Development of an Evaluation Tool for Community Health Centers: A Necessity in a Constantly Changing Healthcare Field

Culminating Experience: Master's in Public Program at Northwestern University

By: Aimee Fata

Friday April 13th

Introduction

Community health centers (CHCs) provide essential medical, dental, behavioral health, and social services to some of the most vulnerable populations in the United States, and meet some of the highest health delivery standards in the country (1). Regardless of patients' ability to pay, CHCs deliver comprehensive, high-quality preventive and primary health care services to patients, many of whom are racial, ethnic, gender, and/or sexual orientation minorities, immigrants or refugees, homeless, and/or prefer to receive their health care information in a language other than English. (1).

With CHCs being the primary health care provider for those without health insurance, when available, insurance reimbursements are essential to CHCs' sustainability in being able to provide health and social services to the vast number of patients who visit CHCs annually (2). The Affordable Care and Patient Protection Act (ACA) was signed into law in 2010, expanding Medicaid (2). As a result of these federal and state initiatives, the total number of uninsured Americans dropped to 36% by 2011 greatly impacting those populations cared for by CHCs (2). Specifically, in 2007, prior to ACA implementation, 40% of patients who were seen at CHCs were uninsured (2). In contrast those that were on Medicaid and served by the community health centers increased from 35% in 2007 to 49% in 2011 showing how those that were uninsured may have been able to be insured through Medicaid, and therefore the expansion of Medicaid was able to help ease the burden uninsured rates on community health centers (2). If the Affordable Care Act was to be repealed the burden of covering people that are uninsured is important for health

centers to understand, and so by creating a grading system those that work with CHCs can determine where resources should be focused.

As sustainability of the ACA is scrutinized by leaders at the federal level, it is imperative that CHCs better understand the strengths and challenges of their business infrastructure and clinical workflows in order to best allocate resources, prioritize quality improvement initiatives, and reflect on the future needs of their patients; the focus of this paper is to describe the development of an evaluation tool designed to aid in this work in a national Health Resources and Services Administration (HRSA)-funded Health Center Controlled Network (HCCN), AllianceChicago.

For over 20 years, AllianceChicago, has convened a network of CHCs to improve personal, community, and public health through innovative healthcare collaboration, health information technology, and health research and education. Much of this work is achieved through AllianceChicago's standardized electronic health record system (EHRS) tool (Centricity), which the nearly 50 network CHC organizations (over 250 locations of care located in 17 different states) have implemented in their clinical practice sites. AllianceChicago prides itself with creating a collaborative environment for network CHCs to "provide exemplary, innovative health services that unite healthcare providers and consumers to optimize effectiveness, efficiency, experience, and outcomes." (3). To meet this goal, AllianceChicago must better understand the strengths and weaknesses of each CHC in order to best support individual and network infrastructure and quality. The

development of evaluation tool created for my Culminating Experience project will be thoroughly described in this paper.

