patients	71		25		67		106		283			
HbA1c Management: Testing	62	87 %	18	72 %	84	97 %	45	42 %	204	72.08 %		
HbA1c Management: Poor Control (Greater Than 9.0%)	17		10		28		19		74			
Patients without HbA1c Results	9		7		9		60		79			
Total Greater than 9.0% or Non-Compliant	**26**	**37 %**	**17**	**68 %**	**31**	**36 %**	**80**	**75 %**	**153**	**54.06 %**	**54%**	**44 %**
HbA1c Management: Control (Less Than 8.0%)	33	46 %	8	32 %	46	53 %	24	23 %	106	37.46 %		
HbA1c Management: Control (Less than 7.0%)	31	44 %	5	20 %	33	38 %	14	13 %	81	28.62 %		
Blood Pressure Management: Control (Less then 140/90)	52	73 %	15	60 %	44	51 %	49	46 %	157	55.48 %		
Blood Pressure Management: Goal (Less than 130/80)	24	34 %	8	32 %	19	22 %	25	24 %	72	25.44 %		
LDL - C Management: Testing	58	82 %	19	76 %	75	86 %	40	48 %	192	67.84 %		
LDL - C Management: Control (Less than 100 mg/DL)	28	39 %	8	32 %	25	29 %	16	15 %		26.50 %		
Nephropathy Assessment: Urine Protein Screening	44	62 %	10	40 %	40	46 %	14	13 %	109	38.52 %		
Eye Examination	0	0 %	0	0 %	0	0 %	0	0 %	0	0.00 %		
Foot Examination	0	0 %	0	0 %	0	0 %	0	0 %	0	0.00 %		
Hypertension - Blood Pressure Control		%		%		%		%		%		
Denominator: Patients 18 and older with Hypertension	258		82		326		464		1125			
Numerator: Patients with last BP < 140/90	154	60 %	34	41 %	149	46 %	154	33 %	498	44 %	**52%**	**60%**
IVD - Blood Pressure Management		%		%		%		%		%		
Denominator: Patients 18 and older with IVD	3		1		0		13		26			
Numerator: Patients with last BP < 140/90	2	67 %	0	0 %	0	0 %	5	38 %	10	38 %		
Complete Lipid Profile		%		%		%		%		%		
Denominator: Patients 18 and older with IVD	3		1		0		13		26			
Numerator: Patients with full Lipid Profile	2	67 %	1	100 %		0 %	5	38 %	10	38 %		
Drug Therapy for Lowering LDL Cholesterol		%		%		%		%		%		
Denominator: Patients 18 and older with CAD	6		6		4		19		43			
Numerator: Patients taking a Lipid Lowering Medication	4	67 %	3	50 %	0	0 %	10	53 %	24	56 %	**56%**	**60%**
Use of Aspirin or Another Antithrombotic		%		%		%		%		%		
Denominator: Patients 18 and older with IVD	3		1		0		13		26			
Numerator: Patients taking Aspirin or another Antithrombo	1	33 %	0	0 %	0	0 %	4	31 %	10	38 %	**40%**	**60%**
Pain Management (Pts w/Opiod Rx) Schedule 2 only	34		2				3					

Based on the Mayor's Healthy City Initiative (MedBR), the top four priorities for 2012-2015 in Baton Rouge are obesity, HIV/AIDS, ER utilization, and mental/behavioral health. Research has shown that more than 70 percent of primary care visits stem from behavioral health issues. Depression is the most common, currently affecting more a quarter of the U.S. adult population, and it is predicted to be the second leading cause of disability in the United States by 2020. Depression is the third

most common condition diagnosed by health centers. It is clear that primary care settings have become an important access point for addressing both physical and behavioral health care needs.

BRPCC has submitted a 2 year HRSA Behavioral Health Integration (BHI) Grant in April 2014. The HRSA BHI grant will start in September, 2014 and run through August, 2016). The BHI integration model used will target low behavioral health and low physical health complexity/risk individuals served at the Center and provide for the use of standard BH universal screening tools (SBIRT and practice guidelines. Use of standardized BH tools and a tracking/registry system will focus on warm "hand-off" referrals of a subset of the population by the PCP to an on-site BH Specialist. The role of the primary care based BH Specialist will be to provide formal and informal consultation to the PCP as well as to provide BH triage, assessment, brief treatment services, community and educational resources, health risk education, chronic care management and referrals (for high complexity services) to Capital Area Human Service District (CAHSD). On-site Integrated BH and support services will include individual or group services, use of cognitive behavioral therapy, psycho-education, brief SA intervention, and chronic care case management. The BH Specialist will be competent and trained to prescribe psychotropic medications using treatment algorithms and will have access to psychiatric consultation regarding medication management.

The Scope of this BHI Project is to integrate BH into the daily patient care process at both of the *Center'* primary care sites and to: 1.) hire 1.0 FTE Medical Psychologist to serve as a BH specialist and provide and curb-side consultation on medication management to Primary Care Providers (PCP's) 5 days each week 2.) to hire 1.0 FTE Chronic Care Manager and 3.) hire 1.0 FTE Enabling Service Worker. This BHI project will result in a fully-integrated BH program. The proposed outcome of this BHI Project is to create a fully-integrated behavioral health service program that provides access and availability to comprehensive health care for the growing number of uninsured, underinsured and homeless living in the East Baton Rouge Parish served by The *Center's* medical clinics. This BHI program will enable the *Center* to provide behavioral health services to 40% of its existing Medical patients and add 1,575 behavioral health patients and 3,006 behavioral health encounters by the end of the Project Period.

