Midwest Clinicians' Network

NETWORK NEWS

January 2017

What's Inside

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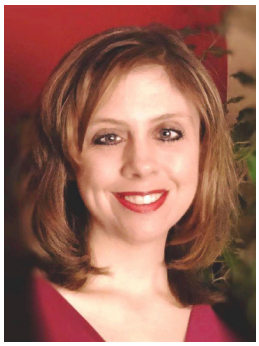
Message from the MWCN President

RESILIENCY

Chris Singer, MAN, RN, CPHQ
Chief Operating Officer
West Side Community Health Services



As we head into 2017, I am delighted and appreciative of the opportunity to serve the Midwest Clinicians' Network as President. The Network has long served our communities in the mission to enhance professional and personal growth for clinicians to become effective leaders and promoters of quality, community-based health care. I am excited to consider the possibilities of enhancing this mission in 2017. I want to take a moment to thank Russ Kolski for his strategic leadership in 2016. His focused approach to improvement strategies has helped us as a community to navigate the days of change that lie ahead.

While we all face and experience periods of change throughout our health centers, the historic election of 2016 and outlook for the years ahead may have a ring of uncertainty. It will take all of our collaboration to solve some of the toughest issues that we currently face as Americans. These issues are challenging when mixed in with this level of unpredictability, but we know we have tackled hard issues before. Community health centers have grown from roots of two community health centers approved in 1965 to now serving over 25 million people nationwide. This staggering fact stopped me in my tracks as I thought about the history that took place, challenges overcome, and the continued vast acceleration of patients served over the past 50 plus years. How did they do it? How did we overcome the odds each and every time that these unsurmountable challenges arose?

Resiliency. Webster defines this as an ability to recover from or adjust easily to misfortune or change. Certainly we can look back and see the resiliency possessed by our predecessors, but how do we become resilient as we look forward to a time of uncertainty and change? We as individuals cannot control for all of the stress that erupts around us, but we can become resilient in our own little piece of the world that we impact each and every day. These small impacts culminate together with the work of our colleagues and peers that lead to the innovation and advancement that benefits our patients each day.

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RESILIENCY *continued from page 1*

In his book, Simple Solutions for Life's Problems, Dr. Dan Johnston writes that employing some key strategies each day can keep us resilient. The three characteristics of resilient people include:

- Attitude. Keeping a flexible, optimistic outlook helps us intentionally look for the best outcome in any situation. It also helps us to reduce stress.

- Know how to manage stress. Setting limits, knowing when and how to avoid known stressors, and what actions to take when stress does set in will help us manage our workload and become more efficient. My daily fitness workout and time in the garden are my personal go-to's. Others may choose to beautify their workspace, journal, attend to spiritual health, meditation, or yoga.

- Enjoy Life. Dr. Johnston states that resilient people enjoy life because they make an intentional choice to participate in it. Each day should provide a sense of accomplishment and joy.

If we can approach our individual days, teams, health centers, and the broader community with resiliency, we will have confidence to face each hurdle, change, challenge, and snag that comes our way. When applied with collaboration, engagement, and partnership across our communities and beyond, we will undoubtedly successfully navigate the arena of health care change in the future.

Health IT and QI Workforce Development: Onboarding for Success

February 16th at 11:30 CST / 12:30 EST for one hour.
Register HERE! Register HERE! Register HERE! Register HERE!

Our speaker, Chris Espersen, will provide an overview of two specific tools for onboarding new staff into your health center with a focus on speeding the onboarding of Health IT and QI staff. The first is a Quality Improvement Specialist Monthly Calendar, a tool to promote data reporting consistency and clarity on data/quality improvement specialist deliverable expectations. The second is a Sample of a Staff Member's Dashboard for Required Tasks. This dashboard can be used in the onboarding and orientation process to ensure understanding of role expectations, and can be tailored for any direct-care staff member. She will review how the tools are meant to be used and how they can customize them for health center's needs.

Thank you to HITEQ for setting up and hosting this webinar opportunity for MWCN. More details on HITEQ (Health Information Technology, Evaluation, and Quality Center) can be found at http://hiteqcenter.org/.

Health Coaching Makes Its Mark in a Community Health Center

Reprinted from the January 2017 "Clinical Health Coach" newsletter.

