March is Severe Weather Awareness Month
By John Longo, Emergency Preparedness Coordinator, IPHCA

The month of March is dedicated by the Illinois Emergency Management Agency (IEMA) as severe weather awareness month. All residents are encouraged to reflect on the severe weather that Illinois has recently endured and focus on preparing for challenges that severe weather can create in the future.

In the past year, Illinois received heavy rain that resulted in flooding across the state, a historic blizzard that left up to two feet of snow in some places, dangerously cold temperatures that endured for several days, and 48 reported tornadoes. Each of these events, and others, caused power loss, prevented staff from reporting to work, caused structural damage and impacted health centers’ ability to deliver services.

As such, community health centers are encouraged to review all existing severe weather plans over the next month. How will your organization handle loss of power? Service interruption? A need to relocate operations in the event the facility is unsafe?

Severe weather can quickly have an impact on a community health center. It is important that staff is prepared to deal with effects, whether minor or severe. Below are some tips for planning for severe weather:

- Know the meanings of severe weather terms, such as “watch,” “warning” and “advisory.”
- Make sure that all clinic sites have an operating National Oceanic and Atmospheric Administration (NOAA) weather radio.
- Have plans in place to deal with the loss of power.
- Encourage staff to develop family preparedness plans and create “to go” bags.

If you have not already, now is a good time to sign up for flood insurance through the National Flood Insurance Program, which can be easily initiated at www.fema.gov/about/programs/nfip/index.shtm.

Organizations are also encouraged to review all other insurance policies to ensure that they are up to date and meet the coverage that is needed by your community health center.

Reference
Established in 1982, the Illinois Primary Health Care Association is a nonprofit trade association of community health centers (CHCs) that proudly serves as Illinois’ sole primary care association. IPHCA is governed by an Assembly of Delegates composed of one director from each Organizational member of the Association.

The Illinois Primary Health Care Association strives to “improve the health status of medically underserved populations by fostering the provision of high-quality, comprehensive health care that is accessible, coordinated, community-directed, culturally-sensitive, and linguistically-competent.” Ultimately, IPHCA works to increase access to high-quality, cost-effective primary health care services in urban and rural populations throughout the state, regardless of an individual’s ability to pay.

IPHCA Health Source™ is a monthly publication that provides information on a variety of topics of interest to community health centers and related organizations.
A Message from Fred Bernstein, IPHCA Board Chair

One aspect of the community health center movement that we have always been able to depend upon is bi-partisan support. As this month’s message is being written, however, the federal budget for health centers is being debated in the House. It is not at all clear how much bi-partisan support there will be for community health centers in the face of the new “mandate” to cut spending. The problem we as health centers face is compounded by the fact that some of the animus driving the cost-cutting is directed at health care reform, and the architects of the plan to cut $100 billion from the president’s budget are the same people who are determined to repeal health care reform.

Our mission is to educate new members, and returning members of Congress alike, about the importance of health centers as cost effective safety net providers—as the best “bang for the buck” in health care anywhere. Our strongest message in the face of the demands to cut the budget is perhaps twofold: We have to be able to show the value in economic as well as health outcomes terms of the quality health care services health centers deliver, but we also have to be able to project what will happen if key support for the safety net is withdrawn. And we need to put dollar costs to that scenario as well.

We have to hope that veterans of Congress from both parties will remember and continue their support of community health centers. We also have to hope that they will be able and willing to voice their support—and the reasons for their support—to those colleagues who are not aware of the history and the mission of the community health center movement, and the role of community health centers in providing health care services to those least able to afford them.

There has never been a point in the history of health centers when our ability to tell our story has been more important. In the rush to cut costs without making distinctions, this may seem like “mission impossible,” but not to accept that mission is not an option. As we all know too well, millions of patients are depending on us.
Illinois to Work on Child Health Measures, Quality Improvement and Medical Home Delivery Through CHIPRA Demonstration Project

By Scott G. Allen, Executive Director, Illinois Chapter, American Academy of Pediatrics

In early 2010, Florida (lead) and Illinois (partner) were awarded one of 10 Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grants by the Centers for Medicare and Medicaid Services (CMS). One activity of the CHIPRA grants is to make use of a new core set of children’s health care quality measures approved for voluntary use by Medicaid and CHIP programs in 2010. These measures are posted on the Agency for Healthcare Research and Quality (AHRQ) website at www.ahrq.gov/chipra/. The demonstration grants were awarded to allow states or combinations of states to work with these measures, as well as undertake a range of child quality improvement activities.

What Will Illinois Do?
Florida and Illinois will work in four grant categories (A, B, C and E). From 2010 to 2015, the grant will fund the following:

- **Experiment with and evaluate the use of quality measures for children’s health care** (Category A). In Illinois, 12 of the 24 core measures are already collected, analyzed and reported centrally. Since receiving the CHIPRA grant, Illinois has begun developing reports for five other core quality measures and will soon begin work on the rest. Illinois will explore new opportunities to build quality measures into provider reporting and incentive programs. Illinois will also develop and test new measures that are in line with priority improvement areas.