BRPCC has identified the following training needs of existing behavioral health providers and plans to use the Advanced Integrated Mental Health Solutions (AIMS) Center Academy for comprehensive training that focuses on training:

- Health Care Providers (PCPs)
  - Patient education and communication
  - The use of clinical tracking tools
  - Evidenced-based SBRIT interventions
  - Evidenced-based medication management for common mental disorders
    - Comprehensive Prescribing
    - Prescribing for Antidepressants
    - Prescribing Directions for Anxiolytics and Hypnotics
    - Prescribing Directions for ADHD
    - Prescribing Directions for Mood Stablizers
    - Prescribing Directions for Antipsychotics
    - Prescribing Directions for Miscellaneous Supplemental Medications
  - Effective mental health consultation

- Clinical Social Workers and Care Managers
  - Introduction to Integrated Depression Care
  - Key Components of Integrated Care
  - Behavioral Activation
  - Antidepressant Medications
  - Problem-Solving Treatments
  - Challenging Cases and Psychiatric Consultation
  - Chronic Pain and Depression

- Chronic Medical Illness and Depression
- Maternal Depression
- Adolescents and Depression
- Implementing Lessons from the real world
- Planning Implementation
- Financing Integrated Mental Health Care

- Health Care Administrators
  - Team Building
  - Billing and Reimbursement
  - Clinical Workflows
  - Change Management

Stage I BHI:
Based on joint planning, shared strategies and mutual goals, additional plans are underway with CAHSD to have CAHSD occupy space at Jewel Newman Community Center and co-locate a CASHD Clinical Social Worker (CSW) on site at BRPCC and also to have both parties to participate in and utilize Louisiana Health Information Exchange (LaHIE) for shared clinical records. This would move BRPCC to a level of BHI best defined as Close Collaboration in a partially integrated system.

Stage II BHI:
Additionally, plans are currently underway to move BRPCC to fully-integrated BHI. Based on joint planning, shared strategies and mutual goals, plans are also underway with another local FQHC, (RKM Primary Care), to share behavioral health staff (specifically a Psychiatrist/Medical Psychologist) and to integrate tele- medicine (through the RKM site) in the provision of integrated behavioral health services and to also have RKM participate in and utilize LaHIE for shared clinical records.
It is important to note that LaHIE as part of the American Recovery and Reinvestment Act (ARRA) advances health information exchange among providers and hospitals in the state of Louisiana and allows authorized provider organizations to electronically access and share health-related information through a secure and confidential network for the purpose of improving patient safety, quality of care and improving health outcomes.

BRPCC also plans to hire a full-time Care Manager to manage and coordinate care, integrate clinical documentation and treatment records as well as to coordinate interdisciplinary clinical meetings to include BRPCC PCPs, CAHSD on-site CSW's, BRPCC Care Manager's and RKM Consulting Psychiatrist's/Medical Psychologist's. The overall goal of this project is to create and implement a fully integrated BHI "Collaborative Care" program. Collaborative Care is a specific type of evidence-based integrated care model that brings high quality mental health care to the familiar setting of a Primary Care Provider's office, like BRPCC. Collaborative Care at BRPCC will be patient-centered and provide integrated care for medical and mental health needs. The IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) model will be fully implemented by the end of the project. Based on documented research evidence as reported in December, 2012 issue of the Journal of the American Medical Association (JAMA), the IMPACT model of depression care more than doubles the effectiveness of depression treatment for older adults in primary care settings. Other published research studies and evaluations of ongoing programs show that IMPACT is also effective with a range of depressed patients including diabetics, cancer patients and adolescents.

The guiding principles and core components of BRPCC's BHI Collaborative Care program, developed by a group of experts in integrated behavioral health care with support from the John A. Hartford Foundation, The Robert Wood Johnson Foundation, the Agency for Healthcare Research and Quality and the California Healthcare Foundation, will include the following:

