BOND COMMUNITY HEALTH CENTER, INC.
Low Income Pool Enhanced Primary Care Project Application

Contact Person: Debra E. Weeks, Chief Administrative Officer and Interim CEO, Bond Community Health Center, Inc.

Medicaid Provider Number: 060551401
Provider Type: Federally Qualified Community Health Center
Amount of application: $141,947.00
Enhanced program funding application: **1 FTE Psychiatrist**

History and Overview of Service Delivery System and Affiliations
Bond Community Health Center, Inc. (BCHC / the Center) is a nonprofit Federally Qualified Community Health (FQHC) center that provides year round comprehensive primary health care services, as required by the Bureau of Primary Health Services. The Health Center operates as a freestanding ambulatory care entity at 1720 South Gadsden Street, Tallahassee, Florida 32301. Medical services include primary care (family medicine, internal medicine, geriatrics, pediatrics, radiology, obstetrics and gynecology, and midwifery services), behavioral health, Ryan White Part C (HIV/AIDS primary care and infectious disease), social services and case management, on-site pharmacy, CLIA waived laboratory, nutrition, oral health and transportation. BCHC serves the homeless population (Health Care for the Homeless grant) at a satellite site--**Kay Freeman Health Center** located at 2729-8 Municipal Way, Tallahassee, FL on the Big Bend Homeless Coalition's campus. In 2009, BCHC collaborated with Apalachee Center, Inc. (not-for-profit behavioral healthcare organization) to establish the **Bond-Apalachee Wellness Integration Center (BAWIC)** to provide point of care primary care services to the outpatient mental health patients who access the main Apalachee Mental Health campus at 2634-J Capital Circle NE, Tallahassee. These were the first centers in the State of Florida to integrate primary care and mental health in one location. Most recently, resulting from our successful partnership, received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand its hours of operation and staffing at the **BAWIC** site. In spring 2012, BCHC opened the **Bond-Housing Authority Primary Care Center** located at 1704 Joe Louis Street, Springfield Housing Community, to provide preventive primary health care and coordinated social and support services to the residents of all Tallahassee Housing Authority sites. BCHC also implemented its **Health Care in Motion** by providing primary care across five counties, reaching the underserved in its two exam room, fully equipped, 40 foot mobile unit. In June 2012, BCHC received a DOH Grant to provide access to supportive specialty care to the underserved living with diabetes, hypertension, arthritis, HIV/AIDS, and other chronic and infectious conditions. This funding will support the implementation of the **Bond Specialty Care & Community Wellness Center** at a location near the main site. This 10,000 square foot building will house podiatry and ophthalmology services, as well as chiropractic care, diabetic support and include space for nutrition counseling and behavioral health group therapy, substance abuse counseling and family support services. It will provide the needed space infrastructure for program expansion.

Medical services that are not directly provided by the Center are obtained by referral or collaboration. Through its long relationship with the Capital Medical Society Foundation and the WeCare Network, the Center utilizes this network of volunteer physician specialists, radiological, hospital, and ancillary care to obtain needed services for its most indigent patients. BCHC's relationship with agencies such as the Epilepsy Association of the Big Bend, Children's Medical Services, the Sickle Cell Foundation, Big Bend Cares (which provides Part B HIV/AIDS services), and the University of Florida Shands Hospital ensures patients a breadth of specialty care services. Most important to the Center is its close relationships with the local hospitals. Bond's physicians hold admitting and affiliate staff privileges at Tallahassee Memorial Hospital (TMH) and Capital Regional Medical Center (CRMC). BCHC is represented on TMH's Medicine Service Line Advisor Board which reviews utilization of services by patients and community physicians.

BCHC has adopted HRSA's "Integrated Primary Care Community Based Health Service" matrix. Aspects of this system include our joining the Community Health Centers Alliance (CHCA) formed in 1999 and funded by a BPHC ISDI grant. This Integrated Delivery Service Network currently has 18 Health Center members across the State of Florida and each Center pays dues and has a seat on the Board of Directors. Previously known as CareNet, BCHC continues to collaborate with the following agencies which consist of the Tallahassee Memorial Hospital, Capital Regional Medical Center, WeCare Network (Volunteer Specialty Providers), Neighborhood Health Services (Health Clinic), Capital Medical Society (Medical Foundation Board) and The Leon County Health Department. BCHC has fostered close relationships and contractual agreements with many other agencies — Big Bend Homeless Coalition, Apalachee Center, Inc., Tallahassee Housing Authority, United Partners for Humans Services.

The Center also has agreements with health professional institutions and programs. The providers of BCHC are adjunct professors to Florida A & M University College of Pharmacy and Pharmaceutical Sciences (FAMU-COPPS) and the Florida State University College of Medicine. Children's Medical Services (a pediatric multispecialty group) and Whole Child Leon (a County-wide pro-child network of agencies) make direct referrals to BCHC for pediatric services and for adult care when they turn eighteen years old. The Florida/Caribbean AIDS Education and Training Center (AETC) collaborate in case conferencing with Bond's providers. Post-graduate, PharmD candidates of FAMU-COPPS administer the ADAP services with faculty oversight. BCHC is also an active member of the Florida Association of Community Health Centers (FACHC). Our full scope of services and our active participation in numerous service networks and associations ensures that BCHC patients and clients are holistically and conveniently served.

