CareFirst Safety Net Health Center as Patient-Center Medical Homes Grantees

**Arlington Free Clinic**, $350,000/ 3 years  
*Enhancing Medical Care with a Safety Net Primary Care Medical Home*

**Baltimore Medical Systems**, $498,906/ 2 years  
*Behavioral Health Informed Health Home Pilot*

**Calvert Healthcare Solutions**, $287,763/ 2 year  
*Patient Centered Care Management for Calvert County, Maryland's Vulnerable Citizens*

**Chase Brexton Health Services, Inc.** $250,000/ 2 years  
*Expanding Access to Support Team Services for Patients with Chronic Illnesses: The Healthy Outcomes through Patient Empowerment (HOPE) Project*

**Choptank Community Health System**, $400,000/ 2 years  
*PCMH for Safety Net Diabetic Patients*

**Community Clinic, Inc., Collaborative**, $1,585,521/ 3 Years  
*Greater Baden  
Medical Services FQHCs as Community Hubs of Care Management*

**Health Care for the Homeless**, $750,000/ 3 years  
*Health Care for the Homeless Primary Care Medical Home*

**Mary's Center**, $596,665/ 3 years  
*Mary's Center's Patient Centered Medical Home Chronic Care Initiative (PCMH-CCI)*

**Primary Care Coalition of Montgomery County Collaborative**, $599,514/ 3 years  
*Holy Cross Health Center and Mobile Medical  
Montgomery Cares Patient Centered Medical Homes Program*

**Spanish Catholic Center**, $300,000/ 3 years  
*Focusing on Our Team Based Approach to Living a Healthier Life*

**Total Health Care Collaborative**, $1,994,876/ 3 years  
*Family Health Centers of Baltimore (FHCB) and Park West Health System, Inc. (PWHS)  
Baltimore FQHC Safety Net Health Center Collaborative*

**Unity Health Care**, $913,801/ 3 years  
*Patient-Centered Medical Home Enhancement Grant*
CareFirst Safety Net Health Center as Patient-Center Medical Homes Grantees

Arlington Free Clinic

Program Name: Enhancing Medical Care with a Safety Net Primary Care Medical Home
Grant Amount: $350,000/ 3 years

Program Description:
The Arlington Free Clinic provides free health care for low income uninsured residents of Arlington County and is supported by volunteers and community partners to provide patient and program services. The Arlington Free Clinic PCMH model will include technical improvements (e.g., implement disease registries, develop templates to measure health outcomes, create mechanism to exchange patient data with community partners) as well as innovative strategies to address and overcome health disparities (e.g., language, gaps in health knowledge, cultural beliefs) in a vulnerable patient population. Every patient will be empanelled to a physician-directed health care team to be managed by a staff Nurse Manager and will include a staff Medical Assistant. Teams will also include pharmacists and nutrition educators. Two disease registries will be implemented (hyperlipidemia and depression) to provide and manage care. CareFirst funds to be used for personnel wages and benefits, administrative support, technology and medical supplies.

Baltimore Medical Systems, Inc.

Program Name: Behavioral Health Informed Health Home Pilot
Grant Amount: $498,906/ 2 years

Program Description:
Baltimore Medical Systems, Inc. operates seven health centers and is the largest community health network in the state of Maryland. BMS provides primary care to Baltimore City and County and serves a multicultural patient base. The BMS program will be piloted at their largest clinic in the Highlandtown area of Baltimore City. The program design is to expand the BMS health home model to address unmet behavioral health needs of complex patients with out-of-control chronic conditions. This is an integrated behavioral health/ primary care model where the patient's primary care physician works with a care manager and psychiatrist to develop, implement, and modify (where necessary) treatment plans to promote better adherence to medications and follow-through on physician orders and to improve biomedical outcomes as measured by clinical indicators related to chronic conditions. A comprehensive clinical assessment will be conducted for every patient and a web-based care management tracking system with a registry function will be used in this project. Grant to fund care coordinators, project manager and data coordinator salaries, psychiatrist consultants and tech support.
Program Name: Patient Centered Care Management for Calvert County, Maryland's Vulnerable Citizens
Grant Amount: $287,763/2 year

Program Description:
Calvert Healthcare Solutions is not a “bricks and mortar” clinic. It utilizes a network of participating physician providers located throughout Calvert County to serve individuals who generate too much income to be eligible for Medical Assistance, yet do not have access to or cannot afford commercial health insurance. The program is run with support from Calvert Memorial Hospital, Calvert County Health Department, Calvert County Department of Social Services and other community agencies.