- **Promote the use of health information technology in measuring and improving children’s health** (Category B). Efforts to establish Health Information Exchanges (HIEs) and enlist clinics to use electronic medical records (EMRs) are ongoing through separate state and federal initiatives. The CHIPRA demonstration grant will connect with those activities to ensure that child health quality reporting, tracking and quality improvement activities are integrated. Of particular note in this category, Illinois hopes to develop a mechanism to allow medical home providers to electronically make referrals to other medical and community service providers and receive care feedback reports. Illinois is also using this opportunity to develop a minimum data set describing women’s use of prenatal care services and prenatal risk and making it accessible to hospitals at the time of delivery.

- **Support and evaluate innovative, provider-based models (medical homes) for delivering children’s health care** (Category C). A key first step to improving the quality of medical home services is to help clinics assess their “medical homesness.” There are many tools to do this, including the Medical Home Index, the National Committee on Quality Assurance (NCQA) recognition standards and more. The Illinois Department of Healthcare and Family Services (HFS), the Illinois Chapter of the American Academy of Pediatrics (ICAAP), Health Management Associates and NCQA intend to identify a range of acceptable strategies that clinics can use for assessment. These organizations will then support up to 200 clinics in conducting assessments to identify strengths and areas for quality improvement. Working with subsets of clinics, ICAAP will lead quality improvement initiatives focusing on systems issues, such as care coordination, and specific CHIPRA core measures. These activities, coupled with provider surveys, will help ICAAP assess how data reports on the new child health measures given to both clinics and individual physicians can become “actionable” and useful for improving health outcomes.

This process will clearly help providers strengthen their medical homes and improve their content and quality of services. It will also help ICAAP identify barriers to the provision of quality services and work at the community and state levels to address them. Furthermore, this work will integrate with Medicaid policy. Project partners will help Illinois Medicaid, with NCQA consultation and assistance, explore options for developing a protocol for recognizing medical homes at various steps in the process of moving toward full NCQA medical home recognition. Jointly, project partners will explore options for incorporating provider incentives, such as bonus or care management payment, CME credit, NCQA certification, and maintenance of certification credit via the American Board of Pediatrics and other boards into these initiatives.

- **Implement a quality improvement collaborative focused on improving perinatal and early childhood health care** (Category E). Efforts in this category include publishing minimum care standards for preconception, prenatal and interconception care, and measuring compliance; developing the prenatal care data set as noted above; improving care coordination for high risk women; connecting neonatal intensive care unit (NICU) graduates to medical homes and early intervention; and implementing and assessing the effectiveness of targeted preconception, prenatal and interconception interventions.

What the CHIPRA Grant Means for Clinics
The CHIPRA grant activities will ultimately provide pediatricians, family physicians and others who treat children in Illinois with:

- Expanded clinic/physician level data that are available any time and able to be integrated into clinic electronic...
Many health care organizations have established a social networking presence to educate the public, connect with potential patients and enhance communication with staff and providers. Typically, organizations create networking channels by linking their own website to various types of media platforms:

- Social networks to share news and information, e.g., Facebook and MySpace
- Video and photo sharing sites to provide rapid exchange of documents and images, e.g., Flickr and YouTube
- Micro-blogging sites to encourage interaction via short published messages, e.g., Twitter
- Business networks to connect job seekers and potential partners to the organization, e.g., LinkedIn
- Forums and discussion boards to support sustained dialogue among community members, e.g., blogs

While these tools may be highly beneficial, their misuse can invite exposure to such perils as bodily injury due to inappropriate content, infringement, disclosure of protected patient information and network infiltration.

Prior to initiating networking activities, consider establishing a social media steering committee that includes risk management, legal, marketing, information security and health records professionals to determine basic guidelines.

During the planning process, the following questions should be addressed:

- What is the underlying purpose of the social media site?
- Which media platform is best suited for this purpose?
- Who is the intended audience?

- What topics, activities and forms of interaction will be promoted (and what will be discouraged)?
- What resources are available for the project?

Some organizations may choose to retain an interactive/social media manager to assist in conducting preliminary vendor assessments; reviewing insurance policies for potential coverage gaps; and establishing practical boundaries, guidelines, operating rules and security controls.

Social media safeguards should include written policies and procedures that protect patient privacy, prohibit misleading and harassing statements, and designate individuals who can speak on behalf of the organization.

Staff training should be offered to all employees, including new hires, on an annual basis. Focus should include social networking rules and etiquette, parameters for use during working and non-working hours, possible legal perils, patient confidentiality issues and disciplinary consequences for misuse.

A directors and officers liability policy may not provide sufficient coverage for risks associated with social networking sites. Health care organizations using these media should consider securing specialized insurance coverage for these types of exposures.

For more information, please contact Mike Reedy or Janie Mueller at (800) 946-4926.
Crusader Community Health: Foundation Grant Makes Electronic Dental Records System a Reality
By Amy Garwood, Communications and Member Services Specialist, IPHCA

The introduction of electronic health records has brought with it a wave of new technology focused on transitioning providers to a more paper-free environment. While many of these advancements are costly, one health center secured foundation funding to help make their digital dreams come true.

