



Massachusetts League  
of Community Health Centers



Monthly Meeting 10am – 12pm  
VIA CONFERENCE CALL ONLY  
November 15, 2016

Call-in: 1-800-531-3250, Conference ID: 9337941

Webinar: <https://communityhealth.adobeconnect.com/crvfhpnov2016/>

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**AGENDA**

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**“To improve access to quality community-based primary care and other health-related services for the migrant and seasonal agricultural worker (MSAW) populations and their families in the Connecticut River Valley”**

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**Introductions**

**Election**

- NACHC Statement on the 2016 Election Results
- Immigration Materials

**Housekeeping / Best Practices**

- Encryption
- Pharmacy Forms

**2016 Program**

- **September 20, 2016 Minutes**
- **October 18, 2016 Minutes**
- **CRVFHP Manager Position Update**
- **Affordable Care Act (ACA)**
  - ACA MSAW Outreach & Enrollment
    - Open Enrollment Started 11/1
    - CAC Trainings
- **Funding:**
  - East Coast Migrant Stream Forum Reimbursement
  - Outreach Payments v. Target Allocation
  - # of farms visited per CHC in 2016 (according to Outreach Contact Sheets received)

- BHC [7] 14 proposed; 50% of goal
- CHCI [20] 15 proposed; 100+% of goal
- CHCFC [16] 60 proposed; 26% of goal
- CHS [22] 10 proposed; 100+% of goal
- GFHC [2] 13 proposed; 15% of goal
- HHC [10] 15 proposed; 67% of goal
- UConn [12] 16 proposed; 75% of goal
- Voucher Payments v. Target Allocation
- Outreach/Voucher Target Allocation Increase Requests

- **Carryover Request Funding**

- Data entry staff increase – DONE
- ECMSF support – DONE
- Transportation vans – SURVEY COMING SOON
- Emergency Preparedness kits with focus on Zika – SURVEY COMING SOON
- Dental kits – SURVEY COMING SOON
- MUST SPEND BY DEC. 31

- **Quality Improvement Plan [HRSA Program Requirement #1: Needs Assessment and #8: Quality Improvement/Assurance Plan]**

- Performance Improvement Reports from **bolded** CHCs

Table of additionally selected performance improvement measures for 2016					
BHC	CHCI	CHCFC	CHS	GFHC	HHC
HIV entry into care & 90-day follow-up	<b>Adult weight screening &amp; follow-up</b>	<b>Colorectal cancer screening</b>	<b>Adult weight screening &amp; follow-up</b>	Pap test/cervical cancer screening	<b>Adult weight screening &amp; follow-up</b>
October December	<b>November</b>	<b>November</b>	<b>November December</b>	October December	<b>November</b>

- November & December reports to include updates on:
  - CHC-specific 2016 clinical performance measure
  - Diabetes Mellitus
  - Intimate Partner Violence Screening
  - Environmental & Occupational Health Safety Screening

- **Patient Satisfaction Surveys**

- Submitted per CHC & 2011-2016 Trend
- Minimum of 30 PSS per CHC to be submitted yearly
- TIP: Make sure not to submit PSS twice
  - BHC [35] MET
  - CHCI [ 0] NOT MET
  - CHCFC [25] NOT MET
  - CHS [45] MET

- GFHC [27] NOT MET
- HHC [19] NOT MET
- TOTAL [151]
- Launching online PSS

- **Focus Groups**

- completed per CHC:
  - BHC [1]
  - CHCI [0]
  - CHCFC [0]
  - CHS [1]
  - GFHC [1]
  - HHC [1]
  - TOTAL [4]

- **Updates from the Field**

- **Resources**

- NCFH: [Health Tips/Consejos de Salud](#)
- Migrant Clinicians Network
  - [Streamline](#) bulletin
  - [Flu Shots Poll](#): How many MSAW have gotten it? How many needed to be reminded to get one or convinced
  - [Revisions to the EPA's Worker Protection Standard](#)
- [Migratory & Seasonal Farmworker Population Estimates](#) (interactive map)
- Farmworker Justice H-2A ACA FAQs & Briefs:
  - [The Affordable Care Act and You: A Guide for H-2A Workers](#)
  - [The Affordable Care Act and H-2A Agricultural Workers](#)
  - [The Affordable Care Act and Taxes: Frequently Asked Questions on How the ACA Affects Taxes for Farmworkers](#)
  - [ACA Curriculum for Outreach Workers and Promotores de Salud](#)

### 2016 Upcoming Events/Meetings

- Nov 17: National Rural Health Day: [NRHD](#)
- Dec 20: CRVFHP Monthly Meeting: from 10:00 a.m. to 12:00 p.m. at CHCI
- Feb. 17: CGKA Turf & Landscaping Conference: [Program](#)

### 2017 Program

- Calendar Review
- Quality Improvement Plan
  - Clinical Quality Champion Meeting
  - League's Clinical Issues Committee

- Brainstorming...
  - *Dashboard schematic*
  - *RFP/Contract process*
  - *Outreach – health curriculum development - <http://outreach-partners.org/resources/>*

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Go

# NACHC Statement on the Results of the 2016 Elections

🕒 [NOVEMBER 9, 2016 \(HTTP://NACHC.ORG/NEWS/NACHC-STATEMENT-RESULTS-2016-ELECTIONS/\)](http://nachc.org/news/nachc-statement-results-2016-elections/) 👤 [AMY SIMMONS \(HTTP://NACHC.ORG/BLOG/AUTHOR/ASIMMONS/\)](http://nachc.org/blog/author/asimmons/)

[\(http://nachc.org/news/nachc-statement-results-2016-elections/\)](http://nachc.org/news/nachc-statement-results-2016-elections/)

Our country has just concluded an historic election – the outcome of which challenges all Americans to work together and solve some of our nation’s hardest problems – no matter on which side of the political aisle we individually stand.

To that end, America’s Health Centers congratulate newly-elected President Donald Trump for his victory in a hard fought race, as well as the many men and women across the country who have successfully campaigned to serve in public office at the local, state, and national levels. Our doctors, nurses, community boards and others who work and volunteer at Health Centers in communities all over the country stand ready to make health care work for everyone.

We are proud that Health Centers have served for decades as an example of true bipartisanship – recognized by both Republican and Democratic lawmakers as an innovative and local solution that brings health and wellness to their communities, generates billions of dollars in savings to the health care system each year, and identifies and addresses emerging public health threats such as the spread of the Zika virus, the nationwide opioid addiction problem and the lead contaminated water crisis in Flint, Michigan.

Our 25 million Health Center patients, including 305,000 veterans, live in rural and urban communities all over America. They are neighbors, friends, and families, and they have urged their local, state and national policymakers to not only ensure that Health Centers remain in their communities, but also to bring services to more people in need.

We wish much success to the incoming Administration and lawmakers in serving the American people and we pledge to work hard with them to build a stronger and healthier America – a goal we can all agree on.

## RESOURCES LISTED ON MASSLEAGUE CRVFHP WEBPAGE:

### Immigration Materials

- Know Your Patients & Your Rights - English & Español  
- prepared by National Immigration Law Center
- How To Be Prepared For An Immigration Raid - English & Español  
- prepared by National Immigration Law Center
- Connecticut flyer: Know Your Rights if You are Contacted or Detained by Immigration - English & Español  
- prepared by American Civil Liberties Union of Connecticut
- Massachusetts flyer: Know Your Rights! What to do if stopped and questioned about your immigration status on the street, the subway or the bus - English & Español  
- prepared by American Civil Liberties Union of Massachusetts
- Know Your Rights! What to Do if Questioned by Police, FBI, Customs Agents or Immigration Officers - English & Español  
- prepared by American Civil Liberties Union
- Guide to Selected U.S. U.S. Travel and Identity Documents - English  
- prepared by Forensic Document Laboratory
- Rights Card - fold in half - English & Español  
- prepared by National Immigration Law Center



Massachusetts League  
of Community Health Centers



Monthly Meeting  
10:00am – 12:00pm  
Generations Family Health Center  
September 20, 2016  
MEETING MINUTES

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**“To improve access to quality community-based primary care and other health-related services for the migrant and seasonal agricultural worker (MSAW) populations and their families in the Connecticut River Valley”**

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**Present**

BHC, Milta Franco  
CHC, Inc., Marilyn Felix-Rodriguez  
CHCFC, Cameron Carey  
CHS, Judy Tallman  
GFHC, Brian Bonds, Matilde Casoni, Coley Jones, RN & Vladimir Rivera  
HHC, Jeanne Allen, FNP & Lellys Nazario  
MLCHC/CRVFHP, Anna Gardner, Michael Malloy, Mary Ellen McIntyre & Barbara Proffitt, RN

**Not Present**

UConn

**Introductions**

Michael Malloy began the CRVFHP September meeting by introducing himself and welcoming participants. Mr. Malloy advised that the meeting’s agenda would include: brief quality improvement quarterly reports, a recap of feedback and suggestions from visits to CRVFHP health centers, and outreach, voucher and contract updates.

**August 16, 2016 Minutes**

Mr. Malloy reminded participants that previous CRVFHP Monthly Meeting Minutes are e-mailed out shortly after each meeting and always available on the [CRVFHP webpage](#). Mr. Malloy directed the group to the August CRVFHP Monthly Meeting Minutes and asked for changes or updates. Jeanne Allen motioned to approve the minutes. The motion was accepted and the August 16, 2016 Minutes were approved. Mr. Malloy suggested that participants review past Monthly Meeting Minutes for resources that may be useful in planning focus groups, health education activities, etc. Mr. Malloy asked that participants please e-mail him with any questions regarding previous months’ meeting minutes.