Siouxland Community Health Center serves individuals in Iowa and Nebraska. It has implemented health coaching as a strategy in working with their high risk patients. Dave Faldmo, a Physician's Assistant who serves as Siouxland's Quality and Medical Director was interviewed on November 30, 2016 regarding Siouxland's service and its use of health coaches in their clinical setting. Following is a transcript of that conversation along with observations from 4 of Siouxland's case managers who have experienced Clinical Health Coach training —Aimee Speck, Cherie Rasmussen, Denise Houts and Cinda Krause.

"Siouxland Community Health Center is a large Federally Qualified Community Health Center that offers dental, behavioral health and urgent care services. We provide most of the HIV care in the area and offer an in-house pharmacy. We are a comprehensive FQHC and a Level 3 Patient Centered Medical Home. We have 20 medical providers that serve around 25,000 patients providing around 100,000 visits per year.

We work to provide comprehensive team-based care for our patients. Our case managers have received training through the Clinical Health Coach—it has been invaluable. The Motivational Interviewing skills they received has been great! As a supervisor of the case managers, when we get a new case manager on board we try to get them in to the next training offered by the Clinical Health Coach and the Iowa Chronic Care Consortium. It has been a wonder training to bring our new case managers up to speed. It helps them become more than just a health educator, and provides them with additional tools to help overcome barriers that patients might be having in taking control of their health."

"Each of our case managers have distinct roles. All are assigned to provider teams, and they also have other roles such as hospital follow-ups, reducing ER visits, and follow-up of procedures that we perform in-house. They follow patients that have complex needs. Each month they reach out to those patients (either face-to-face or by phone) that have A1Cs great than 9 to make contact with them. They are invaluable helping us care for some of these patients who need a little extra help. Each team has an RN assigned to them, but unfortunately these RNs don't have the time it takes to spend with these patients. The case managers are allowed the time to sit down with those patients and motivate them to take control of their health and give them the knowledge and education they need to take control of their own health. When you really need to motivate a patient to make some life style changes or to overcome some social barriers or behavioral health issues, the Clinical Health Coach training has been really helpful!"

"When I think of healthcare going from volume to value—health coaching will become so important in meeting different quality measures that we are expected to meet. Right now, we get paid on how many patients we run through our doors. However, this is transitioning to providing those patients with "value" as a basis for payment. Even though most of the services provided by our case managers and health coaches are not reimbursed by insurance companies, we are ok with that, because we know how important it is to meet those quality measures and know that our main mission is to provide better care for those patients and living healthier lives."

Case Manager #1: "Engaging your patients starts the first time you walk in the room. When you have Clinical Health Coach training, you know you are not just going in to educate a patient. You can tell somebody 15,000 times, "you need to take your medication" but unless they are motivated to do so, it isn't going to happen. I currently have a patient that has diabetes that has been out of control for years and years. She was one that we'd kind of written off and assumed she would eventually be on dialysis. I took care of her dad who has died while on dialysis. That still didn't motivate her. The first time I walked in the room, she crossed her arms and turned her head away—she wouldn't speak to me. Now she tells me how everyone else that has ever tried to help her tells her, "this is what you need to do, this is what you have to do to make changes. You are the only one that comes in and listens to me." Just last month, she has her sugars under control and she's finally taking care of herself. She's motivated, she's engaged, and she calls me when she has questions. She is a completely different person. That is huge!"

Case Manager # 2: "I think coaching has influenced the patient's experience in letting them know they have a personal bond with you. They know that they can trust you and come to you with anything and you will be there to listen. You are more than a person that comes in, hands them education and leaves. I give my patients my phone number so they can call me at any time."

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Health Coaching Makes Its Mark in a Community Health Center *continued from page 3*

Case Manager # 3: "I think another thing with changing the behavior. Through coaching you find out a lot more about your patient. They seem to really open up to you, and often times find out about other problems they are having. Especially with social determinants of health, you find out about what other barriers they are experiencing because they have that trust in you. They know you're not just there throwing education at them, they do open up to you a lot more. You find out a lot more about the patient and find other resources that can help them with."