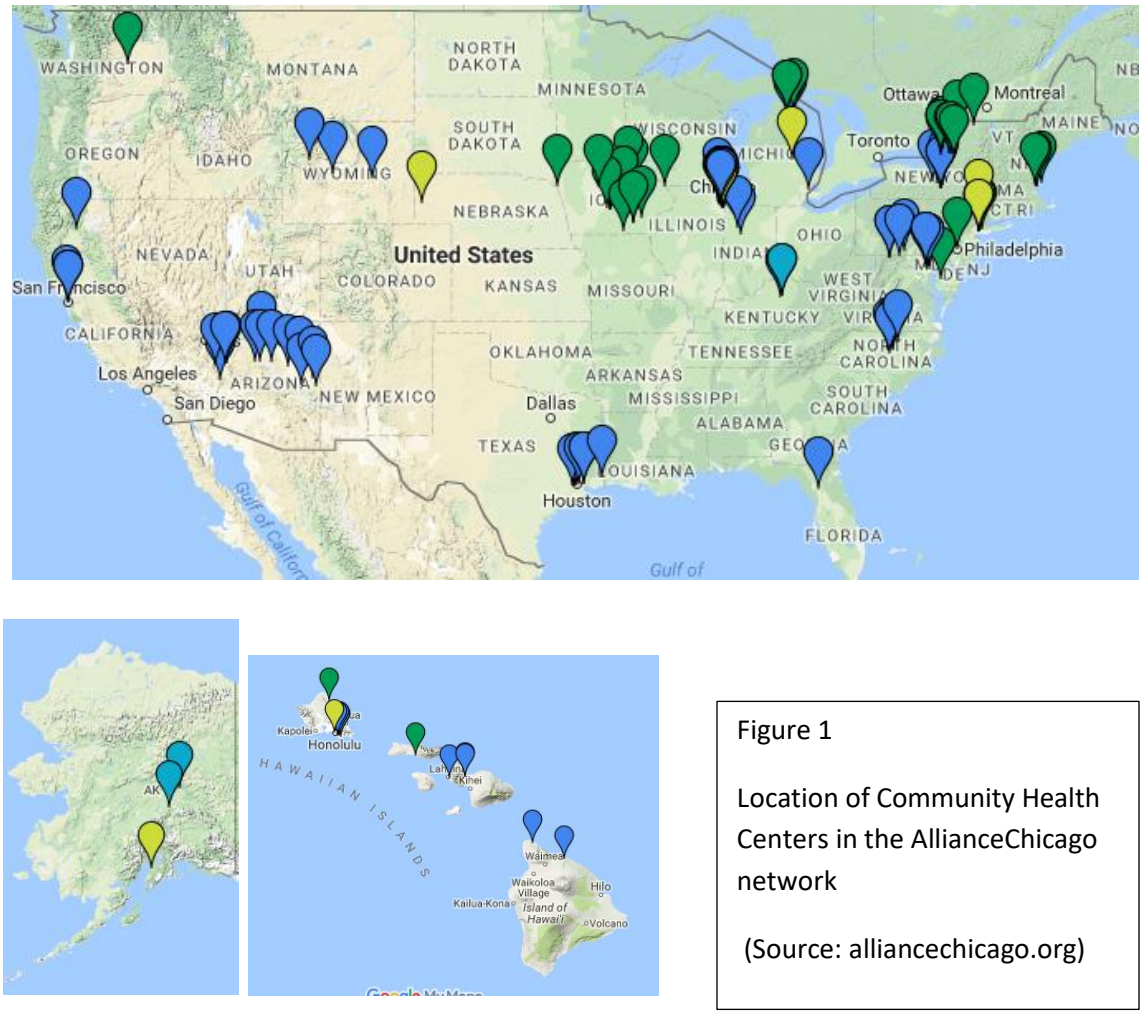

Figure 1

Location of Community Health Centers in the AllianceChicago network

(Source: alliancechicago.org)

Current CHC Climate

As stated above, CHCs are essential to providing health care and social services to vulnerable populations. Around fifty years ago, when the HRSA Health Center Program first started, there were only two health center locations in the United States (1). Today, there are nearly 1,400 CHCs serving close to 26 million people, nationwide (1). These expanding numbers portray why understanding the

strengths and challenges of providing high-quality health care at CHCs is important today, especially with the added constraints and unpredictability of laws and funding in healthcare.

As a result of the implementation of the ACA, those who were uninsured now have access to a patient centered medical home which resulted in a significant influx of patients seen at CHCs, and a change in their insurance status. In 2015, 76% of CHC patients were insured compared to only 65% in 2013 (2). Of those that were insured 49% were insured through Medicaid, largely due to the Medicaid expansion.

Before Medicaid was expanded one would qualify based off their income, household size, disability, family status, and other factors including what state one lived in (5). Once Medicaid was expanded people would be able to qualify based off of their income alone (5). Those that had a household income of below 133% of the federal poverty line are eligible (5).

It is estimated that about 1 in 5 patients in states that expanded Medicaid are uninsured, while in states that did not expand Medicaid this number is 1 in 3 (2). The range of increase of Medicaid enrollees depended by state, figure 2 shows states that did expand Medicaid as of September 2016. Figure 3 portrays the number of people that were enrolled through Medicaid expansion. It can be seen that of the 31 states that have expanded Medicaid as of September 2016, 18 of them have enrolled over 250,000 new participants while 7 have enrolled over 500,000 new participants (6).

This increase in the number of people with health insurance has led to strengthened CHC infrastructures and expansion of services, where possible (2).

Results of the Medicaid expansion is clear in CHCs in states that have expanded Medicaid as they are reporting higher rates of staffing and serving 40% more patients than in states that did not expand Medicaid (2). Although CHCs receive money from insurance reimbursements, federal grants continue to provide about 20% of CHCs' revenue (2). This funding allows CHCs to finance care for those that are uninsured and also cover services that are not covered by insurance. Over 70% of this funding comes from the Health Center Trust Fund that was originally set up by the ACA (2).