## 2016 Program

- **Outreach Payments & Updates**

Mr. Malloy thanked those CHCs that have been consistent with submitting the Outreach Contact Sheet and Outreach Expenditure Report by the 15<sup>th</sup> of each month, reminding health centers that both reports must be received in order for League to reimburse for outreach services.

Mr. Malloy advised that during his visits to CRVFHP health centers, it was requested that the League directly deposited reimbursement checks for outreach and voucher services. Mr. Malloy advised that the League is currently looking into direct deposit options with their current bank, and shared that he would provide updates on this option at a future meeting.

Mr. Malloy reviewed the number of farms visited as part of outreach according to submitted outreach contact sheets. Mr. Malloy debriefed the group on the following list, thanking those health centers for reaching a greater number of farms than what was proposed goal in the 2016 Request for Proposal (RFP).

# of farms visited per CHC in 2016 (according to outreach contact sheets received)

- BHC [7]
- CHC, Inc. [18]
- CHCFC [16]
- CHS [16]
- GFHC [1]
- HHC [8]
- UConn [12]

Mr. Malloy requested CHCs to review goals proposed in RFP to see if progress can still be made in 2016 to establish new relationships with growers or reestablish past relationships. Finally, Mr. Malloy reminded participants of the National Association of Community Health Center's [Agricultural Worker Access 2020 Campaign](#), aims to increase the number of migrant and seasonal agricultural worker patients and their dependents seen at migrant and community health centers by 15% each year until 2020.

Mr. Malloy also shared that during his visits to CRVFHP health centers, Brian Bonds from Generations Family Health Center suggested providing outreach staff with a catalog of outreach activities and health education sessions that can be shared in the fields/at camps during outreach. Mr. Malloy advised that this is a resource the League is interested in providing CRVFHP health centers, stating that catalog of canned health education presentations could be shared on the CRVFHP Webpage for easy and constant access. Mr.

Malloy input that Health Outreach Partners (HOP), a member of the [Farmworker Health Network](#), has various editions of an Outreach Manual, which provides ideas on how to best provide outreach and prepared health education sessions. Mr. Malloy advised that he would send HOP's Outreach Manual via e-mail with the Monthly Meeting Minutes.

- **Voucher Payments & Updates**

Mr. Malloy reminded participants that 3<sup>rd</sup> quarter non-billable visit lists are due by Oct. 15. Mr. Malloy also requested health centers to utilize their Electronic Medical Records/Data Reporting Systems to their maximum utility in running the non-billable visit lists by providing as much UDS-required demographic info as possible, matching what is collected on the CRVFHP Registration Form/Eligibility Application.

Mr. Malloy informed the group that all 2<sup>nd</sup> quarter primary care claims had been entered and approved; remaining reimbursement checks will be sent by the end of September. Mr. Malloy input that Anna Gardner is serving as the temporary administrative assistant as Samantha Dolph resigned in early September. Mr. Malloy shared that Ms. Gardner was keeping up to speed with CRVFHP data entry and that 3<sup>rd</sup> quarter claims were already partially entered. Mr. Malloy advised that he hopes to review 3<sup>rd</sup> quarter claims in late October and send reimbursement checks by early November.

Mary Ellen McIntyre advised that with Ms. Gardner's and other League staff help, a process flow was created to improve data entry, tracking, review, and payment of received CRVFHP forms. Ms. McIntyre informed the group that the League only hopes to better serve CRVFHP health centers, expedite payment, and more readily communicate patient and visit numbers.

- **Quality Improvement Plan** [*HRSA Program Requirement #1: Needs Assessment and #8: Quality Improvement/Assurance Plan*]

Mr. Malloy reviewed the number of Patient Satisfaction Surveys (PSS) submitted to the League by CRVFHP health center, along with the number of focus groups completed. Mr. Malloy stressed that each health center must complete and submit at least 30 CRVFHP PSS by the end of 2016. Mr. Malloy also reminded participants that one focus group must be completed per health center and a report sharing the focus group results must be submitted to the League shortly after the focus group occurs. Mr. Malloy stated that these requirements were outlined in the 2016 CRVFHP RFP and the 2016 CRVFHP Contract.

- Patient Satisfaction Surveys submitted per CHC:
  - BHC [29]
  - CHC, Inc. [0]
  - CHCFC [14]
  - CHS [33]

- GFHC [38]
- HHC [5]
- TOTAL [119]

○ Focus Groups completed per CHC:

- BHC [1]
- CHC, Inc. [0]
- CHCFC [0]
- CHS [0]
- GFHC [0]
- HHC [1]

○ Performance Improvement Reports from bolded CHCs

Table of additionally selected performance improvement measures for 2016					
BHC	CHC, Inc.	CHCFC	CHS	GFHC	HHC
HIV entry into care & 90-day follow-up	Adult weight screening & follow-up	Colorectal cancer screening	<b>Adult weight screening &amp; follow-up</b>	Pap test/cervical cancer screening	<b>Adult weight screening &amp; follow-up</b>
October December	August November	August November	<b>September December</b>	October December	<b>September November</b>

**HHC**

**Adult weight screening & follow-up:** Jeanne Allen presented Holyoke Health Center’s Performance Improvement Report on the adult weight screening & follow-up UDS clinical performance measure. Ms. Allen shared that HHC’s target goals for improvement for this measure is 90%, a 6% increase from the CY 2015 UDS results of 84%. Ms. Allen shared that 63 MSAWs aged between 18 and 65 years old had been seen at HHC since January 1<sup>st</sup> 2016. Ms. Allen advised that 55 of the 63 MSAW patients had an elevated BMI that was recorded and addressed with a follow-up plan, which is a 76% success rate. Ms. Allen reported that this information has been shared with all HHC providers and hopes to see an increase in performance. Ms. Allen also shared that she discovered various patients were erroneously flagged as MSAWs in HHC’s EMR, causing the data for this measure to possibly be skewed. Mr. Allen reported that Lellys Nazario contacted patients marked as MSAWs to verify whether or not they qualified as agricultural worker or a dependent of one.

Barbara Proffitt suggested that HHC create a health education session with visual aids to show the amount of sugar contained in foods and beverages commonly

consumed at camps/in the fields. Mrs. Proffitt advised visual aids may help patients understand the actual amount of sugar being consumed and how that affects their health, especially weight and diabetes. Ms. Allen agreed with Mrs. Proffitt, but input that it is difficult to engage MSAWs in the conversation about sugar consumption since they spend the majority of their time expending energy, and that foods and beverages high in sugar are easily accessible. Mrs. Proffitt encouraged participants to consider hosting nutritionally-based focus groups on sugar intake and the sugar contents in commonly consumed foods.

**Diabetes:** Ms. Allen also reported that for the UDS diabetes health outcome & disparity indicator, two MSAW patients with HbA1c results >9% were seen since the last reporting in June. Ms. Allen stated that HHC will continue with the originally proposed action plan of monitoring HbA1c results for diabetic MSAWs and providing counseling/follow-up when HbA1c results are >9%.

**CHC - There was no report Community Health Services, Hartford.**

- Performance Improvement Measures Report Schedule Review
  - Mr. Malloy reviewed the Performance Improvement Measures Report Schedule to remind participants that during the November & December Monthly Meetings, health centers quality improvement reports must include updates on:
    - CHC-specific 2016 clinical performance measure
    - Diabetes Mellitus
    - Intimate Partner Violence Screening
    - Environmental & Occupational Health Safety Screening
- **29<sup>th</sup> Annual East Coast Migrant Stream Forum (ECMSF)**
  - ECMSF Training Stipend Application
    - Mr. Malloy congratulated Milta Franco, Carolina Kenny, Patricia Miles, and Lellys Nazario for receiving a training stipend from the North Carolina Community Health Center Association, which waived the ECMSF registration fee of \$325.
  - CRVFHP Training Stipend Application
    - Mr. Malloy congratulated Ms. Kenny, Ms. Miles, and Mr. Nazario for also receiving a CRVFHP educational stipend to assist with travel and accommodation expenses of the ECMSF. Mr. Malloy stated that recipients of the CRVFHP educational stipend must report lessons learned from sessions attended at the ECMSF and document their experience at the conference in the monthly narrative as part of the Outreach Contact Sheet for October.
  - League staff to present

Mr. Malloy shared that Mary Ellen McIntyre will present on collecting sexual orientation and gender identity (SOGI) information for MSAWs during the ECMSF. Ms. McIntyre thanked those participants who completed the SurveyMonkey of questions pertaining to outreach staff's experience collecting SOGI information from the MSAW population. Ms. McIntyre advised that the survey responses would be anonymously shared as part of her presentation.

- **Updates from the Field**

Baystate Brightwood Health Center: Ms. Franco reported that H-2A workers have slowly been departing for their home countries and Maine for continued farm work. Ms. Franco shared that flu vaccines and education were provided to H-2A workers prior to their departure, along with various health education sessions relating to remaining personal preparedness kits. Ms. Franco advised that the Mexican Consulate would be visiting Springfield on Friday, September 23<sup>rd</sup> at the UMass Center from 9:00 a.m. to 2:00 p.m.