Case Manager #1: "With the patient experience, we support what the provider says so it feels like a team approach — not just one person telling them what to do. They may feel intimidated talking to their provider about something embarrassing or they feel like they did something wrong. When we come in, they feel like it's a more team approach, they have someone to talk to and ask questions – questions they otherwise may have been afraid to ask. This enhances patient care. Providers and nurses often have very limited time, just when the patients want time. Usually it's "get in, get out" let's get the results and we'll call you with what we find out. Then we walk in, have that time with the patients, and the patients feel like they're getting value from their appointment.

Case Manager #4: "Siouxland Community Health Center is really ahead of the times right now. I think coaching is the future of health care. We are coming to a point in time where we are going to be reimbursed for how well we are taking care of the patients, versus "walking them through the system." This approach is very ahead of the game, and other centers should focus on following."

Case Manager #1: We came back excited because before all we did before was education. We started using the readiness ruler. How motivated are you? Why are you an eight and not a six? All of the sudden, these people when asked why they were motivated for change, they started crying and would talk about their families. We would walk out of the rooms asking each other, "How many people would you make cry today?" This is when we knew we were connecting as a partner with our patients.

HEALTHY RECIPE: *Crock Pot Picadillo*

Picadillo, a flavorful Cuban dish made with ground beef and a sauce made from simmering tomatoes, green olives, bell peppers, cumin, and spices is sure to be a family favorite weeknight meal. Yield: 11 servings, 1/2 cup each

INGREDIENTS:

2 1/2 lbs 93% lean ground beef
1 cup minced onion
1 cup diced red bell peppers
3 cloves garlic, minced
1/4 cup minced cilantro
1 small tomato, diced
1/4 cup alcaparrado (manzanilla olives, pimientos, capers) or green olives
1 1/2 tsp ground cumin
1/4 tsp garlic powder
2 bay leaves
kosher salt and fresh pepper, to taste
brown rice

DIRECTIONS:

1. Brown meat in a large deep skillet on medium-high heat; season with generously with salt and a little pepper. Use a wooden spoon to break the meat up into small pieces.
2. When meat is no longer pink, drain all the liquid from pan. Add the onions, garlic and bell peppers to the meat and cook an addition 3-4 minutes.
3. Transfer the meat to the slow cooker, then add tomato, cilantro, tomato sauce, 1 1/4 cups water, alcaparrado (or olives) [I usually add some of the brine from the jar for added flavor] then add the spices.
4. Set slow cooker to HIGH for 3 to 4 hours or LOW for 6 to 8.
5. After it's ready, taste for salt and add more as needed [I added a little more cumin and garlic powder at the end as well since the crock pot tends to mute the flavors of herbs and spices].
6. Discard the bay leaves and serve over brown rice.

Source: http://www.skinnytaste.com/crock-pot-picadillo/

HITEQ Supporting Health Centers in Population Health Management

Health centers are moving beyond EHR adoption into the next phase of using technology to support their mission. Population health management (PHM) tools help health centers stratify patients by risk and target interventions accordingly. These tools also enable health centers to participate in delivery system transformation projects and advanced payment models that rely on accurate quality indicators. The data aggregation and analytic capacity of PHM systems also support health center business intelligence efforts such as predictive analytics and decision support tools.

HITEQ, a HRSA national cooperative agreement, is supporting health centers by providing HRSA-funded training and technical assistance on how to use the data gleaned from PHM tools to improve population health in the clinic setting and beyond. HITEQ is also helping to ensure that health center data are accurate, timely, and actionable. For example, through a newly developed data validation tool, health centers are able to validate the data coming from their electronic health records and use the information to correct any reporting errors due to incorrect definitions or coding by EHR vendors. One of the health centers that HITEQ worked with had experienced a decline in performance of their adult BMI measure from 31% to 3% when they transitioned in reporting from a sample to the EHR. HITEQ provided the data validation tool as way for the health center to pinpoint the programming of the BMI measure data report and identify how to correct errors. Find population health management tools, resources, and case studies at hiteqcenter.org.

Here are some key challenges that we've heard from health centers and partners and how HITEQ can help:

- **How can health centers make sure data is clean and valid?** HITEQ has developed a Validating Data Report Audit Tool that health centers can use or modify to audit their reports for accuracy and to resolve any issues they identify in the process. It is intended to assist health centers in ensuring they have accurate reporting and a process to resolve issues.

- **How do health centers make sure staff are trained appropriately, especially in positions with high turnover?** HITEQ has a set of resources on health IT and QI workforce development including a Primer for Working with Your Local Community College for Training Your Staff and a brief on involving frontline staff, Engaging the Data Creators.