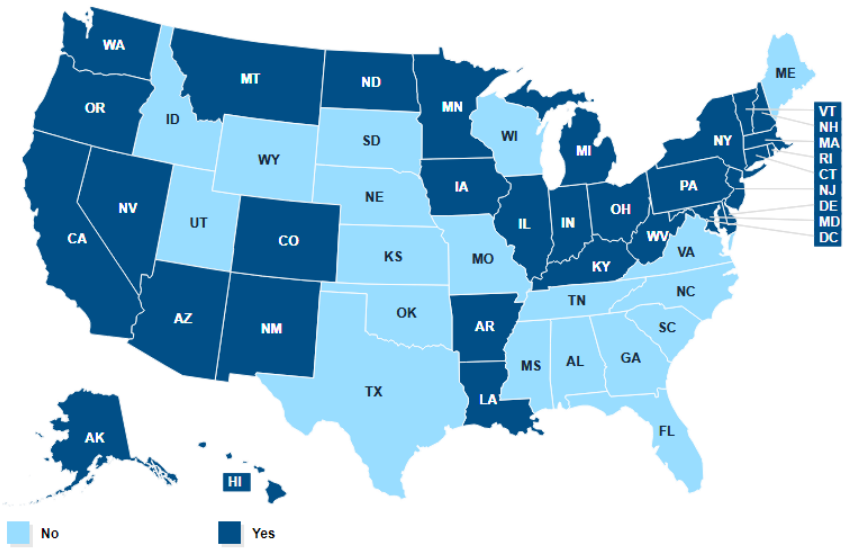

Figure 2 States that have expanded Medicaid as of September 2016 (4)

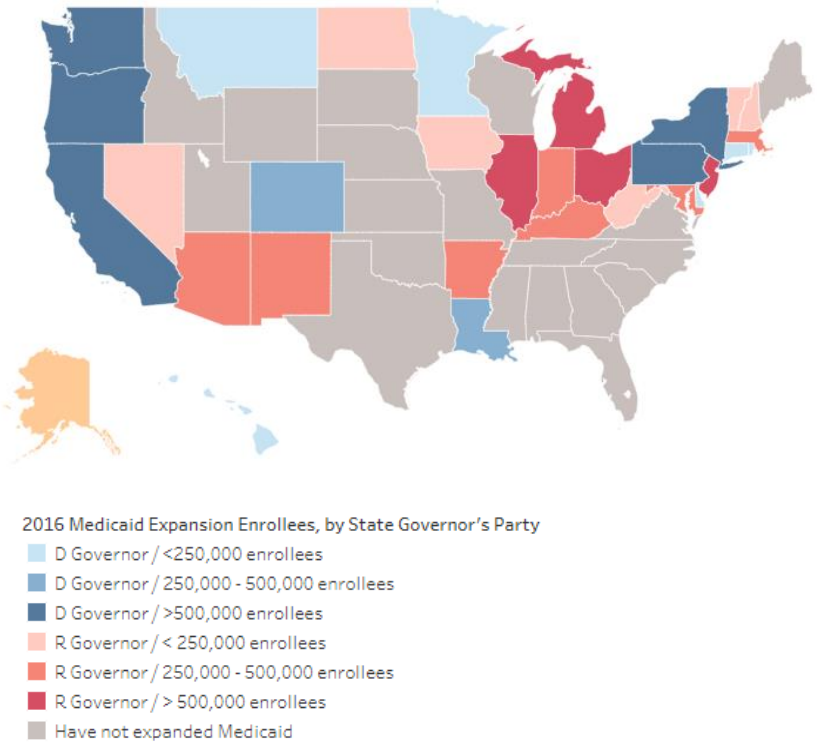

Figure 3 The number of people in enrolled in Medicaid expansion as of 2016 by state governor's party (6)

Additionally, the ACA directly impacted AllianceChicago network CHCs. To examine this more closely, a data analysis was conducted on four AllianceChicago Chicago-based CHCs looking at total changes in patients' insurance status from 2007 to 2016, pre-ACA and post-ACA. Additionally, because the ACA does not include coverage for undocumented patients, the analysis parsed out the differences between those who speak English as a primary language and those who spoke Spanish, to identify how undocumented patients may have been affected differently than documented United States citizens.

Literature Review

A literature review was conducted to determine current methods and tools used to evaluate CHC resources, infrastructure, and quality. From the literature review it was concluded that checklists and theoretical frameworks were mostly used to collect this information. “A Checklist for High-Value Health Care,” one of the resources identified, contains four main evaluation points: foundational elements, infrastructure fundamentals, care delivery priorities, and reliability and feedback (8). Within each of these categories there are subcategories such as governance priority, evidence protocols, shared decision making, and internal transparency. Another checklist looks at readiness in healthcare clinics, and is titled “Clinical Readiness Consultations: Components and Subcomponents” by Hayward (9). This checklist focuses on delivery system design, information systems and decision support, self-management support, linkages with community resources and other health services, and local CHC organizational influences and integration. Frameworks of change were also used to look at CHCs’ readiness to change. This framework is titled “The role of organizational structure in readiness for change: A conceptual integration” by Justin Benzar, and is focused on determining if there is a need for change, if innovation is valued, if there is motivation to do so, if there are resources, and if innovation is difficult; all aspects leading to CHCs’ capabilities to change (10). For this project and paper, AllianceChicago’s Research, Implementation, and Quality Improvement Staff and I reviewed topics from both checklists and theoretical framework, and decided what tools would best support the development of a grading system to identify where AllianceChicago can focus

resources and support of network CHCs (e.g., health information technology infrastructure, staffing, leadership, governance, etc.).