Community Health Center, Inc.: Marilyn Felix-Rodriguez informed the group that fewer MSAW patients have been scheduling appointments at the health center, claiming that many MSAWs have begun to return home or continue migrating for work. Ms. Felix-Rodriguez also noted that she would be leaving CHC, Inc. at the end of October to move to Florida.

Community Health Center of Franklin County: Cameron Carey reported that CHCFC has been working more with local orchard. Mr. Carey detailed that a dental emergency at one of the orchards led to an emergency room referral, and, subsequently, improved communication between the orchard owner and the health center. Mr. Carey noted that the orchard owners provided the transportation of the MSAW to the ER.

Mr. Carey also advised of a greater connection at Atlas Farm, where he discovered patients who weren't aware of the health center. Mr. Carey also advised he discovered overlap in patients served at Atlas Farm and Fairview Farm. Finally Mr. Carey informed the group that the CHCFC transportation van has new graphics.

Generations Family Health Center: Brian Bonds advised that GFHC is planning a flu shot clinic at Prides Corner Farm in the coming weeks. Mr. Bonds also shared that there are not enough remaining MSAWs to hold another mobile health clinic with the medical van in 2016. Matilde Casoni added that less appointments had been scheduled than normal. Mr. Bonds input that a memorandum of agreement was signed between GFHC and Plan Group, a local farm that hires seasonal labor.

Holyoke Health Center: Mr. Nazario stated that he is still registering additional MSAW patients, noting that many workers have been working later than usual. Ms. Allen also

input that many MSAWs have arrived late for the fall harvest, informing the group that the most recent cohort will be in the area for no more than six weeks. Ms. Allen commented that the recent arrivals seems to all be suffering from respiratory issues.

Ms. Allen added that it has grown increasingly difficult to find specialists to accept the voucher payment model. Ms. Franco and Mr. Carey recommended Ms. Allen and Mr. Nazario contact Pioneer Valley providers, stating that they have both had success with engaging specialists there.

- **Health Education Sessions for Outreach**

Mr. Malloy shared an example of interactive dental health and an HIV/AIDS health education sessions that outreach and clinical staff could implement in the fields/at camps. Mr. Malloy encouraged the collaboration of outreach and clinical staff to ensure accuracy in materials presented to patients. Mr. Malloy advised that short, captivating health education sessions often allow patients to come forward with questions and disclose health concerns. Mr. Malloy referenced the Health Outreach Partners Outreach Manual, which he advised contains various examples of similar health educations presentations.

- **Additional Emergency Preparedness Projects**

Mr. Malloy advised that during his recent visits to the Valley, various CRVFHP Partner Agencies requested additional funding to assemble emergency preparedness kits similar to those distributed by the League at the start of the growing season in June. Mr. Malloy advised that CRVFHP Partner Agencies can always request outreach funding to purchase supplies to assemble their own personal preparedness kits, iterating that kits should be tied to health education sessions. Mr. Malloy shared that the League may possibly provide CRVFHP Partner Agencies with monies in 2016 to assemble dental-specific personal preparedness kits for MSAW patients.

- **2016 Contracts & HRSA OSV Follow-up**

Mr. Malloy reiterated that 2016 CRVFHP Contracts were fully executed in August 2016 due to the HRSA Operational Site Visit (OSV). Mr. Malloy informed the group that the HRSA OSV Final Report was submitted to the League on July 28, which detailed seven unmet HRSA Program Requirements (PR). Mr. Malloy stated that the CRVFHP was in the process of creating policies and procedures (some of which may need to be addendums to the CRVFHP contract and approved by the League's Executive Board) to become compliant with those seven unmet PRs.

Mr. Malloy highlighted some important changes to the 2016 CRVFHP Contract:

- Added language re: credentialing and privileging of providers in section 1.2.2: The Provider must submit a copy of the Board-approved Credentialing & Privileging Policy and process for credentialing and re-credentialing of licensed health care

providers and staff to include primary and secondary verification of: licensure, education, training, current competence, health fitness, approval authority/privileges, government-issued identification, immunization and PPD status, DEA registration, and review of other applicable trainings. Board approved re-credentialing must occur every 24 months. Must be submitted as part of the annual RFP process.

- Added language re: 340b drugs and maximum costs of prescriptions and specialty care:
  - The Provider certifies that processes are in place to prevent duplicate discounts for patients covered under Medicaid and who receive a 340B drug
  - Pharmaceutical Services ≤ \$200 are covered without prior approval
  - Specialty Care ≤ \$500 are covered without prior approval
- Added language re: increasing MSAWs patients and training of CHC staff to understand growth and ensure EMR tracks MSAWs correctly to section 2.2.1 and 2.3.1
- Added required UDS fields for non-billable visit lists to section 1.4.3
- Added in stadiometer and scale calibration requirement: The League provided the Provider with a one-time purchase of a BMI (Body Mass Index)-calculating scale and stadiometer in 2016 to support its compliance with documenting BMI of MSAWs / dependents and developing a follow-up plan for patients who fall outside of HRSA clinically-defined parameters. The Provider agrees to schedule regular calibrations of the scale to assure optimal accuracy. As these are portable, recalibration should occur at least monthly

- **Delivery System Health Information Investment Award**

Mr. Malloy announced that the CRVFHP was awarded \$44,093 in Delivery System Health Information Investment, which he detailed may be allocated toward improving communication between the CRVFHP electronic medical record (EMR), *fhases*, and CRVFHP Partner Agencies' EMRs. Mr. Malloy input that increased inter-EMR communication could streamline the current data entry, reporting, and reimbursement process. Mr. Malloy also shared that DSHII funds may be used to digitize CRVFHP Forms, allowing for less paper form completion and collection.

- **Service Area Competition Grant Cycle**

Mr. Malloy reported that the Service Area Competition (SAC) grant was submitted by Ms. McIntyre by the August 31<sup>st</sup> deadline. Mr. Malloy advised that an error in naming the finalizing administrator caused a delay in the grants receipt by HRSA, but stated that the issue was corrected. Mr. Malloy shared that as part of the SAC application process, clinical performance goals were reevaluated, an updated programmatic narrative was created,

and the reimbursement structure was revisited. Mr. Malloy and Ms. McIntyre extended their gratitude to all Partner Agencies that submitted letters of support.

### Resources

- NCFH [Health Tips/Consejos de Salud](#) (electronic & physical copies)
- [Notes from the Field](#) August/September 2016 Edition
- Migrant Clinicians Network [Streamline](#) bulletin
- Massachusetts Migrant Education Program Job Postings
  - [Community Liaison \(recruiters\)](#)
  - [Regional Service Coordinator](#)
  - [New England High School Equivalency \(HEP\) Project Director](#)
- Intimate Partner Violence Prevention & Surveillance Resources
  - [CDC Uniform Definitions and Recommended Data Elements](#) (2015)
  - [CDC: Training Professionals in the Primary Prevention of Sexual and Intimate Partner Violence](#) (2010)
  - [Journal of the American Medical Association: Effect of Screening for Partner Violence on Women's Quality of Life](#)
- [Migratory & Seasonal Farmworker Population Estimates](#) (interactive map)

### Upcoming Events/Meetings

- Sept. 15: [Hispanic Heritage Month](#) begins!
- Sept. 22: National Center for Farmworker Health presents *Migratory and Seasonal Agricultural Worker Identification Registration and Reporting*, a webinar, from 2:30 p.m. to 3:30 p.m. [Click here](#) to register.
- Oct. 13-15: 29<sup>th</sup> Annual East Coast Migrant Stream Forum (ECMSF) in Miami, FL. [Click here](#) to register for the ECMSF; [click here](#) for a draft agenda.
- Oct. 18: CRVFHP Monthly Meeting from 10:00 a.m. to 12:00 p.m. at Holyoke Health Center in Holyoke, MA.

Mr. Malloy ended the CRVFHP September Monthly Meeting at 11:46 a.m.



**Monthly Meeting**  
**10:00am – 12:00pm**  
**Holyoke Health Center**  
**October 18th, 2016**  
**MEETING MINUTES**

**“To improve access to quality community-based primary care and other health-related services for the migrant and seasonal agricultural worker (MSAW) populations and their families in the Connecticut River Valley”**

---

**Present**

BHC, Milta Franco  
CHC, Inc., Marie Yardis  
CHCFC, Cameron Carey  
CHS, Patricia Miles  
GFHC, Coley Jones, RN  
HHC, Lellys Nazario, Jeanne Allen, FNP  
MLCHC/CRVFHP, Savanna Gardner, Michael Malloy, Mary Ellen McIntyre, Barbara Proffitt, RN

**Not Present**

UConn

**Introductions:**

Savanna (Anna) Gardner has joined the CRVFHP team as the new Administrative Assistant.

**2016 Program:**

**2016 East Coast Migrant Stream Forum:**

This year there were five people in attendance (Michael Malloy, Mary Ellen McIntyre, Lellys Nazario, Carolina Kenny, Milta Franco, Pat Miles, Norm Deschaine). We hope to see this many (or more) attend in the future. Mr. Malloy reiterated that there was a session at the forum about enrolling H2A workers that was well attended by CRV health center staff.

**O&E:**

This will be the 4th open enrollment period. Those who were certified in the past can get their recertification online. CHC Inc., Baystate BHC and Generations FHC all have dates for training set near the end of October. Cameron Carey mentioned that CHCFC was awarded the Navigator grant, which allows them to go out to small business communities, and their SHINE training was completed. Now they are awaiting certification. MassHealth will hold open enrollment training on November 9th from 10-4pm at the Franklin Career Center. This

training is open to anyone, and transportation is provided. Mr. Malloy also reminded us all that outreach workers are required to be ACA certified.