- **How can health centers use data to demonstrate value and participate in value-based payment models?** HITEQ has developed tools to support health centers across the spectrum of engaging in value based payment and can provide a subject matter expert to conduct a virtual or in-person training or facilitate a learning collaborative.

Upcoming Webinars

1/26 Provider Engagement for Health Centers: Turning EHR from Barrier to Aid for Health Center Providers. A HITEQ and STAR² Center Webinar
This webinar will discuss health center provider engagement from the three pillars of executive sponsorship, training and education, and governance throughout the life-cycle management of the electronic health record (EHR) system. The presenter will discuss the four phases of EHR lifecycle - EHR selection, EHR implementation, EHR functionality deployment, and EHR optimization. This webinar is a HITEQ/ STAR² Center collaboration. Register here.

2/21 HITEQ Highlights - Health IT-Enabled Quality Improvement: Data Monitoring/Dashboarding/ Population Health Management
This session will provide an overview of why data monitoring is important and what we mean when we talk about it. Then, participants will discuss considerations prior to taking on data monitoring including data validation, transparency, and committed resources. Finally, the session will share case studies from organizations that are currently engaging in various types of data monitoring, including organizations that are using population health management systems and other software solutions. Register here.

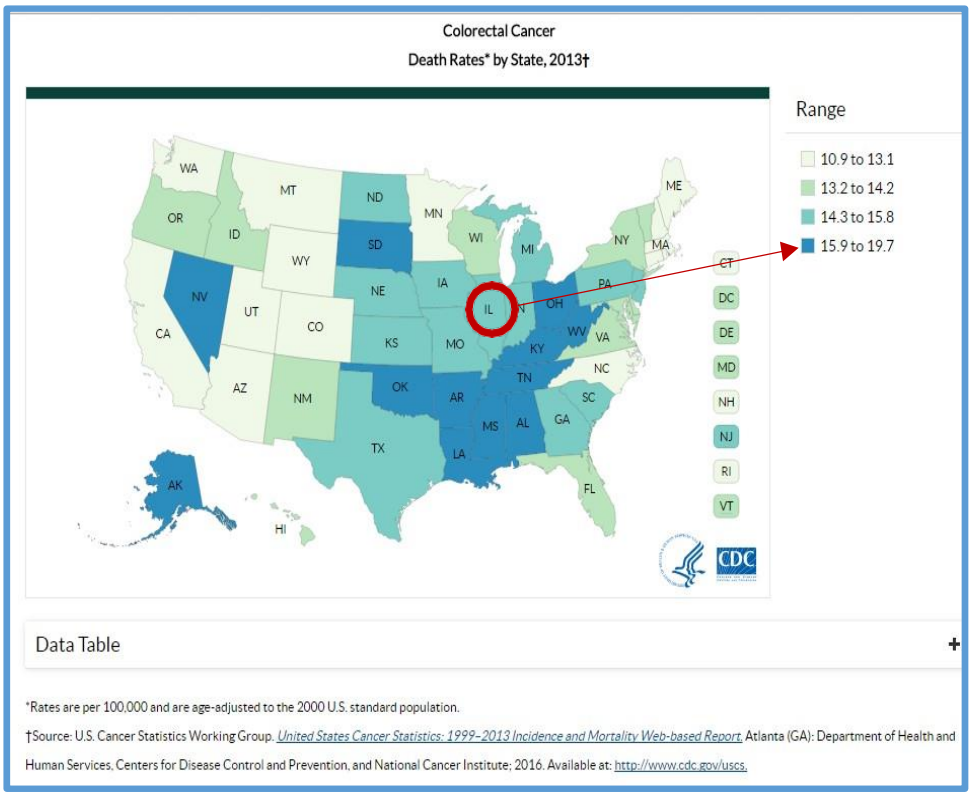
For more freely available health IT resources, upcoming webinars, and training and technical assistance, visit hiteqcenter.org or contact HITEQ by email hiteqinfo@jsi.com or phone (844) 305-7440.