Service Area:
The primary service area for the Bond Community Health Center is the City of Tallahassee and Leon and surrounding counties. The Health Center serves Census tracts 1, 4, 5, 6, 10.01, 10.02, 11.01, 11.02, 12, 13, and 14. Leon County (target area) is an area that is considered both Rural and Urban in nature. The estimated population of Leon

County is 275,500 (U.S. Census Bureau 2010).This area has been designated a Medically Underserved Area (MUA) and a Health Professions Shortage Area (HPSA)—primary care, dental, and mental health and encompasses the 2nd Congressional Districts. BCHC provides primary care to HIV positive patients living in Area 2-B (Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla Counties) as well as mobile health services. These counties comprise the entire service area.

There are significant numbers of indigent and working poor living in the rural areas and in the impoverished inner city neighborhoods of Leon County. There are three institutions of higher education in Tallahassee Florida: Florida State University (FSU), Florida Agricultural and Mechanical University (FAMU) and Tallahassee Community College (TCC). Although these institutions are available, there exist a vast majority of the population that never attended college, with 10% of the residents having less than a ninth grade education and 11% not graduating from high school. The other counties in the service areas have rates as high as 34%. Gadsden County's rate of students repeating the middle school of 10.4 is 4 times the State average of 2.7. (*Florida Charts 2010)* The proposed new project aligns with our mission statement: **"To improve the physical, spiritual, psychosocial and psychological well being of the residents of Leon and surrounding communities, by providing access to the highest quality, comprehensive, family health services with particular concern for the lower social-economic groups, regardless of their ability to pay.**

Table 1, BCHC Service Area Total Population - Mid-Year Population Estimates, Bond CHC Service Area (Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties) Source: Florida Department of Health, Bureau of HIV/AIDS

Mid-year Population Estimates, 2010					
Sex	**Total Pop**		**Age Groups**	**Total Pop**	
Males	215,691	49.5%	0 - 12	63,727	15%
Females	219,626	50.5%	13 - 19	45,470	10%
Total	435,317	100.0%	20 - 24	57,523	13%
			25 - 29	35,309	8%
Race/Ethnicity			30 - 39	53,625	12%
	Total Pop		40 - 49	54,521	13%
White, non-Hispanic	262,112	60%	50 - 59	54,176	12%
Black, non-Hispanic	140,095	32%	60+	70,936	16%
Hispanic	23,053	5%	Total	435,287	100 %
Other*	10,057	2%			
Total	435,317	100%			

The World Health Organization defines the social determinants of health as the circumstance in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. Bond Community Health

Center strives to help patients live a healthier life despite these social determinants by meeting patients where they are in life and providing comprehensive and culturally correct services.

According to the 2010 UDS report, the African American population currently attending BCHC is 65% compared to 27%-White, 3%-Hispanic and 5%-Other. As of June 2012 55% of all patients cared for at BCHC, have no medical insurance which is disproportionately high when compared to the Leon County overall rate of 10.6%, the state rate of 17%-*Florida CHARTS 2010*- and the average for FQHC's of 49.4 percent. As of June 2012, the payor mix was 11% Medicare, 30% Medicaid, and 4% private insurance. Bond's patients benefit from its sliding fee scale that uses the federal poverty level as its guide. Not only does BCHC have a long history of providing for the uninsured and underinsured, typically the working poor fall within the <200% federal poverty guideline.

With the realization of the Health Care in Motion Mobile Unit, BCHC now reaches those hamlets of Leon County that may even lie in affluent zip codes, but are far removed from affordable health care and not in proximity of public transportation. The mobile unit also serves the underinsured citizens of Madison County, which has disproportionate deaths due to suicide; Liberty County, which has elevated rates of injuries due to alcohol related traffic crashes; Jefferson County, which has the highest rate of aggravated assault in the State—twice the rate of Miami-Dade County; Jefferson and Gadsden, both of which have high rates of alcohol related motor vehicle accident fatalities. In fact, all but Leon County exceeds the State rate of deaths secondary to alcohol related motor vehicles accidents.

Table 2, BCHC Service Area – Alcohol-related Motor Vehicle Traffic Crash Deaths(Rolling 3-Year Rates), 2008-2010 Source: Florida Charts

Counties	Rate of Deaths Due to Alcohol Related Motor Vehicle Accidents	Average Number of Total Population	Rate Per 100,000
Franklin	2	12,382	16.2
Gadsden	9	50,684	18.4
Jefferson	2	14,704	13.6
Leon	10	275,164	3.6
Liberty	1	8,347	12.0
Madison	3	20,246	14.8
Taylor	2	23,378	10.0
Wakulla	3	31,577	8.4
Service Area Total	**32**	**436,482**	**7.3**
State Total	**989**	**18,806,650**	**5.3**

The target population experiences health problems that are higher than the state averages partially due to its startling high poverty rate. We term this overall group the "medically indigent", i.e. those who do not have the resources to pay for medical care or may have

the resources to pay for medical care but choose otherwise because of inability to meet conflicting economic demands.

PROJECT SUMMARY

Bond Community Health Center, Inc., recognizes that the social determinants of health are the drivers of stress, behavioral health and substance abuse problems. As such BCHC propose to improve long term physical health, quality of life of children and adults, and strengthen the family unit by hiring a **1.0 FTE Psychiatrist** under the umbrella of the Behavioral Health Program. The Psychiatrist will provide comprehensive psychiatric services in an integrated multidisciplinary model to adults and children. Through cognitive interview, therapeutic testing and observation the psychiatrist will provide a diagnosis and treatment plan for patients with mental illness or substance abuse problems. The psychiatrist will collaborate with primary care providers, clinical pharmacists, families, and case managers to identify the best practice model for each individual. The psychiatrist will use a variety of treatment modalities, including medication management, psychotherapy, behavioral therapy, and group counseling. He/she will secure appropriate care for patients during crisis situations.