Guiding Principles

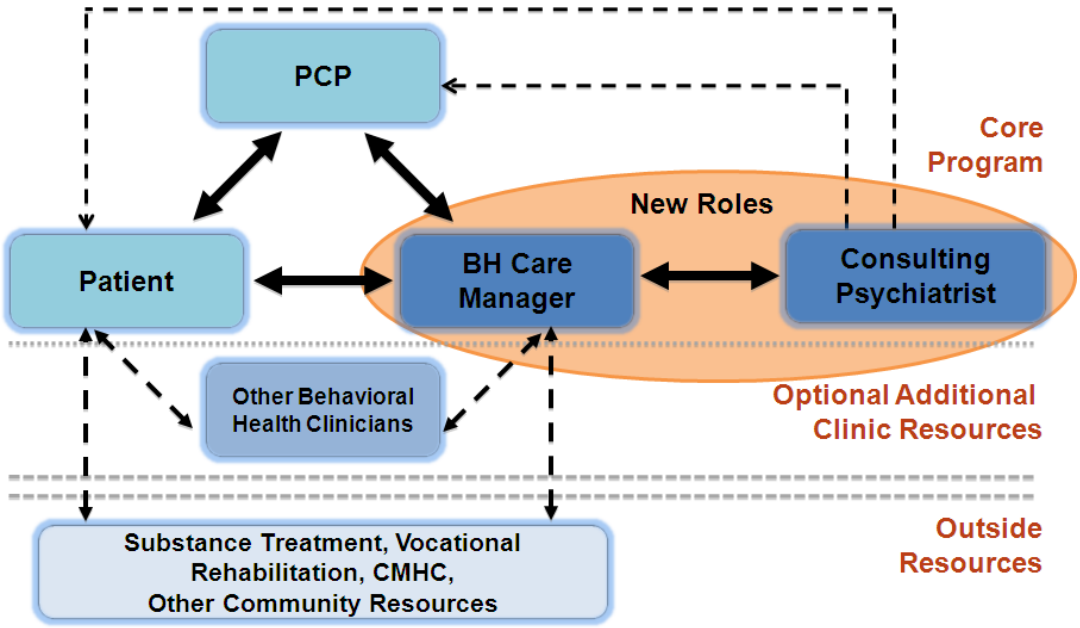
- Patient-Centered Care
- Population-Based Care
- Measurement-based Treatment Targets
- Evidenced-based Care
- Accountable Care
- Patient Identification and Diagnosis
- Patient Engagement in Integrated Care

Core Components

- Evidence-based Screening/Treatment (SBRIT)
- Systematic Follow-up, Treatment Adjustment and Relapse Prevention
- Communication and Care Coordination
- Systematic Case Review and Psychiatric Consultation

This would bring BRPCC to Fully Integrated BHI defined as Close Collaboration in a fully integrated system where providers within one organization are part of the same team with regular treatment meetings and shared systems.

The patient experiences behavioral health treatment as part of his/her regular primary care and would be completed by the end of the project period. See diagram below:



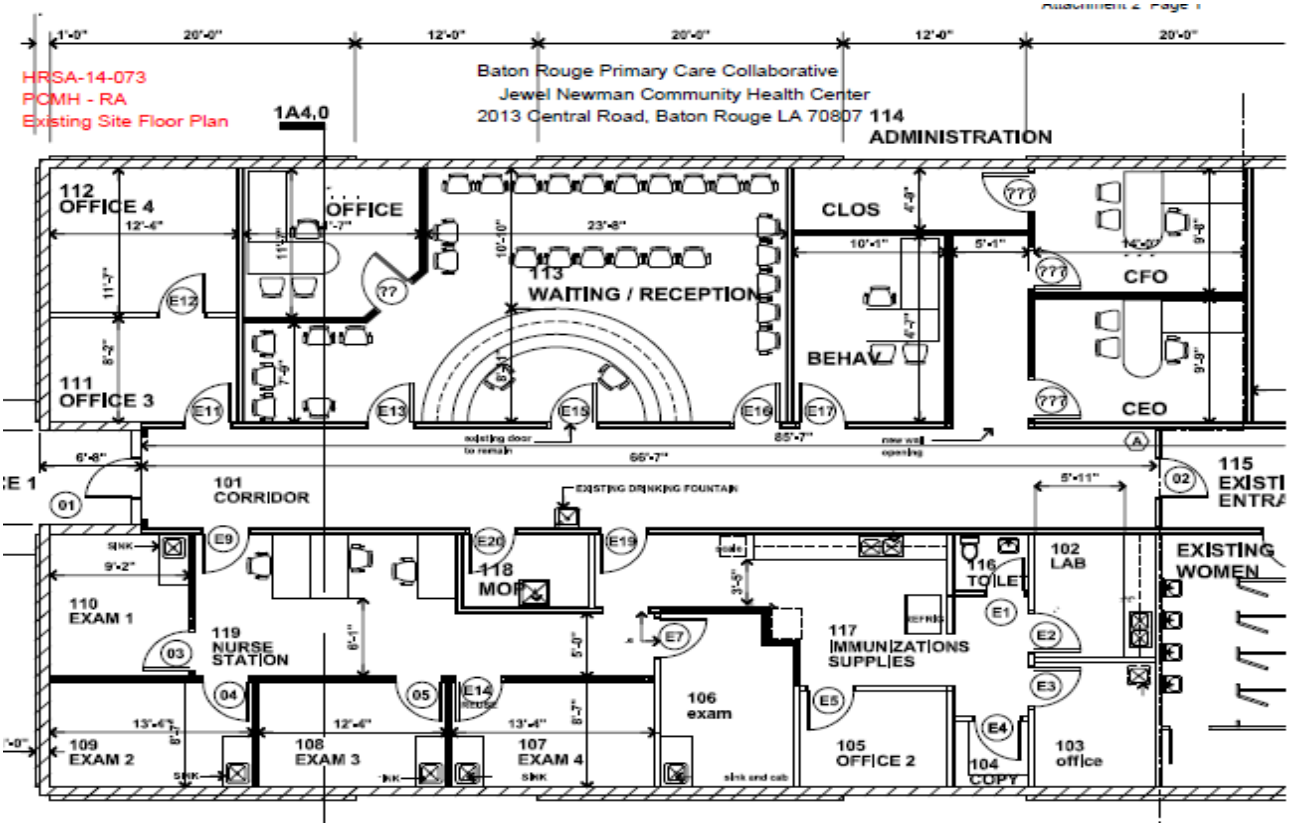
The PCMH Renovation/Alteration (PCMH-RA) grant project was submitted in April, 2014 to HRSA for funding of $250,000 and is ultimately designed to redesigned processes, standard work, create new staff team roles, and renovated space within the Center to dramatically improve patients' experience of care with reduced waiting times and reduced distances to walk. As a model Patient-Centered Medical Home, the newly renovated Center is central to the continuous improvement of both our clinical work and our clinical teaching, reflecting the Center's mission to provide leadership in patient care, education and training. The foundation for this transforming work is an organizational management philosophy called Lean. The basic principles of Lean are respect for people and continuous improvement. With Lean, the Center will use current space more efficiently and create spaces and processes that help our systems work better for patients and staff. As part of this vision, the Center CQI team has will begin working with Lean transformation consultants and architects experienced in health care space design to renovate space to