Crusader Community Health, a provider of dental care since 1972, implemented an electronic dental records (EDR) system, thanks to a grant from the Illinois Children’s Healthcare Foundation (ILCHF). With this funding, Crusader integrated the EDR system with their electronic medical records system – eClinical Works. It also included installation of dental digital imaging that provides better diagnostics, reduced radiation and ongoing cost savings. Crusader received engagement funding from ILCHF to be a pilot site to test the benefits of EDR and institute a benchmark quality program that could be replicated to other oral health programs.

This initiative has already improved continuity of care, resulted in better tracking of outcome measures, and enhanced operational efficiencies. The EDR provides 3D charting with customized chart views and a graphical display of prior existing treatment, current treatment and projected treatment. These tools are helpful in achieving the goal of full mouth restoration. The new EDR system also utilizes a flat screen TV at each operatory for "GURU" – a patient education program that uses animation for child friendly oral hygiene instruction, age appropriate education, and information about sealants, flossing, brushing and prevention. GURU also provides tools to explain treatment plans and prevention of future dental disease.

“We thank the ILCHF for truly understanding that their funding of our dental innovations is an investment that pays off at many levels,” said Gordon Eggers, Crusader chief executive officer. “Our needy patients receive state of the art dental care, the documented quality outcomes help drive further excellence, patient and staff self-esteem and satisfaction are elevated by the modern work environment, and recruitment is easier.”

Due to the significant gap in the number of pediatric patients who are not accessing dental care, a pediatric dental care coordinator has been hired to work with pediatric providers to schedule child dental visits when receiving well child care.

Crusader Community Health, along with many other IPHCA members, continues to find innovative ways to provide expedited and high-quality medical and dental care to the patients they serve. ■

Samela Kuckovic, Crusader dental assistant, x-rays a dental patient with the new digital equipment.

Heather Leber, Crusader dental unit coordinator, demonstrates the GURU patient education program that uses animation for oral hygiene instruction and age appropriate education.
still a relatively new federal community development financing tool, the New Market Tax Credit Program (NMTC) continues to evolve in its application. As a complex tax credit financing mechanism, the program can appear confusing at first glance. However, a growing number of organizations across the country have found that NMTCs can be an excellent tool for financing Federally Qualified Health Centers (FQHCs), and this trend is likely to continue.

What is the NMTC?
The NMTC is a federal tax credit benefit that is generated by the flow of capital through a U.S. Treasury-certified Community Development Entity (CDE). CDEs are a diverse array of private, mission-driven organizations created by banks, nonprofits and government entities that can apply for competitive allocations of NMTCs from The Treasury. Each CDE has a defined geographic service area—ranging from local to national—and a defined set of investment priorities. Many CDEs include the financing of community facilities, such as FQHCs, as a core part of their mission.

CDEs most typically serve as a conduit for capital. The amount of capital flowing through the CDE for a given transaction dictates how much federal NMTC benefit will be generated—the statutory formula is a federal tax credit equal to 39 percent of the total capital investment flowing through the CDE, spread over a 7-year investment period. CDEs in turn allocate this benefit to investors, in exchange for up-front cash invested in the CDE. Because the investor is purely buying a tax benefit, i.e., not seeking much if any cash return from the investment, the CDE is able to package this capital to provide very low-interest loans to Low-Income Community (LIC) borrowers, such as FQHCs.

Why NMTCs Can Be a Great Fit for FQHC Financing
The legislative intent of the NMTC program is to support flexible, borrower-friendly financing for businesses and non-residential development projects located in LIC Census tracts. The program places a high emphasis on projects that generate positive community impacts within LICs, including job creation/retention and expansion of available community services. Given the typical locations, patient base and community impacts of FQHCs, the NMTC program is a natural fit for these types of health care facilities.

How NMTC Transactions Can Work for FQHCs
NMTC deals can take a wide array of forms, but the best option for most FQHC transactions is likely to be the “leverage structure,” whereby the NMTC benefit is used to create a layer of flexible, low-interest “gap financing” that supplements the other sources of capital available to the FQHC. CDE fees and investor pricing can vary widely, but in general, this financing structure can generate additional financing ranging from a 15-20 percent net increase in the capital available to the FQHC. This additional layer of capital generally is packaged as interest-only debt at a rate of about 1 percent. These loans can be used either to directly fund construction or provide “takeout” financing, i.e., a longer-term amortizing loan that replaces the construction loan after completion shortly after project completion. NMTC financing can also, in some cases, be used to provide more holistic business financing for the FQHC’s operations. At the end of the 7-year NMTC compliance period, the deals frequently contain mechanisms whereby the FQHC can purchase this additional layer of debt for a nominal amount, effectively converting the low-interest loan into a permanent subsidy.

The main challenge in a typical NMTC leverage structure transaction is identifying sources of capital (generally equal to 75 percent or more of total project cost) that can be loaned to the NMTC investor up-front. These sources are typically referred to as the “Leverage Loan” in the NMTC structure. In turn, the investor packages the Leverage Loan proceeds with their NMTC equity and invests the combined amount into the CDE. Finally, the CDE lends these funds back to the NMTC borrower, passing on the benefits of increased capital and reduced interest cost. A chart is included on page eight to graphically show a sample of the leverage structure.