The psychiatrist will also work with the pediatric staff to differentiate children who may have psychological, physical, developmental, or behavioral problems and make treatment recommendations. The psychiatrist will oversee the provision of substance abuse treatment and over-see case management activities. He/she will give guidance to the primary care physician when psychiatric patients are deemed stable to return to the primary care setting but will require long-term medications. The psychiatrist will treat patients in such a manner that lends itself to the cannons of the American Psychiatric Association and the American College of Psychiatrist.

This enhancement of existing primary care services will decrease barriers to mental health by collocating and fully blending the primary care and mental health services rendered to the pediatric population and expanding existing mental health services to adults to include full-time psychiatry and substance abuse treatment. With these new funds, the integrated model presently in use will be replicated and expanded to include **full-time psychiatry.**

Some of the achievable objectives are:

- Integrate pediatric/adolescent care with behavioral health care to provide a seamless office visit.
  - Primary care and behavioral health care providers in the pediatric clinic will collaborate to deliver prevention, early identification, treatment, and follow-up services. All children, youth and families will be able to access family and prevention-oriented services regardless of financial situation, geographic, cultural or language barriers.
- Further enhance the integrated adult primary care/mental health services by increasing hours of operation and hours of service of the adult psychiatric service.
- Improve primary care outcomes
- Prevent, identify and treat substance abuse in adults and children

- Improve coping skills of parents who care for children with psychiatric diagnosis and behavioral problems
- Identify pediatric patients early with treatable mental health and behavior problems
- Decrease the mental health disparities in minorities and the underserved by decreasing the stigma associated with seeking mental health care
- Decrease violent acts and deaths associated with mental health and substance abuse
- Decrease ER and inpatient days secondary to decompensated mental health problems or relapses of substance abuse
- Decrease rates of domestic and child abuse
- Decrease stimulant medication prescribed by pediatrician
- Decrease Schedule II and III medications prescribed by primary care physicians
- Decrease expulsion rates and incarceration rates

THE NEED

Between January 2012 and June 2012, BCHC rendered care at 1300 pediatric visits. Of the children seen, one-third of them were either on medications for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder or on a waiting list to be screened for these disorders. Funding is being requested and is critical in order to provide access to needed mental health by adult and children. It will also provide support to families affected by substance abuse and mental illness. As recently as **July 25, 2012, President Barack Obama stated in his speech to the National Urban League Convention, New Orleans, Louisiana, "…one way to decrease gun violence in America is to increase mental health services to our troubled youth".** One-third of all hospital readmissions for primary care complaints are associated with untreated mental illness. Primary care treatment outcomes are directly related to the diagnosing and treatment of mental health problems. Without this funding, the community will continue to see children with great need for stimulant medications and adults requiring pain medications as depression or anxiety masking itself as somatic pain in the place of the delivery of quality comprehensive treatment. Children are on waiting lists to be evaluated for behavioral problems because the numbers of psychiatrists in the area who attend to children are limited. In the meantime, primary care physicians and pediatricians are left to make the call - diagnose and treat mental illness or behavioral problems. According to the Mental Illness, Children and Education Fact Sheet, *Florida Council for Community Mental Health January 2011:*

- Children and youth with serious emotional behavioral disorders get lower grades, fail more courses and exams, miss more days of school, are retained at the same grade level more frequently, graduate at lower rates, get arrested more often (37% within one 1 year and 58% within 5 years), spend more time in the juvenile justice system, and are more frequently placed in restrictive educational environments (Wagner and Cameto, 2004; U.S. Department of Education, 2005; Center for Effective Collaboration and Practice; SAMHSA). So much so that the community through the Department of Children and Families has established the Early

Childhood System of Care, a collaboration of community caregivers who are focused on methodologies and systems necessary to address those issues affecting children with mental health and behavioral issues that inhibit their growth to become successful, self sufficient adult contributors to society.

- A history of social adjustment issues also accompanies many emotionally disturbed youth to high school—almost three-fourths of them have been suspended or expelled at least once, a rate more than twice that of youth with disabilities as a whole (Wagner and Cameto, 2004).
- In 2004-05, 45% of students with an emotional disorder dropped out of high school. (U.S. Department of Education, Report to Congress, 2009)
- Up to 14 percent of adolescents in high school with mental health issues receive mostly Ds and Fs in school, (Blackorby, J., et al., 2003)
- Preschool children are three times more likely to be expelled than older children (kindergarten through twelfth grade), and these expulsion rates are often attributed to lack of attention to behavioral and emotional needs. (Gilliam, W. S., 2005)
- Children in elementary school with mental health problems are three times more likely to be suspended or expelled than their peers. (Blackorby, J., et al., 2004)
- School nurses spend 33% of their time providing mental health services. (GAO, 2007)

SAMHSA 2007 and 2008 reported that:

- More than 20% of youth ages 12-17 who were identified as having experienced a major depressive episode in 2007 reported very severe impairment in at least one of the four major role domains (home, school/work, family relationships, or social life), and almost one-half of youth reported severe impairment in at least one of those domains.
- Among youth ages 12-17 that had a major depressive episode, 29.2% report that they initiated alcohol use. Only 14.5% of youth who had not experienced a major depressive episode report they initiated alcohol use.
- Among youth ages 12-17 that had a major depressive episode, 16.1% report they initiated illicit drug use. Only 6.9% of youth who had not experienced a major depressive episode report that they initiated illegal drug use.
- The two largest barriers to providing adequate mental health services reported by schools were competing priorities (70%) and insufficient community mental health resources.