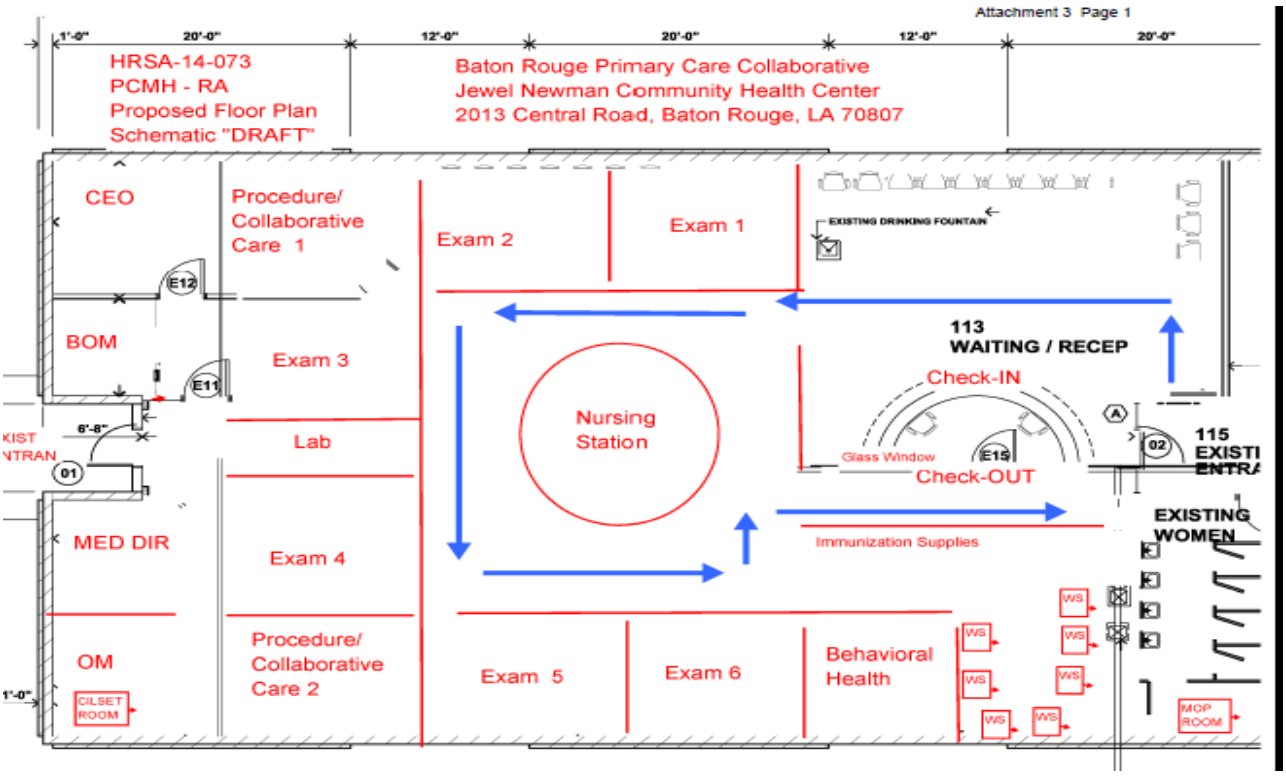
better meet the needs of our patients.

The Proposed outcome of this PCMH-RA project will include:

- A redesign of two procedural suites to allow for continued expansion of Sports Medicine and other procedures
- A redesigned front desk and waiting area to support simplified patient flow with reduced waiting and increased privacy and convenience
- A redesign of clinical space to create two additional exam rooms, including space for group visits
- Creation of space for integrated behavioral health and embedded case management
- Building changes necessary to allow extension of hours to evenings and weekends

In addition, another proposed outcome of this PCMH- RA Project is to complement a fully-integrated behavioral health service program currently underway at the Center that will provide access and availability to comprehensive health care for the growing number of uninsured, underinsured and homeless living in the East Baton Rouge Parish served by The *Center's* medical clinics.





b. Workforce
    i. Shortages
        1. Recruitment = retention through preceptorship
        2. Monthly staff satisfaction surveys
    ii. Teaching Health
        1. Incorporate local students
        2. Expand opportunities for mid-levels
c. Health Fairs

