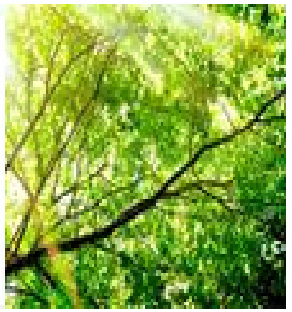
Presentation to the Florida LIP Council
October 5, 2011


Bond Community Health Center



"In the Community, For the Community."
"Helping People Live Stronger, Longer "

WHO WE ARE! WHAT WE DO!

To improve the physical, spiritual, psychosocial and psychological well being of the residents of Leon and surrounding counties by providing access to the highest quality, comprehensive, family health services with particular concern for the lower socioeconomic groups, regardless of their ability to pay.

- Became FQHC in 1978
- Provides comprehensive primary and preventive health care services including x-ray, pharmacy, dental and behavioral health.
- Renovated a 30,000 square foot facility in 2009 to increase access to care.
- Operates 3 sites soon to be five with Public Housing Primary Care (PHPC) and a Mobile Health Care Van.
- 5 year growth rate depicts, Employees increased from 44 in 2006 to 104 in 2010; Patients increased from 9,420 to 12,526; Visits increased from 23,895 to 36,142 respectively, with a current budget of 7.5 million.
- Currently serves 72% African Americans; 23% Caucasian; 4% Hispanic and 1% Asian.
- Population served is 69% uninsured compared to National average of 54% and State average of 49%; Medicaid patients 18% compared to National average of 40% and State average of 35%.
- First in the State to integrate primary health care and mental health.
- Second in the State to obtain funding to operate a PHPC Site.
- Sole provider of HIV/AIDS primary care to a seven county area, Area 2B.
- One of two Florida FQHC's recognized on the DHHS Office of the Assistant Secretary for Financial Resources website highlighting successful Recovery Act grantees.

LIP Enhanced Primary Care Funding 2010-2011

- Received 1 million dollars in funding to increase access to care and avoid unnecessary ER utilization.
- Initiatives under this funding includes:

1) ***Expanding Hours of Operation*** for all services, specifically pharmacy and dental and implementing radiology services;
2) ***Establishing a Continuity Clinic*** using a modified open access scheduling model such as a web portal for both hospitals to log in and schedule follow up discharge appointments in our practice system; establishing a Medical Doctor of the Day for immediate services upon patient discharge from hospitals.
3) Instituting a ***Disease Management/Medication Management Program*** with emphasis on medication needs, health literacy, patients with asthma, congestive heart failure, diabetes, mental health diagnosis and a history of non-compliance;
4) ***Establishing a Comprehensive Wellness Program*** by centralizing our smoking cessation, alcohol and substance abuse support services by recruiting the services of a Nutritionist.

Funding for Initiatives

- **Initiative 1)** Additional 0.5 FTE ARNP; 0.5 FTE LPN; 0.5 FTE MA; 0.5 Pharmacist; 1.0 FTE Dentist; 1.0 FTE Dental Assistant; and a 1.0 FTE Radiology Technician. Purchase equipment and implement Radiology services. Cost for uninsured laboratory testing.
- **Initiative 2)** Additional 0.5 FTE Physician to serve as Medical Doctor of the Day and provide immediate services to individuals discharged from the ER; Medical support staff for physician in the form of a 0.5 FTE LPN and a 0.5 FTE Front Desk Receptionist. Bridge medications for 3-5 days post discharge. Develop web portal for hospitals to log in and make follow up appointments in our practice system.
- **Initiative 3)** Additional 0.5 FTE ARNP to serve as chronic disease management lead provider; 1.0 FTE LPN; 0.5 FTE Pharmacist to focus on medication management and a 1.0 FTE Health Educator to provide patient education and strengthen health literacy .
- **Initiative 4)** Hire 0.25 FTE Nutritionist to conduct sessions in food selection and preparation, evaluations of glucose and lipid levels, blood pressure, body mass index measurements and evaluation of malnourished and underweight patients.

PROGRESS

- **Initiative 1)** All service hours have been extended including Dental and Pharmacy; All staff have been hired; Radiology equipment purchased, installed and x-ray services being provided with contractual arrangements for over reads and transcription.
- **Initiative 2)** Medical Doctor of the Day and support personnel has been hired and providing services to the recently discharged patients. Bridge medications available for those in need. Web Portal to be developed by November 1, 2011.
- **Initiative 3)** ARNP and support staff hired; Pharmacist hired and providing medication management to patients; Health Educator expected to be hired by November 15, 2011.
- **Initiative 4)** Nutritionist hired and provides services primarily to the HIV/AIDS population as population most in need of service.

Anticipated Outcomes

- Conserved community resources by decreasing avoidable readmissions and ER visits solely due to medication non-adherence or limited access to timely follow-up with primary care provider.
- Increased physical well-being through lifestyle modification and self-management, especially regarding obesity, tobacco and substance abuse, and medication adherence.
- Decreased medication cost and increased compliance through medication reconciliation.
- Conserved community resources by decreasing redundancies in laboratory testing and radiological testing.
- Improve patient participation and self-management of chronic diseases.
- Eliminate admissions secondary to poor communication between referring hospitals and primary care provider by providing immediate scheduling and transfer of health information.

Measurement Tools

- Adherence to medication will be evaluated by indicators such as correct interval of prescription refills, A1c less than 8, frequency of use of rescue inhalers.
- Pre- and post testing will be used to gauge improvement in patient health literacy.
- Monitoring stability of weight in patients with congestive heart failure or battling obesity.
- Predetermined benchmark outcomes and health indicators as adopted by the Center's CQI/QA committee that are aligned with HEDIS and BPHC Program Expectations—immunizations, blood pressure control, diabetes control, and cancer screening.
- Quarterly readmission report cards from various managed care organizations.
- Quarterly reports from referral hospitals-utilization review and Main Line Administrative reports.
- Provider schedules, productivity reports and no-show rates.