The PCC Community Wellness Center Example
PCC Community Wellness Center Austin Family Health Clinic—located in a low-income medically underserved area (MUA) on Chicago’s west side—is one example of how FQHCs can use a NMTC. This facility, profiled in the January 2009 issue of IPHCA Health Source™, was completed in 2010.

The clinic is anticipated to serve about 10,000 predominantly low-income patients per year. In August 2010, PCC closed on a NMTC loan with Chicago Development Fund, a nonprofit CDE controlled by the city of Chicago that emphasizes community facility financing and has a highly borrower-friendly fee structure. This $6 million financing provided a permanent loan to PCC, which allowed the “takeout” of PCC’s construction loan for the Austin facility, as well as recovery of funds PCC had advanced during construction. The NMTC benefit was purchased by JP Morgan Chase. Net of all transaction costs, fees, interest and compliance costs, the transaction provided a benefit of $1.25 million to PCC, or about 21 percent, of the facility’s development costs. In turn, PCC has used this benefit to substantially reduce its long-term debt load for the facility, as well as to recover funds it had to advance during the construction process to address site environmental cleanup needs that were substantially greater than the organization had anticipated.

According to Bob Urso, PCC president and chief executive officer, “The NMTC transaction was complicated and challenging to understand. However, the team utilized by PCC to complete the transaction was outstanding. I would highly recommend other FQHC’s look into NMTC transactions when completing major construction projects.”

Continued on page 8.

Using New Market Tax Credits to Leverage FQHC Capital Projects
By Tony Smith, Practice Leader and Executive Vice President, S. B. Friedman & Company
funding. The benefit of this approach is clear: every $1 of financing that flows through the CDE in turn generates additional tax credits that increase the amount of NMTC subsidy that can be provided by the investor by roughly 25 to 30 cents.

On January 20, 2011, HRSA released a policy statement outlining specific requirements regarding use of HRSA grant proceeds in NMTC-financed projects. In general, HRSA’s statement was supportive of FQHCs using NMTCs to increase their capital financing capacity, indicating that the agency “would consider the use of NMTC and/or HTC [Historic Tax Credits] project financing arrangements” on a case-by-case basis. HRSA went on to indicate that its grant funds may not be directly invested in the NMTC structure, but that certain bridge financing structures would be allowed.

Overall, the HRSA guidance appears to point to a prototypical structure where the FQHC would find a third party lender or an internal source of cash to temporarily advance the funds in an amount equal to the HRSA grant commitment. These bridge loan proceeds would be used as a Leverage Loan in the NMTC structure, and create a pool of NMTC-enhanced loan proceeds to pay for project development. This structure, including the Leverage Loan, would remain intact for the full 7-year NMTC period. During construction, the FQHC would submit reimbursement requests to HRSA for actual costs expended. In turn, the HRSA funds could be used to repay the temporary bridge.

The sample structure differs slightly from that used by PCC whose project included about $1.4 million of HRSA Facility Improvement Program (FIP) funding. Under the PCC structure, which also appears to fit within the new HRSA guidelines, the NMTC financing occurred shortly after project completion, by which time the HRSA funds had been fully disbursed. In turn, the NMTC loans repaid PCC’s construction loans, and the previously spent PCC and HRSA funds

Continued on page 10.

NMTC Leverage Structure: Prototypical Example for a FQHC Project

FQHC or FQHC Affiliate: Project Sponsor

Leverage Loan
• Approximately 75% of capital
• Can come from a range of underlying sources including:
  ‐ Senior debt
  ‐ Subordinated debt
  ‐ Project sponsor equity
  ‐ Bond proceeds
  ‐ Grant Proceeds or Bridge Loan
• Leverage sources sometimes loaned directly to Investment Fund, sometimes first pooled at the Project Sponsor level

Investment Fund
• Owned by NMTC Investor
• Typically a transaction-specific special purpose entity

Qualified Equity Investment (“QEI”)

Transaction-Specific CDE Subsidiary
• 99.99% Member- Invested Fund
• 0.01% Member/Manager- Parent CDE

“A” Loan: 
• Interest-only loan that mirrors the principal amount and interest cost of Leverage Sources

Key Benefits:
• Approx 100-200 basis point interest rate reduction on project’s overall cost of capital
• Project gets access to about 20% more capital
• “B” Loan typically sold to FQHC/Project Sponsor at the end of 7 year NMTC compliance period for a nominal amount, thus making NMTC benefit permanent

NMTC Equity Investment
• Approximately 25% of capital
• No cash return expected by Investor; just tax benefits
• Benefit to Investor = 39% of QEI amount, spread over 7 years

Community Development Entity (“CDE”)
• Obtains NMTC allocations from US Treasury
• Makes credits available to specific transactions
• Manages compliance and flows of funds for 7 years
• Fees: Typically 2-5% up-front, plus ongoing 7 year compliance and asset management charges