To establish a patient centered medical home for Calvert County’s low-income, uninsured adult population, Calvert Healthcare Solutions will develop individual physician-directed health care plans for clients at high-risk for diabetes and/or heart disease. Program includes subsequent monitoring of measures, wellness coaching, referrals for tobacco cessation, medical education and mental health services, and access to pharmaceuticals through a voucher program with local pharmacies. Clients will be incentivized to complete a health risk assessment. Grant to fund care coordinator, administrative coordinator, grant coordinator, Hispanic staff, specialty care, medications, IT support and a wellness program.

The program will measure “normalized” blood pressure, blood glucose readings; increased disease self-management skills, physical activity; completed health plans; decreased hospitalization occurrences; use of ER visits for diabetes, cardiovascular disease; appropriate referrals to other resources and improved self-reporting for mental health perception.

Chase Brexton Health Services, Inc.

Program Name: Expanding Access to Support Team Services for Patients with Chronic Illnesses: The Healthy Outcomes through Patient Empowerment (HOPE) Project
Grant Amount: $250,000/2 years

Program Description:
Chase Brexton Health Services, Inc. has four clinic locations and has evolved from a gay health clinic into an FQHC that provides care to disenfranchised, high risk patients through primary care, diabetes management, HIV-targeted case management, substance abuse and mental health services.
Chase Brexton Health Services, Inc. Continued

The Healthy Outcomes through Patient Empowerment (HOPE) Project is an integrated, multidisciplinary model of care to provide adherence assessment, education, support and drug regimen review. The most common chronic diseases in this population are HIV, hypertension, diabetes, and asthma. Specifically this grant will expand the Medication Support Team (MST) to provide increased patient access to an interdisciplinary treatment team (MST nurse and clinical pharmacist) for all patients diagnosed with at least one chronic illness, and add a QI nurse to be responsible for clinical quality performance activities. In addition, Chase Brexton will hire a navigator to provide additional support to chronically ill patients referred to the program. The grant will support MST Coordinator, clinical pharmacist, patient navigator and quality improvement nurse.

Program will measure the number of patients with chronic illness seen for intake and evaluations; number of patients’ visits for medication review; adherence, education, self-care planning, management of chronic illness; number of Club Med (a group that fills pill boxes and provides a forum for group discussions for HIV+ patients) group visits; number of patient visits with behavioral medicine clinician; patient progress on clinical quality measures for key health indicators; electronic registry for HOPE program patients to allow tracking and reporting on both an individual and aggregate basis.

Choptank Community Health System

Program Name: PCMH for Safety Net Diabetic Patients
Grant Amount: $400,000/ 2 years
Program Description:
Choptank Community Health System is located on the Eastern Shore and is a private, non-profit community health center network, providing access to health care through the delivery of comprehensive medical, dental and behavioral health care services in Caroline, Dorchester, and Talbot Counties. The Choptank program will identify the most out-of-control uninsured diabetic patients with HGBA1C's >9% to participate in year long program that will provide intense management of their chronic illness, including meeting with medical provider every three months for follow up. Each patient will also meet with diabetic educator for 30-60 minutes and develop/evaluate self-management, nutrition counseling, review medications, exercise plans, stress management, and coordination of care (screening test, scheduling for dental exams, etc.). Nurse educators may check on patients via phone calls at more frequent intervals. Patients will be incentivized for participation and success. Grant will support two diabetic health educators, clinical administration, evaluation and reporting, supplies, patient incentives, and ophthalmology support. Choptank anticipates applying this model to the larger chronically ill population.
Community Clinic, Inc. Collaborative
Greater Baden Medical Services (Greater Baden)