#### Outreach Payments and Updates:

Mr. Malloy reminded everyone that the 15<sup>th</sup> is the deadline for the outreach contact sheets. As of Oct, 18<sup>th</sup>, no September outreach contact sheets have been submitted. Most outreach and expenditure sheets for August were submitted at the beginning of October. Mr. Malloy also stated that most health centers **are under** the proposed amount of farms to be visited and asked why that could be. Are the health centers not documenting these farm visits, or perhaps are we at capacity? With this said, Mr. Malloy did want to give gratitude to health centers who had gone above and did a great job at making connections. The question of what constitutes an actual connection came up and Mr. Malloy clarified. An actual connection consists of a physical visit to the farm, speaking with the farm owner, the agricultural worker, etc.

#### Voucher Payments and Updates:

Mr. Malloy stated that the 3rd quarter non-billable visit files were due the 15th of October. All 3rd quarter billable visits are entered and he is hoping to get checks out by the end of October.

#### Outreach and Voucher payments:

If a health center expects to meet their target allocations, any request to increase their outreach and/or voucher funds must be received by the Oct. 31<sup>st</sup> deadline stated in the 2016 CRVFHP) Contract.

Mr. Malloy reminded everyone about what was proposed in the RFP as far as medical, mental health, dental and outreach services. Carefully reviewing this can show gaps in missing paper work and health centers should try to get paperwork in to make those numbers accurate.

At this point, Michael opened up the floor for questions and Milta Franco brought up the question of whether or not they could someday include farms that their patients are from, even if they don't visit. Ms. Allen mentioned that Holyoke Health Center may participate in a community event where they will see patients from farms that they haven't physically visited. Mr. Malloy reiterated that the outreach contact sheet is designed to capture outreach workers' physical presence at the farm. That, eventually the goal would be to visit the farm that the patient is from. The third page on the RFP allows you to list those events. List on the 3rd page with the number of attendees. Ms. McIntyre also added that we already can track what farms the patients work on directly from the Eligibility Application. In the future, CRVFHP staff could do a better job at sharing that information back to the health centers. Currently there is not a way to pull that information out of our system, but will think about how to access the farm list for distribution. The point of the outreach contact sheet is to get out to the farms and have a physical presence.

Mr. Malloy also added that even if a health center is not requesting an increase, to please let us know that.

Quality Improvement Plan:

Mr. Malloy reminded everyone that 30 patient satisfaction surveys are required and should be submitted before the end of the year. All of the information from this survey is recorded and hopefully soon will be put in a dashboard.

Anna Gardner shared some of the responses listed:

- *“How do you feel you were treated by outreach staff who visited your camp or home during the past year?” Most of the responses were positive, mentioning how the outreach staff have been kind and helpful.*
- *“They have always supported us in everything we needed.”*
- *“Your service is excellent always on time and very friendly.”*
- *Do you feel that the information that the outreach staff gave you in your camp or home was helpful and clear? Over 90% answered yes.*
- *How do you feel you were treated by staff at the clinic during the past year? Over 70% answered very well and the most common comment was “muy bien”.*

Mr. Malloy mentioned to keep in mind how agricultural workers are welcomed when they enter a health center, from the front desk to the health care provider. Milta mentioned how it could be useful to outline a provider on the PSS.

Ms. Gardner shared an additional question:

- *What health services have you needed in the past year that you had problems getting?*

Response Options	2011	%	2012	%	2013	%	2014	%	2015	%	2016	%
General	3	12%	5	19%	2	5%	28	34%	83	36%	61	30%
Dental	7	28%	4	15%	5	13%	24	29%	63	27%	55	27%
Specialty	0	0%	1	4%	0	0%	4	5%	18	8%	17	8%
Other	0	0%	2	7%	3	8%	1	1%	1	0%	3	1%
Mental Health	1	4%	2	7%	1	3%	1	1%	12	5%	6	3%
No problems getting services	14	56%	13	48%	28	72%	25	30%	54	23%	64	31%
Total	25	100%	27	100%	39	100%	83	100%	231	100%	206	100%

Mr. Malloy noted that the need for eye care has increased. There was one comment from a patient who had difficulty getting a pre-natal visit. Ms. Proffitt recommended the health care agency for this patient should review their protocol for OB care to assure timely access for appointments to pre-natal care. Mr. Malloy then asked what some questions people might add to personalize the survey per health center. Jeanne Allen commented that Holyoke sees many H2A workers and many people in the community are Puerto Rican while Baystate BHC sees

more undocumented people. The services needed can be more local and health centers can focus on specific issues. Perhaps updating some of the questions or personalizing the survey for each health center can be done.

- *What problems have you had in the past year getting health services?*

Response Options	2011	%	2012	%	2013	%	2014	%	2015*	%	2016	%
Transportation	0	0%	3	17%	1	20%	12	22%	46	29%	25	26%
Cost of Services	5	22%	0	0%	1	20%	5	9%	10	6%	10	10%
Permission to leave work	16	70%	8	44%	1	20%	15	27%	54	34%	30	31%
Language	0	0%	3	17%	0	0%	5	9%	21	13%	10	10%
Clinic Schedule	2	9%	2	11%	2	40%	9	16%	9	6%	6	6%
Child Care	0	0%	0	0%	0	0%	1	2%	4	3%	2	2%
Other	0	0%	2	11%	0	0%	8	15%	13	8%	14	14%
Total	23	100%	18	100%	5	100%	55	100%	157	100%	97	100%

The biggest problem is getting permission to leave work. Either agricultural workers are too afraid to ask supervisor, or just focused on working as much as possible. Clinic schedules was also an issue and Mr. Malloy commented on how beneficial it is for clinics to hold later hours. Mr. Carey mentioned that Franklin County started to offer late nights on Mondays. On Oct. 17<sup>th</sup>, they had 4 scheduled appointments and all showed up with their own transportation, showing just how committed these patients were to their health. The biggest problem currently is finding staff that are willing to stay late on Monday nights. Agricultural workers have preference during those hours, but if an appointment is not filled within 24 hours, then it is free to anyone.

Focus Groups:

Health centers provided an update on their planned or already held focus groups:

- Generations: Planned for October 28<sup>th</sup> with a group of six.
- Community Health Centers: Had one on September 18<sup>th</sup>.

Mr. Malloy reminded the group that focus group reports need to be sent in and every health center needs to submit at least one or have one planned.

Performance Improvement Reports

**Generations:**

FHYC reported that all new arriving agricultural workers are getting A1C testing and they are still talking with agricultural workers and staff about healthy eating. 26% of their identified diabetics have an A1C > 9. Generation FHC’s specific 2016 clinical performance measure was to ensure 65% of women aged 21-64 receive Pap tests within the last 3 years and women aged 30-64 receive pap tests within 5 years accompanied by an HPV test. As of October 11<sup>th</sup>, 106 women were enrolled and of those, 85 were eligible for Pap tests. To

date, 57 women (67%) have had a Pap in the last 3-5 years. Generations increased from 56% in July to 67% in October. That is an increase of 11% and exceeds our goal of 65%.

**Baystate Brightwood Health Center:**

Baystate BHC reported that, as of 10/01/16 that 22 MSAW had a DM diagnosis. Of those 22, 10 (45%) had an A1C > 9. 12/22 (55%) had an A1C < 9 and 9/22 (40%) had A1C within the last 3 months. Baystate also reported that 100% of MSAW were offered HIV screenings. 16% accepted and were screened for HIV/HEP C and STI. All were negative. Currently they have opportunities for MSAW to learn about getting screened through health education at the farm and during evening meetings.

**Community Health Services:**

No report available and tabled to the November meeting.

29th East Coast Migrant Stream Forum (ECMSF)

During the East Coast Migrant Stream Forum, there was a presentation about H2A workers titled: *Who are H-2A Workers and How can We Connect Them to Health Insurance: Successful Strategies at the State and Local Level*. The goal of this presentation was to train participants in understanding the H-2A program, including the growth of the program, employer responsibilities, H-2A workers' rights and to develop strategies to educate and enroll H-2A workers in health insurance.

There were still many questions and concerns health care centers had after this presentation including how workers from Puerto Rico are treated and how the copay amount is too much for agricultural workers to pay. There was debate on how long agricultural workers have to be here before getting health insurance and how long they have to apply for health insurance. Many agricultural workers do not have the time to apply for health insurance and the cost of the health insurance is still too much.

Ms. McIntyre's Presentation: Sexual Orientation and Gender Identity (SOGI) questions. It is estimated that 12.6% of the agricultural worker population identifies as LGBT. While these questions are required to be asked, a question to keep in mind is where/when do we ask these questions? Is the farm the best place to ask these questions?

CRVFHP Manager Transition

Mr. Malloy announced that he will be leaving this position, although still staying with the League in a different position. The transition will take place on Nov. 1<sup>st</sup>. We ask that if you know anyone who may be interested/qualified for this position to please submit their resume to Ms. McIntyre ASAP.