“B” Loan:
• Long-term interest-only loan
• Principal amount: NMTC equity less CDE fees
• Reflects net NMTC subsidy to Project
• Nominal interest cost equal to ongoing CDE fees and audit/tax costs (often 1-1.5% total)

Qualified Active Low Income Community Business (“QALICB”)
• Special Purpose Subsidiary set up by FQHC to develop/own real estate and lease back to parent organization or
  • The FQHC itself

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Using New Market Tax Credits to Leverage FQHC Capital Projects, continued from page 7.
Exit Interview: A Tool for Improving Employee Retention
By Ashley Colwell, Recruitment Specialist, IPHCA

Employers often wonder what prompts a staff member to leave the organization. Was she not engaged in her work? Did he find a job that was a better fit for his work/life balance? Exit interviews are a great way to get answers to these questions and more, as well as to evaluate your organization’s work environment. Be sure to let employees know the purpose of the interview.

Internal vs. External Exit Interviews
Many employers conduct exit interviews before the employee’s departure. Some are done internally through the human resources department; others use an external interviewer. An external interview provides a higher level of confidentiality for the employee. Doing the interviews in-house provides the advantage of the interviewer being aware of the employee’s history with the organization. Internal interviews will typically need to be conducted prior to the employee’s departure from the company. However, external interviews can be conducted either before or immediately after the employee leaves the company.

Do Employees Have to Participate?
The success of any exit interview will depend on the employee’s willingness to participate. Some may find it uncomfortable to talk about the company, environment or problems they experienced. Attempt to alleviate the employee’s concerns by letting him know the information will not be shared with anyone directly, but used only to evaluate the company and to increase performance and retention.

A great way to build an exit interview into the employee’s departure process is to include it with a final meeting. This can be done at the time the employee returns any company property they have in their possession. While there is no way to require an employee participate in an exit interview, many employees are often eager to share information and provide feedback. As an employer, be prepared for negative feedback.

How Structured Should the Interview Be?
An exit interview can either be a formal process or an informal conversation. If choosing to make the process formal, the interviewer will need to have predetermed questions. During an informal exit interview, the interviewer will have a conversation with the employee and not follow a set list of questions.

To determine whether to use a formal or informal interview process, gauge the comfort level of the staff involved. If your human resources director will conduct the interview and they are comfortable having a conversation, the informal process is best. If they would prefer to go down a checklist of questions and record the responses, the formal style is better. Also, determine in advance what information your company is looking for and decide how it will be used.

For more information on setting up an exit interview process, please contact Ashley Colwell at acolwell@iphca.org.

"The Great Central U.S. ShakeOut" Earthquake Drill for April 28

More than one million people in an eight-state region are expected to participate in "The Great Central U.S. ShakeOut" earthquake drill on April 28, 2011, at 10:15 a.m. The Illinois Emergency Management Agency (IEMA) encourages schools, businesses, government agencies, families and others to participate in the drill.

Register online at www.shakeout.org/centralus.
Using New Market Tax Credits to Leverage FQHC Capital Projects, continued from page 8.

The PCC Community Wellness Center Austin Family Health Clinic is one example of how the New Market Tax Credit (NMTC) program can be used to leverage construction costs of a Federally Qualified Health Center.

Tony Smith is practice leader and executive vice president at S. B. Friedman & Company, a consulting firm in Chicago that advises on NMTCs and other public/private financing tools. Tony provided consultation to Chicago Development Fund on the PCC Community Wellness transaction. For more information about NMTC financing, contact Tony at (312) 424-4254 or tsmith@friedmanco.com.

Resources
- Chicago Development Fund – www.chicagodevelopmentfund.org
- PCC Community Wellness Center – www.pccwellness.org
- CDFI Fund – www.cdfifund.gov

were able to be counted as leverage for the NMTC structure.

The January 20, 2011, HRSA guidance also states that FQHCs must request prior approval from HRSA before implementing a NMTC transaction involving HRSA funds. Such requests must include:

- Detailed descriptions of the nature and benefits of the proposed HRSA/NMTC structure
- Descriptions of any risks arising from the NMTC structure, and how they will be mitigated
- Confirmation of the likely drawdown schedule of HRSA funds and project timing
- Evidence of commitment from the CDE to participate in the transaction

While the above requirements are detailed and technical, it should not be difficult for a typical FQHC/NMTC project to meet them. The risks referenced in the HRSA guidance are primarily NMTC compliance-related and can be managed through careful deal structuring upfront. In general, HRSA capital grants should be able to work well with NMTCs for future FQHC development projects provided the organization:

- Finds a cooperative CDE partner that is willing and able to accommodate the HRSA approval process in its timing
- Seeks appropriate technical guidance from advisors early on to correctly structure the transaction
- Coordinates early and often with HRSA throughout the process

Outlook for NMTC Program

The NMTC program received a 2-year extension as part of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act passed by Congress and signed into law by President Barack Obama in December 2010. As a result, CDEs will find out in the first quarter of 2011 about the next round of NMTC allocations and will be given an additional opportunity to compete in 2011 for credits. The NMTC allocation is a finite resource, and is often quickly committed following an allocation round, so FQHCs are urged to contact CDEs early in their planning process to evaluate whether this financing option will work for their projects.
IPHCA Hosts Successful CHC Clinical Leaders Training

By Amy Garwood, Communications and Member Services Specialist, IPHCA

In a "sold-out" session, current and future clinical leaders from across the state and beyond gathered at the IPHCA Institute for Learning on January 28-29 for the CHC Clinical Leaders Training. Targeted for new, seasoned and aspiring medical, dental and clinic directors, this training addressed many community health center (CHC) leadership activities, including management principles, styles and skills, program development and evaluation, and business and strategic planning.