**Program Name:** FQHCs as Community Hubs of Care Management  
**Grant Amount:** $1,585,521/ 3 years 

**Program Description:**
This program is leveraging the CareFirst investment over three FQHC centers in two counties. CCI serves the uninsured, underinsured and Medicaid patients in Montgomery and Prince George’s Counties at seven permanent locations. The Community Hubs of Care Management program will be implemented in the CCI Silver Spring and Takoma Park clinic sites and will serve patients from Montgomery and Prince George’s Counties. Greater Baden Medical Services, Inc. provides primary care services to residents of Southern Maryland and will be implementing the program at their Brandywine location in Prince George’s County.

The program will substantially increase support to high-risk patients and families in self-management and accessing services. Specifically: Integration of community health workers (provided by Casa de Maryland) as part of primary care team, expanding use of EMR, collaborating with external entities, and making sound data collection and evaluation a priority. Grant will support a care management coordinator, nurse care manager, health educator, data analyst, nurse practitioner, IT manager and six community health workers.

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**Health Care for the Homeless**

**Program Name:** Health Care for the Homeless Primary Care Medical Home  
**Grant Amount:** $750,000/ 3 years 

**Program Description:**
Health Care for the Homeless (HCH) provides health-related services, education, and advocacy to reduce the incidence and burdens of homelessness. This program will bring the concepts, strategies, and technologies of the PCMH model to this extremely ill, multiple-diagnosed, impoverished, and vulnerable population. Specifically, the program will empanel those with multiple chronic conditions, hire another full-time physician to serve the complex needs of these patients who have three or more chronic conditions as well as behavioral health challenges and, due to the complexity of their conditions, require significant physician engagement, and establish cross-disciplinary teams with a care coordinator (under physician's directives) acting as team conductor. The team will include addiction counselors, therapist case managers, psychiatrist, RN with psychiatric expertise, vocational specialist, patient navigator, and peer counselor. Meeting daily, the care team will complete care plans (in concert with the client), provide prescribed medical and behavioral health services, track appointment and care plan adherence, conduct outreach to clients for whom such compliance has been difficult, and provide same day appointments as necessary.
Mary’s Center

Program Name: Mary’s Center's Patient Centered Medical Home Chronic Care Initiative (PCMH-CCI)
Grant Amount: $596,665/ 3 years
Program Description:
Mary’s Center for Maternal and Child Care, Inc. delivers health care, education and social services to save lives, stabilize families, and strengthen communities. Mary’s Center operates three centers and will soon open the fourth center in Prince George’s County.

The proposed Chronic Care Initiative will operate at all Mary’s Center locations. This program will apply an integrated approach to the needs of the asthmatic, hypertensive and diabetic populations by utilizing the integrated model in place at Mary’s Center, and strengthening the team, through care planning and the utilization of the universal care planning tool with their EMR. This builds on an integrated approach to diabetes which has been piloted over the last 12 months via a “rotational clinic,” so-called because patients meet with all members of the care team – clinician, nursing, health education, nutritionist and family support worker one after another during the course of one extended visit. Specifically, the program will add a RN chronic care case manager who will complete care plans with patients that will encompass the goals of all the team members, adding two panel managers who will ensure that patients are receiving all the services necessary to ensure optimum management of their condition, and adding a health educator with a focus on hypertension to complement the current staffers who focus on asthma and diabetes. The grant will support a panel manager (medical assistant), chronic care case manager, chronic care educator, equipment and supplies.

Primary Care Coalition of Montgomery County Collaborative
Holy Cross Health Center and Mobile Medical

Program Name: Montgomery Cares Patient Centered Medical Homes Program
Grant Amount: $599,514/ 3 years
Program Description:
The goal of this Montgomery Cares Patient Centered Medical Homes Pilot Project is to transform two participating safety-net clinics into patient centered medical homes. Mobile Medical provides health care to the uninsured, low income, working poor and homeless in Montgomery County at 15 locations and is developing fixed facilities to serve as “medical homes” and consolidating mobile sites primary targeting homeless, day labor and other hard-to-reach communities. Mobile Med received a HRSA FQHC Planning Grant in October 2011 to support pursuing FQHC or FQHC look-alike status and plans to pursue Medicaid reimbursement 2011-2012.
Primary Care Coalition of Montgomery County Collaborative Continued

The second organization is Holy Cross Health Centers which provides primary care to uninsured adults in Silver Spring and the surrounding areas at three clinic locations. HCH Clinics will implement a meaningful use compliant EHR (NextGen) during 2012 and plans are underway to participate in Medicaid 2012-2013.