The pediatric team will include the pediatrician, psychiatrist, and most importantly, the case manager. With knowledge, skills and support a parent can raise a healthy, happy child. By continuing to improve integrated care services for children, adolescents and their families in Tallahassee, Bond Community Health Center will further the mission of **helping people live stronger…longer.**

HOSPITAL READMISSIONS

Bond Community Health Center, Inc. will assist to decrease readmission rates to local hospitals secondary to primary care complaints entangled with mental health diagnoses and substance abuse. A review of Identifying Potentially Preventable Readmissions, *Health Care Financing Review/Fall 2008/Vol 3 Table 3* finds a readmission is considered to be clinically related to a prior admission and potentially preventable if there was a reasonable expectation that it could have been prevented by one or more of the following: (1) the provision of quality care in the initial hospitalization, (2) adequate discharge planning and/or inadequate access to care (Halfon et al., 2006; Kripalani et al., 2007) (3) adequate post discharge follow-up, or (4) improved coordination between inpatient and outpatient health care teams. Readmissions are important not only as quality screens, but also because they are expensive, consuming a disproportionate share of expenditures for inpatient hospital care (Anderson and Steinberg, 1984). Three of the top 10 medical initial admissions with potentially preventable Readmission were for diagnoses related to mental health.

Findings published in the October 2010 issue of the *Journal of Hospital Medicine* cited **race** (African-American) and **insurance status** (Medicaid as payer source) as non-clinical predictors of readmission rates, with a 43% and 15% increased risk of readmission respectively after adjustment for other variables. Link to poverty is the association of mental illness and substance abuse. The February 2011 issue of the *Journal of Hospital Medicine* cited depression, anxiety, and hazardous drinking as additional contributors of readmission. Forty-seven percent of depressed patients were readmitted for exacerbations of primary care diagnoses (coronary artery disease, COPD, or pneumonia). Patients with diagnoses of anxiety and hazardous drinking had readmission rates of 38% and 39% respectively. In 2010, a random chart review of all adults of BCHC who signed pain medication contract revealed that 57% had violated this contract as evidenced by urine drug testing, prescription refill practices, abuse or over use. Though most of these patients were in need of pain management, the majority of them also needed alcohol and substance abuse counseling. BCHC seeks to decrease the avoidable admission and readmission rates associated with untreated mental health diseases or substance abuse by continuing to enhance integrated care services for children, adults and families in Leon and surrounding counties.

Table 3. Medical and Surgical Admissions with the Largest number of Potentially Preventable Readmission (PPR). Source- Health Care Financing Review/Fall 2008/Vol 3

Diagnosis	Readmission Rate	All Patients
Heart Failure	12.5	15,053
COPD	9.7	8,271
Schizophrenia	17.7	7,592
Other Pneumonia	7.7	7,579
Major Depression	10.9	5,608
Angina Pectoris and CAD	5.6	5,151
Bipolar Disorders	14.0	4,830
Septicemia and Disseminated Infection	12.6	4,370
Renal Failure	12.8	4,288
Cardiac Arrhythmias and Conduction Disturbance	6.3	4,066
All Other Medical Diagnoses	2.9	41,412
Total Readmissions	5.0	108,220

On January 20, 2010, Leon County Healthcare Advisory Board and its Mental Health and Substance Abuse Reinvestment Advisory Council sponsored a one day summit for stakeholders and mental health professionals to address collaboration needs of community partners in delivering mental health services in Leon County in the face of the increasing shortage of psychiatric services and budget cuts.

In July 2011, the State Health Officer declared a state of emergency changing the prescribing laws of medical physicians and osteopathic physicians who prescribe controlled substances for the treatment of chronic nonmalignant pain. This law had unintentional consequences as it affected the prescribing of all controlled substances, including many of those used to treat many mental health problems. Primary care providers are reluctant to treat these patients or to prescribe many medications that were once the mainstay treatment of many mental health maladies.

The **1.0 FTE Psychiatrist** will be charged with improving discharge outcomes and decreasing readmission rates by assuring that patients are seen timely after release from the hospital or referral centers. Patients will be provided evidenced based treatment regimens. The Psychiatrist will assist with medication reconciliation, physical assessment, and appropriate provider selection upon discharge from the hospital.

PATIENT IDENTIFICATION AND SELECTION

Initially a query of the Medical Management system to identify those active patients whose ICD-9 diagnosis codes reflect mental health or chronic substance abuse will be completed. Referrals will be made through the EHR inter-office referral portal. Patient selection for receiving care from the behavioral health team will be determined by the primary care providers. Some criteria will include: patients who are identified as suffering from a chronic or life threatening disease, patients who screen positive for substance abuse and alcohol, patients who violate their medication contract, patients who are referred from the local schools, and patients identified through the SWAG program — Self Wellness Aiming for Growth. In 2012, Bond Community Health Center, Inc. partnered with Florida State University and University of Florida to participate in prospective study which assess adolescent risk level to participate or be exposed to activities that will be detrimental to healthy living (substance abuse, risky sexual activities, smoking, exposure to abuse and bullying, truancy, etc.) and patients identified as appropriate for the **full-time Psychiatrist** by referral from the local hospital discharge planning staff. BCHC's outreach team has been instrumental in bringing residents into care. BCHC employs outreach liaisons and health educators to identify and educate patients in the target area.