# CRVFHP Performance Improvement Measure Report Template

Name of CHC Generations Family Health Center

Date Completed October 11, 2016

<b>List the Performance Improvement Measure</b>	<b>4. Initial Performance</b>	<b>5. Actions taken</b>	<b>6. Performance Re-Measurement</b>	<b>7. Demonstrated Improvement</b>
<p>To ensure 65% of women aged 21-64 receive Pap tests within the last 3 years and women 30-64 receive Pap tests within 5 years accompanied by an HPV test.</p> <p><b>List the baseline data and time period</b> Baseline Year: 2015 women enrolled: 143</p> <p><b>List the targeted goal for improvement for the PI measure</b> By the end of the project period 65% of MSAW women aged 21-64 will have received a Pap test for cervical cancer.</p>	<p>April 2016- October 2016. At this point in the 2016 season there are 104 women enrolled, 85 of which are eligible for Pap tests due to CDC age parameters. As of July; 48 of those 85 have had Pap tests in the last 3-5 years according to CDC guidelines. 2 have had a Pap test this season and 7 have upcoming scheduled Pap appointments here at Generations. 35 women are eligible and do not have appointments at this time.</p>	<p>Goal still in progress, 56% of the women enrolled age 21-64 have received Pap tests within the last 3-5 years. We are working to provide at least one Women’s Health Services Clinic at the farm during the growing season. To increase the number of appointments with specific female provider during extended evening hours for women’s health appointments</p>	<p>As of October 11, 2016 there are a total of 106 women enrolled. Only 85 of those women are eligible for a Pap due to CDC age parameters. To date 57(67%) have had a Pap in the last 3-5 years according to CDC Guidelines.</p>	<p>Goal met. We increased from 56% in July to 67% in October. That is an increase of 11% and exceeds out goal of 65%. We provided Women’s Health Services during clinics at the farm and worked to increase the number of Pap appointments available with specific female providers during extended evening hours.</p>

# CRVFHP Performance Improvement Measure Report Template

Name of CHC Generations Family Health Center

Date Completed October 11, 2016

List the Performance Improvement Measure	4. Initial Performance	5. Actions taken	6. Performance Re-Measurement	7. Demonstrated Improvement
<p>To ensure no more than 50% of patients with Diabetes aged 18-75 have uncontrolled HbA1c &gt;9.</p> <p><b>List the baseline data and time period</b></p> <p>Baseline year: 2015 Baseline enrolled :367</p> <p><b>List the targeted goal for improvement for the PI measure</b></p> <p>By the end of the project period reduce the percentage of adult diabetic patients with A1c &gt;9 by 50%</p>	<p>4. Initial Performance</p> <p>April 2016 – October 2016. At this point in the season there are 246 total enrolled. Currently we have 4 patients with A1C &gt;9. The A1C range on the 4 patients is 9.1-13.7.</p>	<p>5. Actions taken</p> <p>Goal still in progress. We are continuing to work to ensure diabetes education and literacy materials are provided at MSFW locations. Provide appropriate diabetes education materials to staff from agencies collaborating on outreach activities at the farms.</p>	<p>6. Performance Re-Measurement</p> <p>As of October 11, 2016 there are 265 total enrolled in the program. Of that 265 there are 19(7%) identified as Diabetic with an A1c &gt;6.5. Only 5(2% of total enrolled / 26% of identified diabetics) have an A1c &gt;9. The range being 9.7 – 14.</p>	<p>7. Demonstrated Improvement</p> <p>2% of our total enrolled / 26% of our identified diabetics have an A1c &gt;9. We will still continue to work to ensure that diabetes education and literacy materials are provided at MSFW locations. We will provide appropriate diabetes education materials to staff from agencies collaborating on outreach activities. We will educate staff on cultural common foods in order for staff to be able to talk with MSFW about healthy food choices with diabetes. New arrivals will get and A1c done as baseline.</p>

# CRVFHP Performance Improvement Measure Report Template

Name of CHC- **Baystate Brightwood Health Center**

Date **Completed October 17, 2016**

<p><b>Diabetes UDS Measure</b> –To Ensure that no more than 50 % of our Migrant patients with Diabetes aged 18-75 experience A1C of &gt;9% (2016) Time April 1, 2016- Oct 1, 2016 Baseline Data -(41% Screened FY 15) Goal- improve to 50% of New Agriculture workers will be in control with AIC &lt;9.</p> <p><b>Environmental / Occupational Health screening</b> during the measurement year (2016) Time April 1, 2016- Oct 1, 2016 Baseline Data (0) all new migrant workers -2015 Measurement 2% screened Goal- Improve to 75% of New Agriculture workers will be Screened</p> <p><b>Sexual / Intimate Partner Violence screening</b> during the measurement year (2016) To ensure that 75% of arriving Migrants are screened for Sexual Health Risk/ Partner Violence</p>	<p><b>Beginning May 1, 2016- September 30, 2016</b> All Migrant SAW /Dependents age 18-75. -#13/54 (24% have AIC &gt;9%) -#41/54 (76% have AIC &lt;9%) #54 Migrant Seasonal Agricultural workers between Farm visits/ BBHC Visits with DM Diagnosis</p> <p><b>Beginning April 1, 2016- September 30, 2016</b> 75% of at Risk Seasonal Patients arriving to work farms will be screened -MSFW seen as of October1, 2016- 100% Screened</p> <p><b>Beginning April 1, 2016- September 30, 2016</b> 75% of at Risk Seasonal Patients arriving to work farms will be screened. -Currently 30 new MSAW 100% screened as of June 30.</p>	<p>All known DM patients will be screened for AIC after arrival</p> <ul style="list-style-type: none"> <li>-when available Our Outreach Team will provider BS Monitoring Supplies for Home Testing</li> <li>-Twice a Month Nutrition focused teachings held by Outreach worker at Farm Clinical Sessions</li> <li>-Providers to prescribe approp medication for DM</li> <li>-1:1 DM education to be provided by Medical Provider at Farm Sessions</li> <li>-Repeat AIC Levels Q 3 month</li> <li>-Monthly MSFW education focused sessions to take place at Farm Clinical Sessions.</li> <li>-providers are incorporating into each visit This was emphasized</li> <li>-working to have providers incorporate into each annual physical for BBHC</li> <li>-provider documentation is one issue as every patient is assessed for Environmental and Occupational Health.</li> <li>-working to have providers incorporate into each annual physical for BBHC</li> <li>-Working with Primary Care Providers as assessment is completed annually</li> </ul>	<p>As of 10/01/2015-</p> <p>#22 Migrant Seasonal Agricultural workers between Farm visits/ BBHC Visits with DM Diagnosis -#10/22 (45% A1C &gt;9) -#12/22 (55% A1C &lt;9) -#9/22 (40% had AIC within Last 3 Months).</p> <p>-October 17, 2016- 100% of MSAW have been screened for Environmental Occupational Health Hazards -Provider documentation of assessment for Environmental /Occupational health screenings continue to be an issue -Providers continue to assess at encounters when visiting farms with cue from guidance we have created. -Working on process so that Milta Franco Outreach Worker/Coordinator will enter this assessment into patients chart.</p> <p>-100% of our Seasonal workers were assessed for 2016 however, we continue to address with providers during our Cliniquita schedules.</p>	
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<p>Time April 1, 2016- Oct 1, 2016 Baseline Data (0) all new migrant workers -2015 Measurement was 0% (due to provider documentation- Assessments are completed at Farm Clinical Sessions however documentation needs to improve) Goal- Improve to 75% of New Agriculture workers will be screened</p> <p><b>HIV / STD Testing offered/ completed to each Seasonal Migrant Work traveling to the US / Working Farms and Newly-diagnosed HIV patients &amp; 90-day follow-up</b> during the measurement year (2016)</p> <p>Time April 1, 2016- Oct 1, 2016 Baseline Data (0) all new migrant workers Measurement 0 new infections. Goal- 100% of New Agriculture workers will be offered Screening Measurement 0 new infections.</p>	<p><b>Beginning April 1, 2016- September 30, 2016</b> 100% of Seasonal Patients arriving to work farms will be offered tested. -30 New MSFW arrived since Mid-Late April 2016 -100 % offered HIV/HEP C STI SCREENING -6 persons (16% accepted and were screened all were HIV/HEP C and STI Negative) Migrant workers Seen at BBHC 24 patients screened in total</p>	<p>however, documentation needs to be specific</p> <p>Assessments are completed but documentation is an area of improvement.</p> <ul style="list-style-type: none"> <li>-Monthly MSFW Educational sessions schedule to education MSFW around Risks and Prevention</li> <li>-Condoms and lube distributed at each farm on a weekly basis</li> <li>-Health Educator is part of our Clinical Team both at the Farms and in Cliniquita evening sessions.</li> <li>-100% of those who test HIV + or Arrive with an HIV Diagnosis will be connected to care with 90% follow up.</li> </ul>	<p>-Providers are aware of assessment and question is routine part of annual physical for patients.</p> <p>-We continue to struggle with providers completing assessments on all MSAW. We are working of flow sheets for Cliniquita Sessions.-100% of MSAW Offered Screenings -16 of 40 were for HIV/STD -0 Prevalence</p>
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## Mary Ellen McIntyre

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**From:** Michael Malloy  
**Sent:** Friday, November 04, 2016 11:46 AM  
**To:** Mary Ellen McIntyre; Savanna Gardner  
**Subject:** Fwd: Important: New Mandatory training for Certified Application Counselors (CACs)

Might be a good reminder for MA outreach workers at the MM in Nov.