The program will create a network of PCMHs, with physician-directed patient care and care continuity using a care team model. Care managers will anchor clinical teams to provide enhanced service to a medically and socially complex population. Specialty care services will be provided on-site at clinics and through organized networks of private providers. MCPCC would hire a clinical project director (.5 FTE) responsible for project oversight and two RN clinical care managers (1.5 FTE). Clinic staffing will include physicians, specialists and mid-level practitioners and will vary across clinics.

Spanish Catholic Center

Program Name: Focusing on Our Team Based Approach to Living a Healthier Life
Grant Amount: $300,000/ 3 years
Program Description:
Spanish Catholic Center provides health, education and social services to low-income immigrants in the greater Washington metropolitan region. Spanish Catholic will undergo intensive practice transformations in their Montgomery County and Washington, DC health clinics to become a designated Patient-Centered Medical Home for the region's low-income, uninsured immigrant population. Specifically they will form a community health team comprised of a physician, mid-level clinician, two medical assistants, with registered nurse and prevention and chronic care manager supporting both teams. The physician will focus on clinical or complex issues; the registered nurse will develop care management plans for patients, make follow-up calls and schedule coordinated appointments. Spanish Catholic will also institute the family care membership program to encourage patients to utilize appropriate health services. The family care membership will also encourage patients and their families to make an investment in their health. The grant will support staff, professional development and training, IT/EHR costs, office and medical supplies, and a PCMH NCQA survey.
Total Health Care Collaborative
Family Health Centers of Baltimore and Park West Health System, Inc.

Program Name: Baltimore FQHC Safety Net Health Center Collaborative
Grant Amount: $1,994,876/ 3 years
Program Description:
All three collaborative partners are FQHCs. Total Health Care, Inc. operates nine health centers serving Baltimore’s medically underserved and uninsured residents. FHCB operates four clinics and provides primary care services at low cost to consumers with a one-stop shop model. Park West has four locations and also serves Baltimore residents.

This project will transform 3 FQHCs to a PCMH with nurse care plan coordinators that will work with patients who have multiple chronic diseases to develop a care management plan. A nurse after-hour, first call system will be contracted and a new patient management system will be used by all 3 FQHCs. Grant will cover project director, RN care plan coordinator, contracted nurses, the coordinated EMR system and technical costs.

Unity Health Care

Program Name: Patient Centered Medical Home Enhancement Grant
Grant Amount: $913,801/ 3 years
Program Description:
Unity has a network of 29 health centers and a mobile medical outreach vehicle, which are strategically located within all eight Washington, DC wards. Unity offers primary health care services to the homeless, working poor, under/uninsured, infants, school-age children, the elderly, persons living with HIV/AIDS and/or hepatitis, as well as those who are incarcerated and recently released from jail and prisons. Their scope of primary health care services includes: internal, pediatrics, family practice and obstetric/gynecological medicine. They also offer dental care, social services, mental health, family planning, treatment adherence, substance abuse counseling and numerous specialized services.

Unity began transformation to a PCMH in 2007. This program is designed to enhance the current patient centered medical home by increasing care coordination to support the most vulnerable patients. Specifically the grant will support development of an ER diversion team to provide intense outreach and patient engagement services, enhance care coordination practices, and increase accessibility to primary care services through urgent care alternatives. Teams will consist of staff members from nursing, social services, and registration, along with a community health worker. Team will be responsible for calling patients, providing outreach visits, visiting local ERs, and following up with patients. There will also be increased access through extended hours during the week and on weekends. The grant funding will support service personnel.