The demand from new patients was so great, that the *Center* visits increased by 40% in the past year alone, the Center implemented

1. New FT Nurse Practitioner hired (RG 2/2013 and KT 4/2014)
2. New PT MD hired (moved from .09 to full time 1/2014)
3. Contract for 2 AmeriCorp Service Workers for 1 year (clinical staffing).
   Louisiana Primary Care Association (LPCA) will pay 50% of salary.
4. Medical Director Separation Agreement executed (3/2014)
5. New Medical Director Recruited 12/ 2013 (internal promotion SB)
6. Employee Benefits – enhancement.
   - 401k – Retirement Benefits (pending increased financial performance)

- Health Insurance Opt Out
- PTO Buy-Back Option (includes reduction below 24 hrs/wk)

7. Quarterly Incentive Bonuses were tied to Patient Revenue goals/targets in 2012
8. Job Performance Evaluations now include Productivity standards 2013
9. Quarterly performance evaluations now tied to both Patient visit and clinical outcome measures 2013
10. OLOL College Physician Assistant Training Agreement (currently 2 PA students rotating)
11. OLOL Service Learning Program Training Agreement (currently 28 PA students rotating – 2 per week)
12. Volunteer RN – One Stop (4/2014)

3. Operations
    a. Efficient and Effective Operational Systems
        i. Clear plans and goals
        ii. EMR system that is user friendly
        iii. Desktop PC vs Notebook vs voice activated systems (IPads)
        iv. Staff properly skilled and trained
        v. Effective way of time keeping (ID badge)
        vi. Transportation for patients (reestablish bus line, grant for vans, etc)
        vii. Enough staff to adequately do the job
        viii. Emergency equipment and training/contingency planning (CPR, disaster plan, etc)
        ix. Security for staff and patients
        x. Offer comprehensive services (dental, mental, rehab, vision, pain mgmt., referral services, etc)
    b. Insurance Exchange (Marketplace) Implementation
        i. Efficient and Effective telephone system
        ii. Make sure all providers are properly credentialed and all HIPAA guidelines are met
        iii. Ensure BRPCC is identified as a PCMH facility
        iv. Social Services bulletin board (WIC, food stamps, housing, food, etc)
        v. Services membership on site (Medicaid, LaCHIP, etc)
        vi. Grant funding, expansion funds, support funds (vision, etc)
        vii. Partnership with health units

Baton Rouge Primary Care Collaborative
Patient-Centered Medical Home
Team Assignments

Dr. Stacey Bland - TEAM 1

	Clinic Sessions				Work Schedules												
					Christi Gwinn, FDC				Kimberly Hawkins, MA				Stacie Bland, FNP				
	AM JN	HRS	PM JN	HRS	FDC	SHD HRS	Lunch	Work Total	Clinical	SHD HRS	Lunch	Work Total	Provider	SHD HRS	Lunch	Work Total	
Monday	8am-12pm	4	1pm-5pm	4	7:45am-5pm	9.25	1	8.25	8am-5pm	9	1	8	8am-5pm	9	1	8	
Tuesday	8am-12pm	4	1pm-5pm	4	7:45am-5pm	9.25	1	8.25	8am-5pm	9	1	8	8am-5pm	9	1	8	
Wednesday	8am-12pm	4	1pm-5pm	4	7:45am-5pm	9.25	1	8.25	8am-5pm	9	1	8	8am-5pm	9	1	8	
Thursday	8am-12pm	4	1pm-5pm	4	7:45am-5pm	9.25	1	8.25	8am-5pm	9	1	8	8am-5pm	9	1	8	
Friday	8am-12pm	4			7:45am-12pm	4.25		4.25	8am-12pm	4		4	8am-5pm	8		8	Includes 4 Hours Provider Admin
		20		16		41.25		37.25		40		36		44		40	

Dr. Corey Hall - TEAM 2

	Clinic Sessions				Work Schedules												
					Domonique Harris, FDC				Donna Smith, MA				Corey Hall, MD				
	AM OS	HRS	PM JN	HRS	FDC	SHD HRS	Lunch	Work Total	Clinical	SHD HRS	Lunch	Work Total	Provider	SHD HRS	Lunch	Work Total	
Monday	9am-1pm	4	2pm-6pm	4	8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-6p	9.00	1	8	
Tuesday	9am-1pm	4			8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-1p	4.00		4	Non-Provider Staff work at JN for PM session
Wednesday	9am-1pm	4	2pm-6pm	4	8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-6p	9.00	1	8	
Thursday	9am-1pm	4	2pm-7pm	5	8:30am-7p	10.50	1	9.5	9am-7p	10.00	1	9	9:am-7p	10.00	1	9	
Friday			9am-1pm	4	8:45am-1:00p	4.25		4.25	9am-1pm	4.00		4	9am-1pm	8.00		8	Includes 4 Hours Provider Admin
		16		17		41.75		37.75		41		37		40		37	

April 14, 2014

Baton Rouge Primary Care Collaborative
Patient-Centered Medical Home

Dr. Corey Hall - TEAM 2 (CHANGE EFFECTIVE May 1, 2014)