During the two-day training, attendees focused on the different aspects of CHC operations, expectations of them as clinical leaders, and how they fit into the CHC’s overall governance structure. Participants included many IPHCA member clinicians, as well as representatives from the Missouri Primary Care Association and health center staff from Indiana, Iowa, Michigan, Ohio and Wisconsin.

Dr. Paul Luning, chief medical officer at PCC Community Wellness Center, played an integral part in developing the CHC Clinical Leaders Training. Dr. Luning provided an important lesson for all aspiring clinical leaders about the history of the CHC movement. A panel of IPHCA member medical directors discussed key aspects and provided personal accounts of clinical leadership.

Attendees were grateful for the opportunity to learn additional management skills, especially strategies for managing employees. Mary-Margaret Warrick, DDS, dental director of Central Counties Health Centers, Inc., in Springfield, Illinois, noted, "The human resource and quality improvement information will be most helpful to me as a dental director.

The human resource lecture was very informative, as it gave me ideas on conflict resolution and staff appreciation." Dr. Warrick encourages others to attend this training, explaining that "CHC providers have one of the most rewarding, yet challenging, jobs and it is very useful to learn how other CHCs operate, manage their finances, and manage their employees."

Networking opportunities were offered each day and provided attendees with a chance to discuss current issues at their health centers. Some also shared information on transitioning to an electronic health records system—a process in which many health centers are currently engaged. Case studies were presented for small group discussions and allowed participants to share real-life experiences.

According to Dr. Theodore Ross, medical director at Southern Illinois Healthcare Foundation, Inc., "As a new medical or dental director, the information needed to be a better leader is to know the federal regulations that are directed to you and your responsibilities as the medical director to your clinicians, administrative and support staff, board and community." Dr. Ross noted that the skills and knowledge acquired at this training can be put to use immediately and continuously, and if applied, will allow clinicians to become efficient and effective leaders in their organizations.

Based on the success of this session, IPHCA is planning a second CHC Clinical Leaders Training this summer.

Partial sponsorship for this training was provided by the University of Illinois MidAmerica Center for Public Health Practice. For additional information, contact Rajesh Parikh, IPHCA’s vice president of clinical services and workforce development, at rparikh@iphca.org or (312) 692-3032.
Introducing the Your Healthcare Plus Provider Recognition Program

By Carrie E. Nelson, M.D., Your Healthcare Plus

Your Healthcare Plus (YHP) is excited to introduce the YHP Provider Recognition Program. Your Healthcare Plus is a program for approximately 280,000 Medicaid recipients designated by the Illinois Department of Healthcare and Family Services as eligible to receive extra support for understanding and managing their medical conditions. There are 170 YHP staff distributed throughout Illinois who provide these extra services, including nurses, social workers, pharmacists, behavioral health nurses and lay community educators. In addition to supporting patient adherence to the provider’s treatment plan, the YHP program provides claims-based clinical metric feedback to providers in the areas of diabetes, asthma, congestive heart failure (HF), coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD).

Many providers have been striving to achieve measurable excellence in care. After reviewing statewide claims-based clinical metric reports for each of the top five chronic conditions (diabetes, asthma, COPD, HF and CAD), YHP leaders have identified performance excellence thresholds. Practices that surpass these performance thresholds in several areas within a given chronic condition will be recognized in a variety of ways. The first year of the program is being implemented for diabetes.

Several IPHCA members received Your Healthcare Plus Diabetes Care Excellence Recognition. Awardees include:

- Access Community Health Network – Alma Medical Center
- Access Community Health Network – Armitage Family Health Center
- Access Community Health Network – Ashland Family Health Center
- Access Community Health Network – Near West Family Health Center
- Access Community Health Network – South State Medical Center
- Access Community Health Network – Southwest Family Health Center
- Alivio Medical Center – Western Avenue
- Christopher Rural Health Planning Corporation – Rea Clinic
- Community Health Improvement Center
- Erie Family Health Center, Inc.
- Erie Family Health Center, Inc. – Humboldt Park Family Health Center
- Heartland Community Health Clinic – Carver Clinic
- Lake County Health Department/Community Health Center – Zion Clinic
- PrimeCare Community Health, Inc. – Fullerton
- Southern Illinois Healthcare Foundation, Inc. – Alton Health Center
- Southern Illinois Healthcare Foundation, Inc. – Good Samaritan Health Center
- Southern Illinois Healthcare Foundation, Inc. – Salem Medical Center

For this condition, practices with 16 or more YHP diabetes patients that surpass the performance excellence threshold for three of seven clinical metrics receive the YHP Diabetes Care Excellence Award. Those practices that surpass thresholds in more than three metrics are given the added distinction of YHP Diabetes Care Blue Ribbon Excellence.