ENHANCED ACCESS TO PRIMARY CARE

To enhance the integrated adult primary care/mental health services the Center will increase hours of operation and hours of service of the adult psychiatric service. BCHC will extend its psychiatric operating hours to 8 am to 5pm three days per week, 11am to 8 pm on two days per week and a minimum of one Saturday per month to reach the working patients and to align mental health services with the non-traditional hours of the pediatric department. Patients will be able to see the primary provider and enjoy a warm hand-off to the mental health team in a familiar setting, thus avoiding some of the stigma often associated with seeking mental health care. The integrated model permits bi-directional referrals between mental health and primary care.

In addition to case conferencing, case management coordination, and the "warm hand-off" strategy that will be employed with each patient and family, both the behavioral health department all other departments, including pharmacy, share the same Electronic Health Record (EHR) system. This allows even greater connection and oversight by the clinical leadership within each department to facilitate outcome measurement and reporting and to enhance clinical decision making at the point of greatest impact –during the office visit. Patients will benefit from real time collaboration of health professionals regarding treatment regimens, interpretation of laboratory results, and outcome goals.

CULTURAL SENSITIVITY; HEALTH CARE LITERARY; DIVERSITY

While BCHC serves a limited number of individuals best served in a language other than English (approx. 8% UDS 2010), nearly 90% of those are Spanish speakers. The Hispanic population is growing by leaps and bounds. It is important to provide guidance, education and health services that encourage our newest citizens to live a healthy lifestyle. Bilingual staff, student interns and volunteers bridge the language

barrier to educate this population on services, resources and health care. In 2012, BCHC identified and hired a fulltime Spanish-speaking Clinical Social Worker. This social worker has unique experience with diverse Spanish speaking cultures. She assists the primary care providers in identifying the psychosocial needs of the patients and directs them to the appropriate resources. In addition, several primary care providers, and staff members speak competent Spanish, Arabic, Creole, and Caribbean Island dialects. Several mechanisms are in place to ensure culturally linguistically appropriate services at BCHC. Employees are trained semi-annually regarding cultural awareness and sensitivity, and patients are assessed regarding cultural issues, religious beliefs and learning ability. Services are available for the hearing impaired, and all documents are appropriate for low-literacy readers as well as being culturally appropriate. The pediatric department has seen a slight increase in patients of Asian descent. Translators of the most common languages (Vietnamese and Mandarin) volunteer services.

The Center utilizes a patient advocate (who is a retired nurse) to assist patients with literacy problems. She combs the office identifying patients who may need help with completing forms or understanding written instructions. Outreach programs are specifically geared to the health risks of an increasing diverse population. Biannually, training sessions are held for clinicians and staff on cultural competence issues, including care to special populations, such as Gay, Lesbian, Bisexual, and Transgender (LBGT), the morbidly obese patient, etc. BCHC utilizes nationally-recognized best practices in regard to culturally sensitive chronic disease prevention and screening programs and the Board of Directors is representative of the population served as required by The Health Resources and Services Administration (HRSA).

MEASURES AND DATA SOURCES TO EVALUATE EFFECTIVENESS

The behavioral health team will be led by **1.0 FTE Psychiatrist** who has experience and training in treating both adults and children and who will oversee the treatment protocols and prescribing activities of the psychiatric Advance Registered Nurse Practitioner. The integrated behavioral health/primary care team will:

- Assess the health and functional status of patients
- Formulate a comprehensive care plan
- Select, initiate, modify, or recommend changes to medication therapy
- Monitor patients' response to therapy
- Provide means to enhance medication adherence
- Utilize case conferences to additional care providers
- Utilize best practice models and nationally accepted quality standards to make treatment recommendations
- Utilize the group visit to impact a greater number of patients with similar behavioral health problems.

It is the Board of Directors' (BOD) policy for Bond Community Health Center (BCHC) to provide the highest quality of care in all its services and activities. To that end, leadership has established a planned, organization-wide approach to monitoring/improving organizational performance. This approach is expected to provide systems/process improvements, enhance staff performance, increase customer

satisfaction, reduce risks, and sustain improvements. Evaluations of health care programs at BCHC are the responsibility of the Continuous Quality Improvement/Quality Assurance (CQI/QA) Committee. Adapted from the diabetes health disparity collaborative, BCHC utilizes the “Plan-Do-Check-Act" (PDCA) model for performance improvement. All departments participate in performance improvement and outcome measurement, with review of indicators on a regular basis, under the leadership of the Continuous Quality Improvement/Quality Assurance sub-committee of the Board of Director.