	Clinic Sessions				Work Schedules											
					Domonique Harris, FDC				Donna Smith, MA				Corey Hall, MD				
	AM OS	HRS	PM JN	HRS	FDC	SHD HRS	Lunch	Work Total	Clinical	SHD HRS	Lunch	Work Total	Provider	SHD HRS	Lunch	Work Total	
Monday	9am-5pm	8			8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-6p	9.00	1	8	
Tuesday	9am-1pm	4			8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-1p	4.00		4	Non-Provider Staff work at OS all day
Vednesday	9am-5pm	8			8:30am-5:30p	9.00	1	8	9am-6pm	9.00	1	8	9:am-6p	9.00	1	8	
Thursday	9am-1pm	4	2pm-7pm	5	8:30am-7p	10.50	1	9.5	9am-7p	10.00	1	9	9:am-7p	10.00	1	9	
Friday			9am-1pm	4	8:45am-1:00p	4.25		4.25	9am-1pm	4.00		4	9am-1pm	8.00		8	Includes 4 Hours Provider Admin
		24		9		41.75		37.75		41		37		40		37	

Karra Thomas and Rachel Gray - TEAM 3

	Clinic Sessions				Work Schedules												
					Arleatha Jack, FDC				NaQuilla Morris				Karra Thomas/Rachel Gray				Staff Changes
	AM JN	HRS	PM JN	HRS	FDC	SHD HRS	Lunch	Work Total	Clinical	SHD HRS	Lunch	Work Total	Provider	SHD HRS	Lunch	Work Total	
Monday	8am-12pm	4	1pm-5pm	4	8am-5pm	9.00	1	8	8am-5pm	9.00	1	8	8am-5pm	9	1	8	
Tuesday	8am-12pm	4	1pm-5pm	4	8am-5pm	9.00	1	8	8am-5pm	9.00	1	8	8am-5pm	9	1	8	
Vednesday	8am-12pm	4	1pm-5pm	4	8am-5pm	9.00	1	8	8am-5pm	9.00	1	8	8am-5pm	9	1	8	
Thursday	8am-12pm	4	1pm-5pm	4	8am-5pm	9.00	1	8	8am-5pm	9.00	1	8	8am-5pm	9	1	8	
			4pm-7pm	3	5pm- 7pm	2.00		2	5pm- 7pm	2.00		2	4pm -7pm	3		3	BG only
Friday	8am-12pm	4			9am-12pm	3		3	9am-12pm	3		3	8am-5pm	8		8	Includes 4 Hours Provider Admin
Saturday	9am-12pm	3			9am-12pm	3.00		3	9am-12pm	3.00		3	9am-1pm	3		3	BG only- Every Other Wk
		23		19		44		40		44		40		50		46	

April 14, 2014

BATON ROUGE PRIMARY CARE COLLABORATIVE

HRSA 2013 UDS Report
HRSA (SAC) Grant
HRSA (BHI) Grant
Applications Projected Goals