For both award categories, recognition includes:

- Certificate of Excellence presented to providers and staff
- YHP Performance Excellence insignia for display on websites and print materials
- Acknowledgment on the YHP provider website
- Recognition as an awardee in various planned publications
- Draft press release for organizations to share with local publications

Recognition for excellence in diabetes care is currently being extended to 25 Federally Qualified Health Centers and Rural Health Clinics, 11 of which are Blue Ribbon awardees; as well as 39 private providers, 13 of which are Blue Ribbon awardees.

It is very clear that the practices and clinics that have accomplished such results have done so through a concerted team effort. For this reason, recognition efforts reach out to both providers and staff. As one medical director stated, “This means so much to the staff. It has inspired them to work that much harder toward our chronic illness improvement goals.”

One of the Blue Ribbon awardees—Erie Clinic-Humboldt Park—has made a concerted effort to enhance the services for its diabetes patients over the past year. During a recent conversation, Ana Cesan, diabetes care coordinator at Erie Clinic-Humboldt Park, shared the following success strategies:

- A “go-to” person was identified at Erie for coordinating the diverse needs of patients with diabetes. This person makes sure patients are referred to resources, such as the eye clinic, dentist and any needed behavioral health services. In addition, patient-specific barriers to follow-through with guideline-based care recommendations are addressed.
- The clinic has a “Drop-In Diabetes Education” program. Health educators promote these monthly sessions with flyers and waiting room signs encouraging attendance by patients, families and loved ones. Special topics include depression, nutrition and physical activity. Erie has been able to attract approximately 10-12 people each month.
- A provider and diabetes educator co-lead group visits for the provider’s patients. The series starts out with a two-hour “basics of diabetes” class held by the diabetes educator. The following month, the provider joins the educator for the first of these quarterly group medical visits.
- Erie is able to generate a list of people with diabetes from their electronic health record. Medical students assist with reaching out to those not seen in more than six months.
- The Erie Chronic Care Team meets regularly to collaborate for solutions to enhance chronic condition management across the Erie system. They test new programs and share success stories. This has led to a planned expansion of the chronic care coordinator role to another clinic site.

YHP staff are excited to be able to offer congratulations to so many of Illinois’ primary care providers. For more information, contact Dr. Carrie Nelson, YHP medical director, at carrie.nelson@mckesson.com.
Diabetes is a fast growing health threat in the nation, affecting the lives of children and adults. If not managed, this deadly disease can lead to heart disease, stroke, blindness, kidney failure and amputations. In Lake County, Illinois, more than seven percent of adults are confirmed diabetics.

To address this rising epidemic, the Lake County Health Department/Community Health Center (LCHD/CHC) and NorthShore University HealthSystem (NorthShore) joined forces to develop Be Well-Lake County – a transformational, multidisciplinary program that is designed to address this chronic health problem in low income communities. The two-year-old comprehensive program started in North Chicago where it is providing several hundred patients with access to a broad range of individualized care and personalized services to help them adapt their lifestyles to reduce the risks of diabetes.

“Communities like North Chicago face numerous health challenges – little access to healthy foods, inadequate access to health care, lack of nutrition education and unsafe areas that discourage outdoor physical activity,” said Irene Pierce, executive director, LCHD/CHC. “Residents can truly benefit from this kind of ground-breaking collaborative initiative that relies on the strengths of both NorthShore and the Lake County Health Department to address the growing incidence of diabetes and obesity.”

Be-Well features a bilingual program to meet the needs of the ethnically diverse population in North Chicago. It also provides a continuum of care that addresses individual patient needs and ultimately impacts the lifestyles of their families by creating new health habits that will help avoid the recurrence of diabetes in their children and extended families.

The integrated program offers patients consistent and comprehensive LCHD/CHC and NorthShore physician visits, medication and testing supply assistance, self-management education, medical nutrition therapy, an exercise program, peer support, and nutrition resources that include a community garden and healthy food distribution. Patients also receive access to top quality specialists in cardiology, endocrinology, ophthalmology and nephrology at NorthShore to address the more serious complications of diabetes.

Since its launch in 2009, Be Well-Lake County has enrolled approximately 450 patients who have participated in primary care visits and individual medical nutrition therapy sessions.

Key clinical and program highlights include:

- Patients with good diabetes control increased from 25 percent to 30 percent of patient population.
- Patients with blood pressure under good control increased from 41 percent to 46 percent of patient population.
- Patients with good cholesterol numbers increased from 51 percent to 61 percent of patient population.
- NorthShore has provided approximately 200 specialty care consults and diagnostic visits.
- Approximately 100 patients have participated in the Diabetes Self-Management Education classes.