HEALTH INFORMATION TECHNOLOGY, HITEQ EVALUATION, AND QUALITY CENTER

Cook County Colon Cancer Alliance to Reignite and Enhance Screening Program Cook County CARES

Project Goals

Cook County CARES is a partnership among a diverse group of healthcare system partners, including several Community Health Centers in Illinois. The overall aim of Cook County CARES is to establish a multilevel, multi-faceted framework to increase organized approaches to CRC screening and prevention in partnership with a diverse group of healthcare system sector partners. The program purpose is to increase colorectal cancer (CRC) screening rates among a defined target population of persons 50-75 years of age within partner health systems, defined geographical area (Cook County), and disparate populations. The program is currently progressing through Year 2 of the five year CDC-funded grant.



Project Partners include local Federally Qualified Health Centers and Hospital Systems including University of Chicago Medicine, Heartland Health Centers, Friend Family Health Centers, and Asian Human Services.

Planned Interventions focus on provider-oriented evidence based interventions (EBI).

1. ***Provider Assessment and Feedback***
2. ***Provider Reminders***
3. ***Client Reminders***

Lessons Learned and Highlight from Year 1:

Pre-Implementation and Needs Assessment of Health System current CRC screening protocol(s)

Taking the time to understand the current patient flow / process for CRC screening helps identify existing and specific gaps; builds understanding and trust among health system staff; and helps tailor new interventions and EBI's to meet the specific and unique needs of each health system.

Tiered EBI Implementation & Quarterly Data Updates

Another important highlight from Year 1 is the value taking planned and tiered implementation approach using the framework: "Plan, Do, Study, Act". This measured approach allows for regular evaluation and assessment of new interventions and help ensure replicable and sustainable changes within the overall health system. Partners are provided and assisted in the review of data reports on a quarterly basis to evaluate intervention success and associated changes in screening rates.

Ensure Complete Continuum of Care for All Patients

The need to enhance and bridge access to care between community clinics and hospitals / specialty care is essential to ensure the complete continuum of care for all patients regardless of insurance status or how the patient is screened. Many FQHC's face significant challenges coordinating and ensuring patients receive diagnostic colonoscopies / care.

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Cook County Cares *continued from page 6*

The CARES team and partners have developed a creative solution utilizing technology to enhance and streamline the referral process to specialty care from community clinics. www.ILColonCares.org

Example Community Clinic Health System
FQHC Health System "X" *** Economic Study Partner; ~ 40 providers; Primary screening test: FIT

	Baseline 2014 - 2015	Quarter 1 01/2016 - 03/2016	Quarter 2 04/2016 - 07/2016	Quarter 3 08/2016 - 09/2016
CRC Screening Rate	26.6%	30.4%	32.66%	35.8%
EBI Implementation	None	Provider Reminder	Provider Assess/Feedback	No new EBI

What's Ahead:
The CARES Team and partners are excited to continue our efforts as we continue through Year 2 and into Year 3. Highlights include additional FQHC partnerships; CDC led Economic Evaluation of intervention efforts; and a CDC Health Equity Conference in May 2017.

May 2017 Conference Opportunity:

MIDWEST HEALTH EQUITY CONFERENCE
Health Equity through Evidence Based Interventions and Sustainable, Practical System Change: Preventing Liver and Colorectal Cancer**
Chicago, IL
**Limited travel / lodging scholarships available for FQHC attendees

Contact:
Matt Johnson
CARES Program Director
johnson8@uchicago.edu

Centers for Disease Control & Prevention (CDC)-Organized Approaches to Increasing Colorectal Screening, Funded by Center for Disease Control grant numbers: 1 NU58DP006079-02-00, 1 NU14PS005073-01-00

JOB POSTINGS

Illinois

Dentist
We have an opening for a fulltime Dentist Position at Eagle View Community Health System in Oquawka, IL. Contact Cathy Anderson, Dental Director at Eagle View Community Health System, PO Box 198, Oquawka, IL 61469 or call 309-867-2770.

Various Positions
IPHCA seeks clinicians for urban and rural locations in Illinois and Iowa. Clinicians needed: Primary Care Physicians, Medical Directors, Dentists, Dental Hygienists, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Psychologists, LCPCs and LCSWs. To take advantage of IPHCA's complimentary recruitment service please send your CV to Ashley Colwell, acolwell@iphca.org.