Enviado desde mi iPhone

Inicio del mensaje reenviado:

**De:** "MAhealthconnectorUpdates (EHS)" <[MAhealthconnectorUpdates@MassMail.State.MA.US](mailto:MAhealthconnectorUpdates@MassMail.State.MA.US)>

**Fecha:** 4 de noviembre de 2016, 8:41:39 AM PDT

**Para:** "MAhealthconnectorUpdates (EHS)" <[mahealthconnectorupdates@state.ma.us](mailto:mahealthconnectorupdates@state.ma.us)>

**Asunto:** Important: New Mandatory training for Certified Application Counselors (CACs)

Dear Certified Application Counselors:

**\*\*\* Mandatory Training in the LMS for Certified Application Counselors (CACs)\*\*\***

New mandatory training has been assigned to all Certified Application Counselors (CACs). Please review all of the information below. It contains important information about what courses are updated, when the mandatory training needs to be completed, and how to access each course.

### *What training has been assigned to CACs as Mandatory?*

- **Course 4-Citizens and Noncitizens** (mandatory annual refresher)
- **Course 9-Certified Application Counselors** (mandatory annual refresher)
- **Course 8-Health Plan Selection and Enrollment** (Updated Content) \*
  - **Course 08B:** An Assister's Guide to **Health Insurance Literacy**
  - **Course 08C:** An Assister's Guide to Shopping for and Enrolling in **Health Connector** Plans
  - **Course 08D:** An Assister's Guide to Shopping for and Enrolling in **ConnectorCare** Plans
  - **Course 08E:** Health Connector-Health Plan Selection and Enrollment Assessment

Assisters can help consumers shop for the Health Connector plan that best meets the consumer's health insurance needs. To help Assisters become more comfortable with basic health insurance terminology and the Health Connector shopping process, these three new lessons are available in the Learning Management System (LMS).

These three lessons have a new, improved look and feel compared to the other courses in the Learning Management System. They also offer an audio option that guides you through each course. In the coming weeks, we will be asking you for your feedback on the new format and your experience with these lessons.

*\* Note, Course 08A, MassHealth Plan Selection and Enrollment (for MassHealth MCO/PCC plans) is in the process of being updated and will be shared with you shortly. We will notify you as soon as this new mandatory course is available.*

**Who needs to take this mandatory training?** The training is mandatory for all Certified Application Counselors (CACs,) as part of your ongoing education as Certified Assistants.

**When do CACs need to take the training?** CACs must complete training by Friday 12/02/16.

**How do I take the mandatory training?** All of the mandatory courses are offered online in the [Learning Management System](#). They can be found in the Certified Application Counselor Curriculum 2015-16.

**Important:** Use the following steps to complete this set of mandatory trainings:

1. Log into the LMS: <http://mahealthconnector.absorbtraining.com> (use the Forgot Password link if you forgot your Username or your Password).
2. Select the **My Courses** button
3. Select the **Certified Application Counselor Curriculum** folder
4. Scroll down to **Course 4-Citizens and Noncitizens**. You will see the message “You must complete 1 of the following courses.”
5. Click the **Open** button
6. Take both lessons and complete the Assessment by clicking the Launch button next to each one
7. Return to the **Certified Application Counselor Curriculum** folder. You are now able to take the next mandatory training in Module 8.
8. Scroll down to **Module 8**. Although you will see 5 courses listed, you only need to complete Course 08B, 08C, and 08D.
  - Click the **Open** button
  - Click the **Launch** button (course may take a moment to load)
  - Read the first slide in the first course to familiarize yourself with the new layout
  - Click each slide in the Menu on the left or use the Prev/Next buttons (bottom right) to advance through the course
  - Advance through all of the slides before closing the course *to receive full credit for the course*
    - Click the **Narrative** tab if you wish to see the text the narrator is saying (most of the text is already on the slide)
  - Follow the instructions to close the course and access the next course
  - Follow the process outlined above for all three courses (08B, 08C, and 08D) as well as the Assessment (08E)
9. Return to the **Certified Application Counselor Curriculum** folder. You are now able to take the next mandatory training
10. Scroll down to **Course 09: Certified Application Counselors 2016**. You will see the message “You must complete 1 of the following courses.”
11. Click the **Open** button
12. Take all lessons and complete the Assessment by clicking the Launch button next to each item
13. Return to the **Certified Application Counselor Curriculum** folder and check to be sure that all of your mandatory courses are complete. All courses will be ‘green’ and you will see a checkmark to the left of each course name.

If you have any questions about accessing the training content or receiving credit for training, please contact the training team at [MAhealthconnectorTraining@state.ma.us](mailto:MAhealthconnectorTraining@state.ma.us).

The Health Connector and MassHealth

**Important Links**

[MAhealthconnector.org](http://MAhealthconnector.org)

[MassHealth Website](#)

TOTAL BY

Outreach	January		February		March		April		May		June		July		August		September		October		Novemeber		December	
	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill	Contact	Bill
Brightwood	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√						
CHCI	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√						
CHCFC	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√					
CHS	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		√				
Generations	√	0	√	0	√	0	√	√	√	√	√	√	√	√	√	√	√	√						
Holyoke	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√						

**Missing data**

Monthly Outreach Expenditure Reports must be submitted by the 15<sup>th</sup> of the month following the reporting month.  
 Monthly Outreach Contact Sheets must be submitted by the 15<sup>th</sup> of the month following the reporting month.  
 In addition, all Outreach Expenditure Reports and Outreach Contact Sheets from Jan. 1, 2016 through June 30, 2016 must be submitted to MLCHC no later than Aug. 15, 2016;  
 all Outreach Expenditure Reports and Outreach Contact Sheets from July 1, 2016 through Dec. 31, 2016 must be submitted no later than Jan. 15, 2017.

**Color Key**

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# CRVFHP Performance Improvement Measure Report Template

Name of CHCFC \_\_\_\_\_

Date Completed 11/9/16

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p><b>1. DM</b></p> <p><b>2. A1C&lt;9% 70%</b></p> <p><b>3. 20%</b></p>	<p><b>4. Jan 2016 – March 2016</b></p> <p><b>75%</b></p>	<p><b>5. No. We had a lot of issues with pt. compliance, no shows for follow up appt.'s</b></p>	<p><b>April 2016 – June 2016</b></p> <p><b>57%</b></p> <p><b>July 2016 – October 2016</b></p> <p><b>55%</b></p>	

# CRVFHP Performance Improvement Measure Report Template

Name of CHCFC \_\_\_\_\_

Date Completed 11/9/16

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p>1. EOH</p> <p>2. 4% (2014)</p> <p>3. 60%</p>	<p>4. Jan 2016 – March 2016</p> <p>20%</p>	<p>5. No, we began using the EOH screening tool as part of PVP</p>	<p>April 2016 – June 2016</p> <p>21%</p> <p>July 2016- October 2016</p> <p>51%</p>	

# CRVFHP Performance Improvement Measure Report Template

Name of CHCFC \_\_\_\_\_

Date Completed 11/9/2016

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p>1. IPV</p> <p>2. 0 -14% (2014)</p> <p>3. 60%</p>	<p>4. Jan 2016 – March 2016</p> <p>25%</p>	<p>5. No, we began using the IPV screening tool as part of PVP</p>	<p>April 2016 – June 2016</p> <p>30%</p> <p>July 2016 – October 2016</p> <p>49%</p>	

# CRVFHP Performance Improvement Measure Report Template

Name of CHC Community Health Services Inc

Date Completed November 9, 2016

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p><b>1. Ensure no more than 20% of patients with Diabetes aged 18-75 have uncontrolled HbA1c&gt;9%</b></p> <p><b>2. Baseline year – 2015, enrolled 105 (entire Adult Medicine population at CHS)</b></p> <p>By the end of the project period, reduce percentage adult</p>	<p>The CHS IT Data Analyst provided the following data for the period of 1/1/16 through 9/30/16:</p> <p>8 of 42 (19%) patients have a diagnosis of Diabetes Mellitus Type 2</p> <p>8 of 8 (100%) had their HbA1c during this year</p> <p>6 of 8 (75%) have HbA1c readings of &lt;7%</p>	<p>CHS has a Certified Diabetes Educator on Staff. She provides educational material and counseling to our MSAW clients at CHS.</p> <p>All MSAW clients with uncontrolled DM will be referred to the CHS Diabetes Educator</p>	<p>As of 10/1/2016, 25% of patients diagnosed with DM have HbA1c readings of &gt;7%</p>	

<p>diabetic patients with AIC &gt;9% by 20%</p>				
<p>1. Ensure 100% of MSAW patients aged 18 and older are screened for Environmental/Occupational Health (EOH)  2. Base Year – N/A  By the end of the project period, all patients will be screened for EOH</p>	<p>April – November 2016  Statistics not available at this time</p>	<p>All patients will be screened for signs of heat/sun exposure, dehydration, repetitive injury and other conditions related to the proper use of protective clothing and footwear. The Outreach Educator will advise and educate workers and family members about identifying signs of heat/sun stroke, dehydration and other occupational risks. MSAW's will also be advised on proper hydration, use of protective clothing, safety shoes and other protective apparel and equipment.</p>	<p>A new template will be developed for Next Gen, the CHS EMR that will record this information.  Until that template is in place, this information will be compiled manually</p>	