Funding for the program is provided by the NorthShore University HealthSystem Foundation and the NorthShore Auxiliary at Highland Park Hospital. As Be Well develops, there will be rigorous data collection and evaluation to assess the program and share its impact with health providers in other low income communities. The data will help revolutionize diabetes care in a community setting and further research how to adapt that care across multicultural audiences.
We understand that every individual, and every community, faces unique challenges. That is why IlliniCare Health Plan was established with Illinois healthcare professionals serving as our chief advisors.

Through our collaborative partnerships with hospitals, physicians and other providers, we bring better solutions for better health outcomes at lower costs.

Trust IlliniCare.

IlliniCare Health Plan™ is proud to support the Illinois Primary Health Care Association

www.illinicare.com
Through its Clinician Recruitment and Workforce Development Service, IPHCA provides complimentary recruitment and retention assistance to its member community health centers (CHCs) in Illinois and bordering states.

The IPHCA team is currently working to recruit for the following positions:

- Certified Nurse Midwives
- Dental Hygienists
- Dentists
- Family Practitioners
- Internists
- Licensed Clinical Professional Counselors
- Licensed Clinical Social Workers
- Medical Directors
- Medicine/Pediatric Physicians (Med/Peds)
- Nurse Practitioners
- OB/GYN
- Pediatricians
- Physician Assistants
- Psychiatrists/Child-Adolescent Psychiatry

Clinicians interested in pursuing a career in a CHC should submit their CV to Ashley Colwell, recruitment specialist, at acolwell@iphca.org or fax to (217) 541-7310. IPHCA will send job descriptions and updates directly to you as new positions become available. For more information about IPHCA's Clinician Recruitment and Workforce Development, visit www.iphca.org or call (217) 541-7309.

Please note: These positions are in addition to those appearing below.

Alivio Medical Center (Chicago) – To apply for the following position, fax cover letter and resume to the Human Resources Department at (773) 650-1239 or e-mail to hr@aliviomedicalcenter.org.

- Health Information Manager

Erie Family Health Center (Chicago) – To apply for the following positions, e-mail resume, CV and/or application to jobs@eriefamilyhealth.org; fax to (312) 432-4354; or mail to Human Resources Department, Erie Family Health Center, 1701 W. Superior St., 3rd Floor, Chicago, IL 60622. Visit www.eriefamilyhealth.org for more information.

- Case Manager
- Chief Financial Officer
- Community Health Nurse
- Development Coordinator
- Finance Manager
- Patient Accounts Representative
- Referral Coordinator (Temporary)
- Telephone Triage RN

VNA of Fox Valley (Aurora/Elgin) - To apply for the following positions, e-mail cover letter and resume to hr@vnafoxvalley.com; mail to VNA of Fox Valley, Attention: Human Resources, 400 N. Highland Ave., Aurora, IL 60506; or fax to (630) 892-0262. When applying, please reference IPHCA Health Source™. For more information, visit www.vnafoxvalley.com.

- CNA – Bilingual (Aurora – Full-time/Part-time/PRN)
- Family Case Manager – Bilingual (Elgin – Full-time)
- Health Educator Assistant – Bilingual (Aurora – Part-time)
- MIS Data and Process Analyst (Aurora – Full-time)
- Physical Therapist/Physical Therapy Assistant (Aurora/Elgin – Full-time/Part-time/PRN)
- Registered Nurse (Aurora – Full-time/PRN)
- Registered Nurse – Behavioral Health (Aurora – Part-time)
- Registered Nurse Weekend Supervisor (Aurora – Part-time)
- Registration/Exit – Bilingual (Aurora – Full-time)

Near North Health Service Corporation (Chicago) – To apply for the following positions, e-mail cover letter with job code and resume/CV to ecarroll@nmh.org; fax to (773) 624-5642; or mail to Human Resources Office (w/ job code), Near North Health Service Corporation, 4829 S. Cottage Grove, Chicago, IL 60615. Additional details are available at www.nearnorthhealth.org.

- Director of Comprehensive Services (YC/DCS)
- Director of Nutrition (BT/DON)
- Director of Quality Improvement (CL/QI)
- Nutritionist (AJ/NT)
## Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>April 14, 2011</td>
<td><strong>HR Today, Tomorrow and Yesterday</strong>&lt;br&gt;IPHCA Institute for Learning&lt;br&gt;Springfield, Illinois</td>
<td>Springfield, IL</td>
<td>For more information, please visit <a href="http://www.iphca.org">www.iphca.org</a>.</td>
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<tr>
<td>April 20, 2011</td>
<td><strong>Patient Centered Medical Home</strong>&lt;br&gt;IPHCA Institute for Learning&lt;br&gt;Springfield, Illinois</td>
<td>Springfield, IL</td>
<td>For more information, please visit <a href="http://www.iphca.org">www.iphca.org</a>.</td>
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<tr>
<td>May 3, 2011</td>
<td><strong>Statewide Symposium on Family Planning and Reproductive Health</strong>&lt;br&gt;Illinois Public Health Association&lt;br&gt;Springfield, Illinois</td>
<td>Springfield, IL</td>
<td>For more information, please visit <a href="http://www.ipha.com">www.ipha.com</a>.</td>
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