Utilization and productivity data is shared with the provider staff and reported monthly to the Board of Directors. Quarterly, the CQI/QA committee will review each new initiative’s successes and challenges in reaching predetermined outcome indicators. The activities of the new projects will comply with BCHC’s other risk management practices such as:

1. Evaluation of pre-determined benchmark outcomes and health indicators (HEDIS, BPHC Program Expectations, Florida Board of Pharmacy practice guidelines, State statutes)
2. Utilization of evidence based medicine and best practices
3. Tracking and recall
4. Informed consent
5. Patient satisfaction
6. Credentialing and privileging
7. Peer review
8. Re-evaluation of protocols, policy and procedures

The CQI/QA committee maintains a sub-committee that addresses patient complaints, patient satisfaction, incident reports and accident reports of the Center. These surveys and reports are compiled and sent to the CQI/QA committee for corrective action and follow-up as needed. This committee functions very well and its activities have resulted in numerous recommendations being submitted to the Board of Directors for policy revision and/or adoption. Every third patient attending the center is given a patient satisfaction survey to complete and submit, which are analyzed quarterly. Patients are also given a copy of the Patient Bill of Rights and Responsibilities upon enrollment and these are also prominently displayed in the waiting rooms.

DATA COLLECTION AND REPORTING

BCHC utilizes Medical Manager as its practice management system, GE Centricity as its electronic health record, CareWare for the gathering of HIV/AIDS data, Florida Shots for documenting and gathering pediatric date, UDS information and the Florida Department of Health’s CHARTS for information on health status indicators, patients served, services provided and costs. These MIS systems provide an excellent foundation for reporting patient utilization and outcomes that can be upgraded to track and report additional required information. Bond Community Health Center, Inc. has invested heavily in its electronic health system and meaningful use activities. In 2013, BCHC will begin to integrate the EHR with the practice management system to assure the seamless and complete capture of medical data and to decrease dual entry and wasted resources. The

electronic health system supports evidence-based medicine and addresses health disparities. It will ready the Center as it prepares to become a certified Patient Centered Medical Home. CQI/QA efforts, patient safety concerns, and operational cost efficiency will be supported by this technology. It will also support pay-for-performance, provider recruitment and retention programs.

REPORTING TEMPLATE

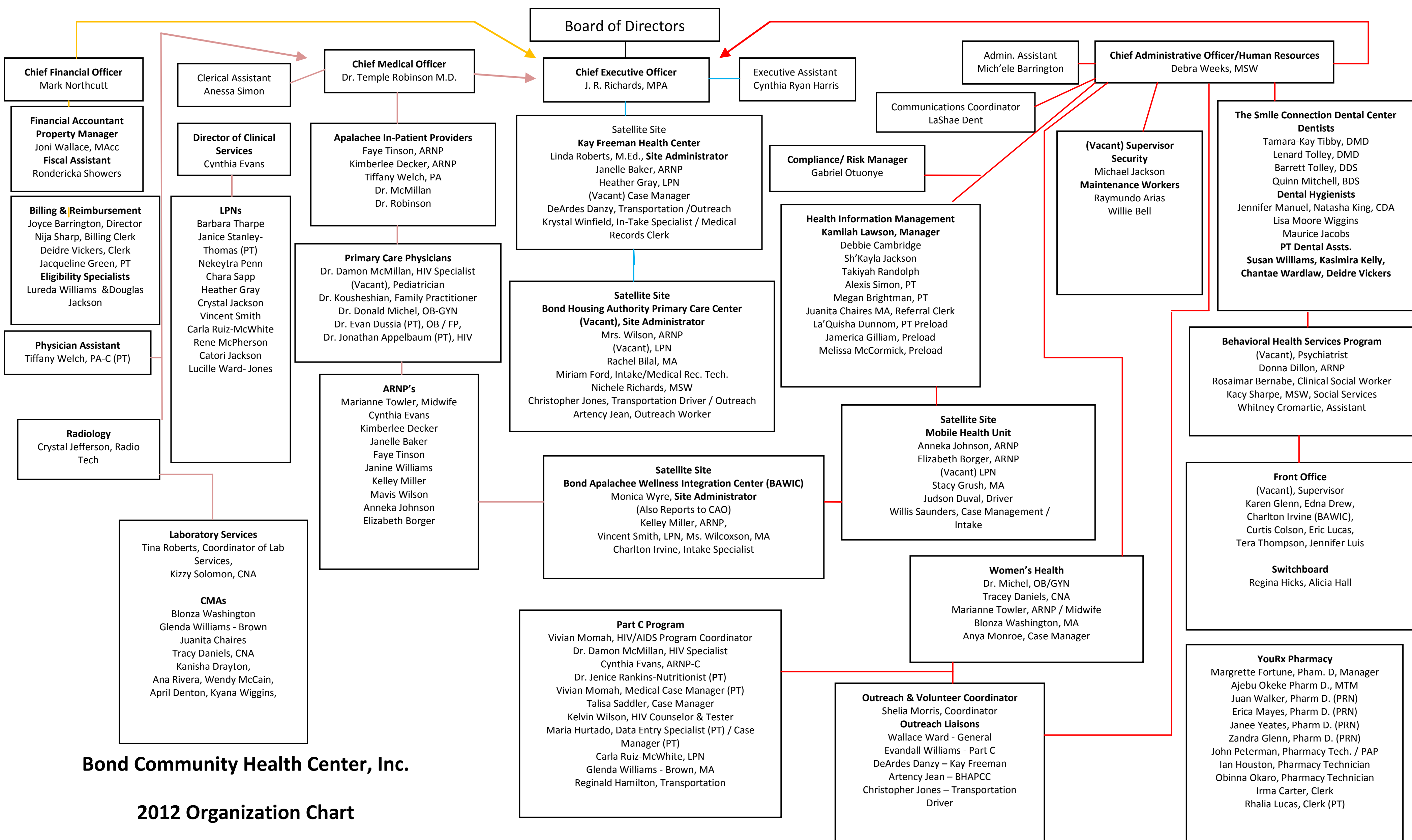
Need Addressed/ Focus Area	Project Period Goal(s) with Baseline	Performance Measure(s)	Data Source & Methodology	Progress to Date
Adolescent Risk Assessment	By 2014, increase # of adolescents screened for mental health/depression and risky behaviors from baseline of 50% in 2012 to 80%.	Percentage of adolescents completing annual behavioral risk questionnaires	*Chart Review; Outcomes of the SWAG project*	
Prescribing of Mood Altering Medications to Pediatric Patients	Baseline to be established. Goal to decrease use of these mediations and the prescribing of these mediation by primary care physicians—deferring to psychiatrist	Number of prescriptions written for Schedule II medications.	*EHR and YouRx (Bond's in-house pharmacy) CQI-QA report to measure and establish baseline.*	
Substance Abuse	By 2014, increase by 35 % of patients referred for counseling who screened positive for active substance abuse from 35% to 70%	Number of patients referred/Number of patients who screen positive by any method (questionnaire, urine drug screen, etc.)	*EHR Chart Review*	
Adult Mental Health	Baseline to be established. Goal is to increase the number of adults who are evaluated by a psychiatrist secondary to direct referral from	Number of patients referred to behavioral health after screening positive for depression or having been previous diagnosed	*PHQ-9 screen that is embedded in adult office visit form of EHR system to measure and establish*	