<p>1. Sexual/Intimate Partner Violence Ensure that 100% of female aged 18 and older are screened for intimate partner violence</p> <p>2. Baseline Year – 2015, 50 women</p> <p>By the end of the project period, all female patients ages 18 and over will be screened</p>	<p>April – November 2016</p> <p>Statistics not available at this time</p>	<p>The Outreach Educator will conduct at least one educational session about domestic violence protection. MSAW's will receive information about signs of domestic violence, what to do if you are a victim and the DV Hotline Number and the services they provide</p>	<p>A new template will be developed for Next Gen, the CHS EMR that will record this information.</p> <p>Until that template is in place, this information will be compiled manually</p>	
<p>1. Adult Weight Screening and Follow-Up.</p> <p>2. Baseline Year – 2016</p> <p>By the end of the project period, all MSAW medical care clients will have their BMI recorded. Appropriate follow-up will occur with the provider and the CHS Nutritionist</p>	<p>The CHS IT Data Analyst provided the following data for the period of 1/1/16 through 9/30/16:</p> <p>41 of 42 (97%) of patients have BMI reported to the medical department</p> <p>28 of 41 (68%) reported patients have BMI out of range - &gt;25%</p>	<p>Every MSAW brought into CHS for a medical appointment will have their BMI recorded. If the BMI is not within acceptable limits, additional counseling on healthy nutrition and activity habits will be given by the provider and if appropriate, the CHS Nutritionist</p>	<p>As of 10/1/2016, 97% of all patients had their BMI recorded.</p> <p>85% of the patients with BMI &gt;25% have a documented plan to address diet and exercise.</p>	

	<b>24 of 28 (85%) of patients with documented BMI &gt;25% have a documented plan to address diet and exercise</b>			
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# CRVFHP Performance Improvement Measure Report Template

Name of CHC Holyoke Health Center, Inc.

Date Completed 11/7/16

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p><b>1. To ensure <u>90%</u> of MSAW patients aged 18 &amp; older have documented BMI percentile charted, and when the BMI is outside of normal parameters, had a documented follow-up plan. [UDS-ADULT WEIGHT SCREENING &amp; FOLLOW-UP – Excludes pregnant</b></p>	<p>Out of 82 MSAW/dependents age 18+, 70 had BMI recorded &amp; had FU plan if BMI out of range (CY 2015) <b>84%</b></p>	<p>We now have portable stadiometer.</p> <p>(1) Will measure height &amp; weight of MSAW at each visit on farm.</p> <p>(2) Those who have BMI &gt;25 will be seen by provider to evaluate diet &amp; exercise level, and make individual recommendations.</p> <p>(3) Referral to Nutritionist will be made available.</p>	<p>78 AW 18+/&lt;65 seen since January 1, of whom 55 had elevated BMI that was addressed (<b>78.4%</b>)</p> <p>Will reinforce to providers who saw patients the importance of intervening on elevated BMIs.</p> <p>In reviewing results from prior report, it turns out that several of them were</p>	<p>Prior report was <b>76%</b>.</p> <p>Reviewed prior report manually; many were not FWs.</p> <p>QI director will address at upcoming provider meeting.</p>



<p>Improve to 75%</p> <p><b>3. To ensure 90% of female MSAW patients aged 18 or older have documentation of screening for sexual/intimate partner violence. [HRSA-SEXUAL/INTIMATE PARTNER VIOLENCE SCREENING]</b></p> <p><b>A. Baseline data &amp; time period</b> CY 2014 (medical chart review done for CRVFHP) <b>0%</b></p> <p><b>B. Targeted goal for improvement</b> Improve to <b>90%</b>.</p> <p><b>4. To ensure no more than 50% of patients with diabetes aged 18-75 have uncontrolled HbA1c&gt;9%. [UDS-DIABETES HEALTH</b></p>	<p>Of 18 female MSAW/dependents age 18+, 2 had screening for sexual/ intimate partner violence - CY 2015 <b>(11%)</b></p> <p><b>0%</b> (CY 2014 CRVFHP medical chart review)</p> <p>Out of 8 MSAW/dependents age 18-75 with diabetes, 1 had A1c result greater than 9% - CY 2015 <b>(12.5%)</b></p>	<p>patients who are seen at HHC/CHC for primary care.</p> <ol style="list-style-type: none"> <li>(1) In-service given to all HHC/CHC providers, reminding them of the importance of this screening measure, and showing them where they can document it in NextGen.</li> <li>(2) Reminded them that this will NOT show on Master-IM.</li> <li>(3) Protocol is to screen at all well-woman and annual exams, regardless of MSAW status.</li> <li>(4) Patients with positive screens will be offered Behavioral Health intervention</li> </ol> <p><b>(1)</b> For known diabetics, patient's A1c will be checked at earliest</p>	<p>Of <b>15</b> adult female AW patients seen, 3 of them had screening for domestic violence <b>(20%)</b></p> <p><b>8</b> MSAWs with diabetes were seen. One had A1c &gt; 9. <b>(12.5%)</b></p>	<p>This is an improvement over 11% last year, but still needs work.</p> <p>I am not sure they are all AW/dependents. Lellys &amp; I will verify that each of these women is a MSAW.</p> <p>I did a manual chart review and data was not entered. I will work with data manager to see if there is somewhere else this information could be entered and tracked to make it easier for providers to document information.</p> <p>I will meet with QI director to educate other providers about importance of this measure, since it is required of all our female patients, regardless of AW status.</p> <p>I am working with that AW to encourage him to self-monitor BS. He has gone home for the season, and was not willing to adjust his medications before he left. I gave him lab results and last</p>
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<p><b>OUTCOME &amp; DISPARITIES – Excludes patients diagnosed with gestational diabetes or steroid-induced diabetes or patients with polycystic ovaries that do not have two face-to-face visits with the diagnosis of diabetes.]</b></p> <p><b>A. Baseline data &amp; time period</b></p> <p><b>B. Targeted goal for improvement</b> Improve to &lt;50%.</p>		<p>possible visit after patient arrives.</p> <p><b>(2)</b> Provider will provide home BS monitor &amp; supplies, for daily testing. Patient to bring monitor to all visits.</p> <p><b>(3)</b> Provider will prescribe appropriate medication, as well as recommend appropriate lifestyle and behavioral changes.</p> <p><b>(4)</b> Referral to nurse CDE &amp; nutritionist will be made available.</p> <p><b>(5)</b> Provider will check BS &amp; review home BS log at each visit, and adjust medications as appropriate.</p> <p><b>(6)</b> Literacy-level and language appropriate literature will be made available to reinforce</p> <p><b>(7)</b> For patients newly diagnosed with</p>	<p>Last report was 0% over 9% but was just a sample size of 2.</p>	<p>visit note to take to his LMD in home country.</p>
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		<p>diabetes, process will initiate at time of diagnosis.</p> <p><b>(8)</b> Repeat A1c level will be drawn after 3-6 months.</p> <p><b>(9)</b> Information on care while in MA will be given to patient to bring to home-country provider, for continuity of care.</p>		

# CRVFHP Performance Improvement Measure Report Template

Name of CHC Community Health Center, Inc. Date Completed 11/7/16

<p><b>1. List the Performance Improvement Measure</b></p> <p><b>2. List the baseline data and time period</b> (must include a numerical value)</p> <p><b>3. List the targeted goal for improvement for the PI measure</b> (can be benchmark goal or CRVFHP goal)</p>	<p><b>4. Initial Performance</b></p> <p>List the time period for the data collection and the data results (must include a numerical value)</p>	<p><b>5. Actions taken</b></p> <p>Did you meet the targeted goal? If not, list the actions and/or steps taken for improvement and the start date. If goal met, repeat data collection once again. If goal met a second time, select a new PI measure.</p>	<p><b>6. Performance Re-Measurement</b></p> <p>Repeat the data collection and note the results (numerical value) and time period. This step is done <i>after</i> actions/steps for improvement made.</p> <p><b>Repeat Step #6 until targeted goal is achieved.</b></p>	<p><b>7. Demonstrated Improvement</b></p> <p>Describe the improvements made, data results and time periods. Include any planned follow-up activity. Or new PI measure.</p>
<p><b>1a-</b> Objective 11: To ensure MSAW patients aged 18 and older (excluding those seen only at a farm) have documented BMI percentile charted, and when the BMI is outside of normal parameters, had a documented Follow-up plan. [UDS-ADULT WEIGHT SCREENING AND FOLLOW-UP - Excludes pregnant women and terminally ill Patients.]</p> <p><b>1b-</b> <b>52.4%</b>- this number is reflective of CHC Inc. total</p>	<p>Our business Intelligence (BI) team provided us with the most recent data reported for UDS measures for the time period of 1/1/15-12/31/15. We will review our goals and pull data again in June, allowing for 4-6 weeks of peak season program visits to take place.</p>	<p><b>1- Objective 11 (Adult weight screening and follow-up)</b></p> <p><b>We did not meet this performance measure as laid out in the RFP for 2015.</b></p> <p>Action Step(s): It is CHCI's standard of care to take vitals for every patient at every visit, in addition, counseling all patients regarding physical activity, nutrition and lifestyle intervention. This includes documenting BMI percentile and working with the patient to develop a follow-up plan regarding the outcomes of their screening. As the UDS measures currently stand, the BMI and the follow</p>	<p><b>1- Objective 11 (Adult weight screening and follow-up)</b></p> <p>As of 11/7/16 the UDS measure outcome stands at 59.6% which a slight increase since 6/2016 when last reported. We had a low turnout for our Monday evening clinics in Meriden this year- are considering eliminating this clinic in the 2017 grant year, focusing on regularly scheduled appointments.</p>	<p>Overall:</p> <p>We have seen an improvement in our Adult weight screening/follow up measure. We hope this continues throughout the end of the year, although it doesn't appear that we will meet our objective. From the data, we see that a very high number (nearly All screened patients) have their weigh taken; the problem lies in the follow up. As we train our new full time program</p>

agency-wide collected data from **1/1/15-12/31/15**  
**1c- 80%**- We aim to improve our performance measure in this area by **+27.6%** across our CRVFHP patient population. (additional narrative and template preview attached)