Various Positions
Family Christian Health Center in Harvey, IL, a federally qualified, state-of-the-art health center, has multiple openings for Family Practice Physicians, OB/GYN Physician, Nurse Practitioners/Physician Assistants, Licensed Clinical Social Worker or Licensed Clinical Professional Counselor, and Certified Medical Assistants. Excellent benefits package. Contact Regina Martin, HR Manager at rmartin@familychc.org or 708-589-2017.

JOB POSTINGS

Indiana

Licensed Clinical Social Worker

Echo Community Healthcare, in downtown Evansville IN, is seeking a Licensed Clinical Social Worker to work directly with our Provider team to assess and serve the behavioral needs of our patients. Competitive pay and benefits package. Apply at www.echochc.org or by email to jderoche@echochc.org.

Various Positions

Porter-Starke Services, Inc. (PSS), a CMHC based in Valparaiso is seeking Psychiatrists, Nurse Practitioners, Therapists, and more in offering services for virtually all mental health and addiction needs for adults, children and families. PSS also operates Marram Health Center, a FQHC in Gary, IN, providing comprehensive primary and integrated care. PSS offers competitive salary and a benefit package. Visit the PSS Careers website at http://www.porterstarke.org/careers/current-job-opportunities/ for both locations, or contact Mark Goodrich (219)476-4582, Recruitment and HR Coordinator at mgoodrich@porterstarke.org for more information.

Iowa

Various Positions

Primary Health Care, Inc. (PHC) is seeking to hire a variety of positions, including a physician, and a nurse practitioner/physician assistant. our careers page at https://pm.healthcaresource.com/cs/phc#/search to search and apply for positions. Contact Rachael Miller at rmiller@phcinc.net for more information.

Michigan

Various Positions

Cherry Health, located in Grand Rapids, Michigan is a community health center is seeking full time psychiatrists to join our organization to provide quality out-patient care, as well as full or part-time Family Practice/Internal Medicine Physician for our Greenville location (Montcalm Area Health Center). Cherry Street offers a competitive salary with incentive package and excellent fringe benefits including generous loan forgiveness programs. Contact Bob Lackey, by phone at (616) 776-2124, Boblackey@cherryhealth.com.

Minnesota

Physician

People's Center Health Services, a FQHC in Minneapolis, seeks an Associate Medical Director to join its clinical staff! We provide expense allowance for CME training and eligibility for loan repayment. More information is available at www.peoples-center.org/jobs. If interested, send a resume to careers@peoples-center.org.

Various Positions

Indian Health Board, a FQHC, seeks a Board Certified/MN Licensed Family Practice Physician for its Minneapolis, MN Community Clinic as well as a Licensed Psychologist needed at IHB with therapy experience with high risk children, adolescents and adults. Experience with Native Americans a plus. We offer a competitive salary, excellent benefits and qualify for loan repayment program. Contact Courtney at cfields@ihb-mpls.org or visit our website for more.

If you have a job posting you would like added to our newsletter, forward it to Renee Ricks at

rricks@midwestclinicians.org

Missouri

FNP/PA

Tri-Lakes Community Health Center, located in beautiful lakeside Kimberling City, Missouri, is hiring one FNP/PA for a clinic that sees a busy mix of family practice and urgent care. We offer competitive pay, loan repayment, full benefits, and a four-day work week. E-mail resumes to Robert Marsh, ED, rmarsh@fordlandclinic.org.

Nebraska

Various Positions

OneWorld Community Health Centers, Inc. in Omaha, NE is seeking a Midwife, RN/RD Diabetic Educator, Medical Nutritionist, Behavioral Health Therapist, RN Clinic Manager, Outreach & Reproductive Health RN, and Registered Nurse. OneWorld is a FQHC and is a Certified Level III Patient Centered Medical Home (NCQA.) Out of 1,400+ Community Health Centers nationwide, we rank in the top 1% in clinical quality. Our clinic is growing, and we need dedicated individuals to come join our team! We offer a competitive salary and generous benefits. Our clinicians are eligible for student loan repayment through NHSC and NURSE Corps. Please apply at www.oneworldomaha.org/careers

Ohio

Various Positions

Community Health Centers of Greater Dayton is searching for a fulltime FP, IM physician or Nurse Practitioner, and a Medical Quality Assurance Manager. Competitive salary and benefits package, including loan repayment for physicians and nurse practitioners. Submit your CV to sfleming@chcgd.org or visit our website at www.communityhealthdayton.org.