	2010 UDS	2011 UDS	2012 UDS	2013 UDS filed 2/10/2014	HRSA Health Plan or Business Plan GOAL END OF PROJECT PERIOD (6/2014)	% of Goal Achieved	2012-2013 Trend		2011-2013 Trend		HRSA Grant Renewal Submission 1/24/2014 Revised for BHI Submitted 4/2014					
											SAC Yr 1 FYE 2015 PLUS BHI YR1		SAC Yr 2 FYE 2016 PLUS BHI YR2		SAC Yr 3 FYE 2017	
							Change	%	Change	%	Addt'l	Total	Addt'l	Total	Addt'l	Total
Patients																
Total Number of Medical Patients Served	2,231	1,927	2,064	2,801	2,485	114%	737	35.71%	874	45.36%	504	3305	529	3834	1190	4495
Total Number of Behavioral Health Patients Served	124	43	0	0	638	0%	0		-43	-100.00%	525	525	1050	1575	1050	2625
Total Vision Patients	0	0	6	10	0	#DIV/0!	4	66.67%	10							
Total Patients	2,355	1,970	2,070	2,811	3,103	91%	741	35.80%	841	42.69%	1029	3840	1048	4888	1382	5223
Total Homeless Patients Served	1,099	773	591	931	904	103%	340	57.53%	158	20.44%	168	1099	300	1398	439	1838
Encounters																
Total Number Medical Encounter	4,936	4243	4428	6319	7799	81%	1891	42.71%	2076	48.93%	670	6989	900	7889	2656	10531
Total Number of Behavioral Encounters	882	335	0	0	638	0%	0		-335	-100.00%	1002	1002	2004	3006	2004	5010
Total Vision Encounter	0	0	6	10	0	#DIV/0!	4	66.67%	10							
Total Encounters	5818	4578	4434	6329	8437	75%	1895	42.74%	1751	38.25%	1672	7991	2904	10895	4660	15541
Total Homeless Encounters	2,150	1779	1224	1840	2,531	73%	616	50.33%	61	3.43%	331	2171	463	2634	782	2953
Quality Of Care/Health Outcomes	**Med Prod**			**2434**								**2765**				**4090**
Diabetic Patients with HbA1c < 7 (control/ideal)	31.37%	32.73%	29.38%	29.00%	NA	NA	-0.38%	-1.29%	-3.73%	-11.40%						
Diabetic Patients with HbA1c < 8 (control)	Data Not Collected until 2011	47.88%	37.85%	38.00%	NA	NA	0.15%	0.40%	-9.88%	-20.63%						
Diabetic Patients with HbA1c > 9 (poor control)	47.71%	54.55%	43.50%	46.00%	46%	100%	2.50%	5.75%	-8.55%	-15.67%		56%				LPHI Affiliation
HTN Patients with Blood Pressure < 140/90 (control)	54.81%	49.42%	50.27%	52.00%	70%	74%	1.73%	3.44%	2.58%	5.22%		60%				LPHI Affiliation
HTN Patients on Lipid Lowering Therapy (CAD)	Data Not Collected until 2012		45.45%	56.00%	65%	86%	10.55%	23.21%				60%				LPHI Affiliation
HTN Patients on Antithrombotic Therapy (IVD)	Data Not Collected until 2012		40.00%	40.00%	60%	67%	0.00%	0.00%				60%				LPHI Affiliation
Asthma Patients with Appropriate Meds Intervention	Data Not Collected until 2012		62.00%	62.00%	50%	124%	0.27%	0.44%	62.00%			80%				
Screening - Cervical CA - Pap Test	49.04%	47.88%	62.85%	34.00%	58%	58%	-18.85%	-35.67%	-13.68%	-28.69%		59%				
Screening - Colorectal Cancer	Data Not Collected until 2011		1.44%	2.00%	25%	8%	0.56%	38.89%				25%				
Screening - HIV Testing	Data Not Collected until 2011	4.00%	3.00%	not reported	43%							50%				OPH Affiliation
Screening - Depression	Data Not Collected until 2012		0.00%	not reported	8%							20%				BHI - RKM Affiliation
Screening - Behavioral Health referrals	Data Not Collected until 2011	0.00%	0.00%	not reported	20%							20%				BHI - RKM Affiliation
Screening - Oral Health Referrals (ages 3-18)	10.00%	10.00%	2.00%	not reported	30%							30%				
Screening - Child/Adol Weight Screening /Counsel	Data Not Collected until 2011	61.72%	78.90%	86.00%	64%	134%	7.10%	9.00%	24.28%	39.34%		90%				RKM Affiliation
Screening - Adult Weight Screening and Follow-up	Data Not Collected until 2011	41.24%	40.01%	33.00%	43%	77%	-7.01%	-17.52%	-8.24%	-19.98%		75%				
Screening - Tobacco Use	Data Not Collected until 2011	60.20%	99.73%	99.80%	80%	125%	0.07%	0.07%	39.60%	65.78%		90%				
Screening - Tobacco Users w/Cessation Advice & Meds	Data Not Collected until 2011	67.95%	39.09%	62.00%	75%	83%	22.91%	58.61%	-5.95%	-8.76%		60%				
Immunizations	0.00%	0.00%	95.83%	98%	15%	653%	2.17%	2.26%	98.00%	#DIV/0!		90%				
Percentage of pregnant women beginning prenatal care in first trimester												25%				
Percentage of births less than 2,500 grams to health center patients												10%				
Financial Cost/Viability																
Total Cost per Total Patient	$617.76	$839.59	$527.80	$434.32	$642.00	68%	-93.48	-17.71%	-399.27	-47.90%		686.68				
Medical Cost per Medical Visit	$231.9	$371.46	$242.56	$192.90	$142.88	135%	-49.66	-20.47%	-178.56	-48.07%		150.38				
Change in Net Assets as a Percent of Expense	23.00%	-14.00%	25.00%	0.08%	15%	1%	-0.249	-99.68%	0.141	100.57%		0.8				
Working Capital to Monthly Expense Ratio	2.67	-1.45	1.13	2.31	6.00	39%	1.18	104.42%	3.76	259.31%		4.00				
Long Term Debt to Equity Ratio	0.00	0.00	0.00	0.00	0.05	0%										
Patient Care Collections as a % of Gross Patient Care Charges			33%	33%	61%	54%	0.00	0.00%	0.33			60%				
Revenue Mix Growth Rate																
Patient Service Rev	27%	27%	27%	32%	50%	64%	0.05	18.52%	0.05	16.79%		NA				
FEDGrant Rev	69%	72%	68%	63%	40%	158%	-0.05	-7.35%	-0.09	-12.50%		NA				
Other Rev	0.3%	0.47%	5.0%	5%	10%	54%	0.00	8.00%	0.05	1048.94%		NA				

Provider/Team Specific for Q4 Bonuses

Provider/Team Specific for Q4 Bonuses

Revised 3/2014

Includes:

1. Actual 2014-2016 HRSA Grant SAC Application Goals
2. Actual 2013 UDS Report Data submitted to HRSA
3. Actual 2014-2016 BHI Grant Submission Due 4-1-2014

LPHI (HCCN Project)

Health Care Plan

Business Plan

The Center has submitted 2 HRSA grants (BHI for $500k over 2 years) and PCMH ($250 over 2 years) to expand services, (add CSW and Mental Health services) and renovate JN site to achieve Level 3 PCMH recognition.

The Center also recently entered into a MOU with DHH, Office of Public Health (OPH) to conduct rapid HIV test (free to patients) with OPH providing testing supplies, training and reporting assistance.

The 7/2013 HRSA site visit team performed an operational assessment to establish baseline measurement of overall health center performance and to ensure compliance with the Bureau's 19 program requirements. Areas of non-compliance were identified and relevant technical assistance provided. In addition, opportunities for performance were provided.