**2a- Objective 21: To ensure female MSAW patients aged 18 or older have documentation of screening for sexual/intimate partner violence.** [HRSA-SEXUAL/INTIMATE PARTNER VIOLENCE SCREENING]

**2b- no baseline data available-** although we do screen for IPV using the HARK survey; we don't currently have it set up in the backend mapping of our electronic health records. We don't pull it for reporting purposes. (additional narrative attached with template preview). We have data from

up are together in one measurement; however for 2016 the UDS measures are now separated out so we can reflect on the BMI being calculated and documented, and then reviewing the follow up that has taken place i.e. physical activity counseling and/or nutritional counseling. We have created a new template (screen shots attached) with this as part of the HPI in our EHR (documented as part of the progress note). Utilization of this template will allow for better measurement, and clear expectations of screening steps during the visit.

**2- Objective 21 (Sexual/intimate partner violence screening)**

Action Steps: It is CHCI's standard of care to assess each female patient at every visit regarding sexual/intimate violence. If applicable, the patient is followed up by their primary care provider and referred to additional resources as appropriate. With this being an increased area of focus this year We have created a new template (screen shots attached) with this as part of the HPI in our EHR (documented as part of the progress note). Utilization of this template will allow for better measurement, and clear expectations of screening steps during the visit.

We will have a full time,12 month position created and will have the provider training a responsibility of this new staff. We are hopeful to have that position filled within the next couple of weeks. The use of the template has been minimal, but the staff available for oversight has also been minimal so the outcomes are not surprising. Our full time program coordinator will be monitoring our visits and our data closely, as we move forward in these goals.

**Objective 2a (Sexual/intimate partner violence screening)**

A report I received on 11/7/16 shows an increase from 0% to 8% screened. It remains a very weak screening outcome, but it is a recognized increase. As with other goals- We will have a full time, 12 month position created and will have the provider training a responsibility of this new staff. We are hopeful to have that position filled within the next couple of

coordinator, this will be a high priority. The use of the template is essential to ensuring that our program goals are being met. The training and education that is needed for provider buy-in is the only way this plan will be successful. In addition, we should see some helpful and concrete data come from the template specifically for the IPV and EOH measures, when used consistently. We have a very specific structure in place that will allow us to capture data in real time and determine its usefulness. We have a small improvement in our IPV outcomes, but still an improvement! I believe our barrier exists in the fact that this screening is traditionally used during a female patient's women's health visit, rather than asked routinely at a routine or sick visit. This will be one barrier we are working to breakdown with our Chief Nursing Officer.

2014 chart review that shows 25% completed.

**2c- 80%-** We have now created a template to track this performance measure beginning in June, when our on site evening medical clinics begin. Since there is no hx of tracking outcomes in this area, we will have a clear point of standing when we pull the outcomes for reporting in August. From that point, we will either maintain this measure or increase it for the remainder of the grant year.

**3a- Objective 20: To ensure MSAW patients aged 18 or older are screened for Environmental/Occupational Health (EOH) risk. [HRSA- ENVIRONMENTAL/OCCUPATIONAL HEALTH SCREENING]**

**3b- no baseline data available-** although we do screen for EOH using basic questions; we don't currently have it set up in a structured manner for assessment, or set up in the backend mapping of our electronic health records. We don't pull it for reporting purposes. (additional narrative

**3- Objective 20 (Environmental/Occupational Health Screening)**

Action Step(s): As a result of working with this population, our CHCI providers are well versed and familiar with the environmental/occupational health risks associated with the work of the MSAW.

MSAW's will be assessed for these risks at the time of their initial visit, with appropriate follow-up in place as needed. With this being an increased area of focus this year, We have created a new template (screen shots attached) with this as part of the HPI in our EHR (documented as part of the progress note). Utilization of this template will allow for better measurement, and clear expectations of screening steps during the visit.

**4- Objective 22 (Diabetes Health Outcome and Disparities)**

We did not meet this performance measure as laid out in the RFP for 2015.

weeks. The use of the template has been minimal, but the staff available for oversight has also been minimal so the outcomes are not surprising. Our full time program coordinator will be monitoring our visits and our data closely, as we move forward in these goals.

**3- Objective 20 (Environmental/Occupational Health Screening)**

There has been a slight increase to our EOH outcomes of this measure as of 11/7/16. For those patients that were billed out to CRVFHP, we had 12% of female patients and 2% of male patients assessed in this area. we can pull accurate real time data based on the visits that take place at the clinics throughout the season. The data is interesting and a place to delve into a bit when looking at the discrepancy between male and female farm workers. Again, with

We had a very small improvement in EOH screenings but this is better than 0%. It is still not a part of standard measurements agency-wide but again, the use of the template and proper billing and coding of visits will bring us to a greater level of management on this measure.

Our Diabetes measure has improved since our last report in June, however still remains lower than when we began our grant year. In respect to ebbs and flows of data, we are trying to find a consistent place for screening and remain hopeful that we will be below the target of 20% by the completion of this grant period.

attached with template preview)  
**3c- 80%**- because of the population we are targeting in this program, we know that this measure is a priority and therefore we have created a template to track this performance measure. Since there is no hx of tracking outcomes in this area, we will have a clear point of standing when we pull the outcomes for reporting in August. From that point, we will either maintain this measure or increase it for the remainder of the grant year.

**4a- Objective 22: To ensure no patients with diabetes aged 18-75 have uncontrolled HbA1c >9%).**

**[UDS-DIABETES HEALTH OUTCOME & DISPARITIES -**  
 Excludes patients diagnosed with gestational diabetes or steroid induced diabetes or patients with polycystic ovaries that do not have two face-to-face visits with the diagnosis of diabetes.]

**4b- 21.9%.** this number is reflective of CHC Inc. total agency-wide collected data from **1/1/15-12/31/15**

Action Steps: As a part of CHCI's standard of care, patients will receive support in diabetes management from the provider, nurse and the diabetes educator to adhere to the needs based clinical treatment plan developed by the provider and patient together.

the start of a full time program coordinator, the use of the template will be more closely monitored with additional trainings completed.

**4- Objective 22 (Diabetes Health Outcome and Disparities)**

As of 11/7/16 the UDS measure outcome stands at 22.4%, a 2% improvement since June, but still a deficit where we started the grant year. Our hope and objective is to decrease this value to 20% over the next couple of months, to end the grant year. We are so close! We will be looking at the data outcomes from the template very closely to see where tweaks need to be made to make the screening as efficient as possible.

**4c- 20%-** We aim to improve our performance measure by +1.9% (maintaining) for now. As we continue to monitor this measure, we will review the need to increase our goal throughout the grant year.




Massachusetts League  
of Community Health Centers



<b>Date</b>	<b>Comment</b>	<b>Location</b>
Jan. 10, 2017	UDS Training	TBD
<b>Jan. 18, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
<b>Feb. 15, 2017</b>	<b>Initial UDS Submission Deadline</b>	
<b>Feb. 21, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
<b>Mar. 21, 2017</b>	<b>CRVFHP Monthly / RFP Call 10:00am-12:00pm (perhaps to be moved up)</b>	<b>Conference call only</b>
Mar. 28-April 3, 2017	NACHC P&I Forum	<b>Marriott Wardman Park, Washington DC</b>
<b>Mar. 31, 2017</b>	<b>Final UDS Submission Deadline</b>	
<b>April 18, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>Holyoke Health Center</b>
May 2-5, 2017	Pre-CHI Session & Community Health Institute and Exhibit Fair	Seacrest Hotel, Falmouth
May 16, 2017	CRVFHP Monthly Meeting 10:00am-12:00pm	TBD
<b>May 22-24, 2017</b>	<b>NACHC Nat'l Conference on Agricultural Worker Health</b>	<b>Savannah Marriott Riverfront, Savannah GA</b>
<b>June 20, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
<b>July 18, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
<b>Aug. 15, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
Aug. 26 – 30, 2017	NACHC Community Health Institute (CHI) & EXPO	Manchester Grand Hyatt, San Diego, CA
<b>Sept. 19, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>Holyoke Health Center</b>
<b>Oct. 2017 (TBA)</b>	<b>East Coast Migrant Stream Forum</b>	<b>TBA</b>
<b>Oct. 17, 2017</b>	<b>CRVFHP Monthly Meeting 10:00am-12:00pm</b>	<b>TBD</b>
Nov. 21, 2017	CRVFHP Monthly Meeting 10:00am-12:00pm	TBD
Dec. 19, 2017	CRVFHP Monthly Meeting 10:00am-12:00pm	TBD

**Quality Improvement Meeting(s) to be scheduled**  
**RFP Timeline to be scheduled**

Also, check [www.massleague.org](http://www.massleague.org) and Click on 'Calendar of Events' for any changes to meeting schedule.