Need Addressed/ Focus Area	Project Period Goal(s) with Baseline	Performance Measure(s)	Data Source & Methodology	Progress to Date
	primary care provider or psychiatric nurse practitioner.	for other mental health disorders.	*baseline.*	

SOURCE of LOCAL MATCH

BCHC has historically garnered the support of the Leon County Board of County Commissioners (LCBCC). The LCBCC has provided a letter of commitment for the required local match.

Appendices: A - Organizational Chart
B - Line Item Budget
C - Letter of Support



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Chief Medical Officer
Dr. Temple Robinson M.D.
Apalachee In-Patient Providers
Faye Tinson, ARNP
Kimberlee Decker, ARNP
Tiffany Welch, PA
Dr. McMillan
Dr. Robinson
Primary Care Physicians
Dr. Damon McMillan, HIV Specialist
(Vacant), Pediatrician
Dr. Kousheshian, Family Practitioner
Dr. Donald Michel, OB-GYN
Dr. Evan Dussia (PT), OB / FP,
Dr. Jonathan Appelbaum (PT), HIV
ARNP's
Marianne Towler, Midwife
Cynthia Evans
Kimberlee Decker
Janelle Baker
Faye Tinson
Janine Williams
Kelley Miller
Mavis Wilson
Anneka Johnson
Elizabeth Borger
Laboratory Services
Tina Roberts, Coordinator of Lab Services,
Kizzy Solomon, CNA
CMAs
Blonza Washington
Glenda Williams - Brown
Juanita Chaires
Tracy Daniels, CNA
Kanisha Drayton,
Ana Rivera, Wendy McCain,
April Denton, Kyana Wiggins,
Satellite Site
Kay Freeman Health Center
Linda Roberts, M.Ed., Site Administrator
Janelle Baker, ARNP
Heather Gray, LPN
(Vacant) Case Manager
DeArdes Danzy, Transportation /Outreach
Krystal Winfield, In-Take Specialist / Medical Records Clerk
Satellite Site
Bond Housing Authority Primary Care Center
(Vacant), Site Administrator
Mrs. Wilson, ARNP
(Vacant), LPN
Rachel Bilal, MA
Miriam Ford, Intake/Medical Rec. Tech.
Nichele Richards, MSW
Christopher Jones, Transportation Driver / Outreach
Artency Jean, Outreach Worker
Satellite Site
Bond Apalachee Wellness Integration Center (BAWIC)
Monica Wyre, Site Administrator
(Also Reports to CAO)
Kelley Miller, ARNP,
Vincent Smith, LPN, Ms. Wilcoxson, MA
Charlton Irvine, Intake Specialist
Part C Program
Vivian Momah, HIV/AIDS Program Coordinator
Dr. Damon McMillan, HIV Specialist
Cynthia Evans, ARNP-C
Dr. Jenice Rankins-Nutritionist (PT)
Vivian Momah, Medical Case Manager (PT)
Talisa Saddler, Case Manager
Kelvin Wilson, HIV Counselor & Tester
Maria Hurtado, Data Entry Specialist (PT) / Case Manager (PT)
Carla Ruiz-McWhite, LPN
Glenda Williams - Brown, MA
Reginald Hamilton, Transportation
Admin. Assistant
Mich'ele Barrington
Chief Administrative Officer/Human Resources
Debra Weeks, MSW
Communications Coordinator
LaShae Dent
Compliance/ Risk Manager
Gabriel Otuonye
Health Information Management
Kamilah Lawson, Manager
Debbie Cambridge
Sh'Kayla Jackson
Takiyah Randolph
Alexis Simon, PT
Megan Brightman, PT
Juanita Chaires MA, Referral Clerk
La'Quisha Dunnom, PT Preload
Jamerica Gilliam, Preload
Melissa McCormick, Preload
Satellite Site
Mobile Health Unit
Anneka Johnson, ARNP
Elizabeth Borger, ARNP
(Vacant) LPN
Stacy Grush, MA
Judson Duval, Driver
Willis Saunders, Case Management / Intake
Women's Health
Dr. Michel, OB/GYN
Tracey Daniels, CNA
Marianne Towler, ARNP / Midwife
Blonza Washington, MA
Anya Monroe, Case Manager
Outreach & Volunteer Coordinator
Shelia Morris, Coordinator
Outreach Liaisons
Wallace Ward - General
Evandall Williams - Part C
DeArdes Danzy – Kay Freeman
Artency Jean – BHAPCC
Christopher Jones – Transportation Driver
(Vacant) Supervisor
Security
Michael Jackson
Maintenance Workers
Raymundo Arias
Willie Bell
The Smile Connection Dental Center
Dentists
Tamara-Kay Tibby, DMD
Lenard Tolley, DMD
Barrett Tolley, DDS
Quinn Mitchell, BDS
Dental Hygienists
Jennifer Manuel, Natasha King, CDA
Lisa Moore Wiggins
Maurice Jacobs
PT Dental Assts.
Susan Williams, Kasimira Kelly,
Chantae Wardlaw, Deidre Vickers
Behavioral Health Services Program
(Vacant), Psychiatrist
Donna Dillon, ARNP
Rosaimar Bernabe, Clinical Social Worker
Kacy Sharpe, MSW, Social Services
Whitney Cromartie, Assistant
Front Office
(Vacant), Supervisor
Karen Glenn, Edna Drew,
Charlton Irvine (BAWIC),
Curtis Colson, Eric Lucas,
Tera Thompson, Jennifer Luis
Switchboard
Regina Hicks, Alicia Hall
YouRx Pharmacy
Margrette Fortune, Pham. D, Manager
Ajebu Okeke Pharm D., MTM
Juan Walker, Pharm D. (PRN)
Erica Mayes, Pharm D. (PRN)
Janee Yeates, Pharm D. (PRN)
Zandra Glenn, Pharm D. (PRN)
John Peterman, Pharmacy Tech. / PAP
Ian Houston, Pharmacy Technician
Obinna Okaro, Pharmacy Technician
Irma Carter, Clerk
Rhalia Lucas, Clerk (PT)
Bond Community Health Center, Inc.
2012 Organization Chart