Program Requirement	Not Met	PI	Program Requirement	Not Met	PI
1 – Needs Assessment			11 – Collaborative Relationships		
2 – Required/Additional Services		X	12 – Financial Management & Control Policies		X
3 – Staffing Requirement		X	13 – Billing and Collections		X
4 – Accessible Hours/Locations		X	14 – Budget		
5 – After Hours Coverage		X	15 – Program Data Reporting Systems		X
6 – Hospital Admitting Privileges and CC	X		16 – Scope of Project	X	X
7 – Sliding Fee Discount		X	17 – Board Authority	X	X
8 – QI/QA Plan		X	18 – Board Composition	X	
9 – Key Management Staff			19 – Conflict of Interest Policy		
10 – Contractual/Affiliation Agreements					

A summary of **primary compliance issues and concerns** follows:

- The health center must obtain a hospital contract – **FIXED 8/2013 OLOL Agreement fully executed and 1/2014 Hospitalist Contract in place with Dr. Jonathan Roberts**
- Patient volumes are much lower than grant projections – **IN PROGRESS 75% of HRSA visit goal met by 12/2013, 100% HRSA visit goal planned to be met by end of FY 6/30/3014 – monitoring monthly (currently 156 visits below goal)**
- The board of directors must exercise appropriate authority and oversight. - Attendance
- 51% of the health center board must be patients of the health center.

This is a marked improvement over the 16/19 Conditions cites as not met in the prior HRSA Site visit conducted in 2012.

After several months of working with local community organizations (Together Baton Rouge, AARP, and local churches), attending Metro-District Council 2 Board meetings and rallying support of the Center's local District-Council representative, the Capital Area Transit System (CATS) Director informed the *Center* in November, 2013 that he agreed to support the *Center's* formal appeal requesting that the *Center* as a Medical facility be included in the proposed CATS Proposed Transit plan scheduled was implemented in March, 2014. Board member were very active and successful in rallying support from local political leaders to make this necessary change occur which will significantly increase access to the *Center's* Jewel Newman Community Health Center.

New Computers- $37,000 is being invested in the purchase of NEW computers and all employee workstations will be upgraded to either tablets and thin clients beginning May, 2014.

Facility-wide Training scheduled for April-May, 2014 (Every Friday afternoon p-4p) to cover EHS and BRPCC Operating P/Ps.

4. Marketplace
    a. Identify partnerships
        i. LSU Health – new urgent care center for new/follow up patients
        ii. Hospital Social Worker for referrals to Primary Care Provider
        iii. Small businesses in area
        iv. Specialty Practices
    b. Establish wellness partners
        i. Restaurants
        ii. Grocers
    c. Accountable Care Organizations (ACO)
        i. Ochsner
        ii. Physicians Alliance

iii. Specialists
iv. Organize own

d. Add Dental Services

In November, the Center began discussions with Louisiana Primary Care Association (LPCA) and member FQHC's on creating an Independent Practice Association (IPA) and authorizing the new entity to act as agent of the FQHC's to negotiate with Physician Practices, Hospitals and Health Plans. Many professional alliances are being formed ass Accountable Care Organizations (ACO) and will be better positioned organizations for Pay-for-Performance (P4P) reimbursement changes. Negotiations are underway to create a separate IPA for the FQHCs in Louisiana which BRPCC will be a participating member and health insurance contracts including shared savings agreements will be negotiated via messenger model through the IPA (shared savings will be generated based on health outcomes)

In late December Children's Charter School, a pk-5th grade school, currently located on North Street in Baton Rouge informed the Center that a few years ago, the school acquired 24 acres of property on E. Brookstown between Winbourne and Prescott, in downtown Baton Rouge where they plan to build a new school building. The plan is to take the additional land (24 acres) and create a community redevelopment project. The school expects in the next few weeks to begin plans for a low-income senior housing development on the property. In addition, they are considering athletic fields, a community garden, and a training center with one or more local nonprofits. There community surveys and focus groups have shown a real need for additional health services in the area. Ideally, we would like to offer health services to the children, families and surrounding community. Experts on our strategic vision committee suggested that Baton Rouge Primary Care Collaborative place a site on the property as the best solution and the Center will be meeting in January, 2014 with project consultants on this community redevelopment project. BRPCC is currently in discussion with the School to create a satellite location on the redeveloped property.

The Center attended several Together Baton Rouge meetings and Health Subcommittee meetings and worked together to create an ACA "What you need to know" brochure for the most underserved in north Baton Rouge. In December, Together Baton Rouge used their resources to contact and meet with all African-American Church Pastors in the community and asked them make an announcement during service about the ACA. Together BR and used their pool of over 500 volunteers to distribute the brochure and placed their volunteers at each Sunday Church as a resource for questions and answers.

Through its collaboration with Together BR, the Center was invited to join and become a participating member of the Mayor's Healthy Cities Initiative (MHCI) and currently sits on the MedBR committee to connect, coordinate, and communicate resources for medical, dental, and prescription services with a focus on the medically fragile, vulnerable populations and the uninsured and underinsured. The top four priorities for 2012-2015 identified by MedBR are obesity, HIV/AIDS, ER utilization, and mental/behavioral health.