Appendix B BCHC State Department of Health (DOH) 2012-13
Low Income Pool (LIP) Tier-One Milestone (STC 61) Grant Application
Line Item Budget Justification Spread Sheet

SALARY AND WAGES:		
Psychiatrist--1.0 FTE *To provide adult and pediatric psychiatric services using a proven integrated model*	$141,947	*
TOTAL SALARY AND WAGES	**$141,947**	
FRINGE BENEFITS: 28%		
FICA: 7.65%	$10,859	
DENTAL & HEALTH: 8.35%	$11,853	
DISABILITY: 3%	$4,258	
WORKERS COMP: 2%	$2,839	
CME: 3%	$4,258	
RETIREMENT: 3%	$4,258	
UNEMPLOYMENT: 1%	$1,419	
TOTAL FRINGES	**$39,744**	**
TOTAL BUDGET:	**$181,691**	

* Request for Funding
** In Kind Funding

Leon County

Board of County Commissioners

301 South Monroe Street, Tallahassee, Florida 32301
(850) 606-5302 www.leoncountyfl.gov

Leon County Office of
Human Services and Community Partnerships
918 Railroad Avenue
Tallahassee, Florida 32310
(850) 606-1900

Commissioners

BILL PROCTOR
District 1

JANE G. SAULS
District 2

JOHN DAILEY
District 3

BRYAN DESLOGE
District 4

KRISTIN DOZIER
District 5

NICK MADDOX
At-Large

AKIN AKINYEMI
At-Large

VINCENT S. LONG
County Administrator

HERBERT W.A. THIELE
County Attorney

July 30, 2012

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Re: Bond Community Health Center, Inc. 2012-13 Low Income Pool (LIP) Tier-One Milestone FQHC Grant Application

In response to Bond's request, we are pleased to provide this Letter of Commitment for cash matching funds in the amount of $60,000 (sixty thousand dollars) from the Bond Community Health Center's (BCHC) 2012/2013 Primary Healthcare Program funding, to be utilized by the State Department of Health (DOH) 2012-13 Low Income Pool (LIP) Tier-One Milestone FQHC grant opportunity.

BCHC has indicated that this grant proposal is to add a full time Psychiatrist to address the social determinants of health that are the drivers of stress, behavioral health and substance abuse problems. BCHC will improve long term physical health, quality of life of children and adults. This enhancement of existing primary care services will decrease barriers to mental health.

Pending funding approval and ratification of the FY 2012/13 Annual Adopted Budget, the Leon County Board of County Commissioners will provide $60,000 in matching funds to The Agency for Healthcare Administration (AHCA) on behalf of the Bond Community Health Center. As requested, this match represents the required local match of 42.27%.

If funding is approved, the County commits to begin the process of submitting payment to AHCA after approval of funding to Bond Community Health Center and adoption of the FY2012/13 Annual Budget. If awarded, a contract will be executed for an effective date of October 1, 2012. If you have any questions or require additional information, please feel free to contact me at WilsonCa@leoncountyfl.gov or 850-606-1900.

Sincerely,

Candice M. Wilson

Candice M. Wilson, Director
Office of Human Services and Community Partnerships