Methods

To complete an evaluation of each AllianceChicago network CHC organization, data was collected through a variety of methods. First, an Excel spreadsheet was developed by AllianceChicago staff and me that included pertinent data variables that would be needed to evaluate CHCs. After all data variables were defined, I met with different team members and went through different data resources available to populate the spreadsheet's variables. Data resources included the HRSA Uniform Data System (UDS), AllianceChicago data documents and reports, and internal team documents. The HRSA UDS includes data on patient demographics, clinical services, staffing, and quality of care at each federally-supported CHC in the nation. Individual CHC site data was collected from the HRSA UDS with a total of 45 sites being reviewed, in total. Missing data will be completed by AllianceChicago staff via communication with CHC leadership in 2018/2019.

Mind Mapping

Once data was populated into the spreadsheet, AllianceChicago Research, Implementation, and Quality Improvement Staff and I met to identify which categories would be most important to include in the evaluation tool. To facilitate this work, a mind map was created. Mind mapping is a graphical way to connect ideas and concepts (figure 5). The main categories that AllianceChicago determined

to be the most important included: communication, infrastructure, operations, attitude, funding, leadership, and technology. Within each of these categories subcategories of importance were discovered. Each subcategory was determined to have a certain amount of importance and was weighted accordingly. In the process of mind mapping the team came up with as many variables as possible that can be included. These variables were then whittled down to what was seen as the most important categories to focus on. For example in the Technology category the "Add-on" category was put in during the first brain storming session. After going over the evaluation tool serval times, it was decided that it was not necessary and was taken out in the final version.

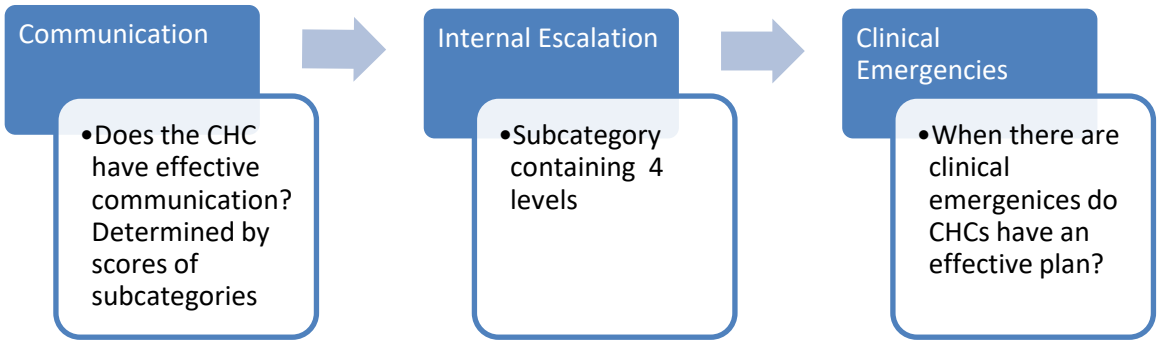

Figure 4 Example of categories defined and what questions the graders ask when deciding on what score to give

Grading Scale

The process for grading CHCs was developed through collaboration with different teams at AllianceChicago. The categories stated above were weighted based on AllianceChicago team members' expertise and experience with CHCs and resulted in the following weights: leadership 5%, funding 5%, infrastructure 10%,

attitude 5%, operations 10%, communication 30%, and technology 35%. Within each of these categories, sub-categories were created for which CHCs will be scored on a scale from 0 to 100. Use of a 0 to 100 scale was determined by the AllianceChicago team. Information located in the Excel spreadsheet will also inform these scores.

Once final scores are determined for each of the CHCs, they will be categorized into either being red (requires the most amount of intervention), yellow (middle ground intervention), and green (needs the least amount of intervention). This evaluation tool will be piloted on four CHCs, then evaluated to determine if and how improvements are needed.

The sub-categories were determined based off the literature review and a team at AllianceChicago. Leadership category was taken from the “Clinical Readiness Consultation”, within this category the subcomponents of governance/leadership style, strategic planning, board (existence of one), research, and clinical. It was determined that these subcategories were the most important categories to determine if the leadership was both engaged and organized. All categories were scored on a scale from 0 to 100, 0 meaning weaker and 100 meaning stronger.

Funding was the next category and was focused on how a site gets funded. It was decided that the best way to evaluate funding was to determine if a CHC had a budget on record, and what personnel (providers and mid-levels) were able to be funded through the budget. Services provided was focused on next, and included if there was primary care, pediatric care, OB/Gyn, behavioral health, dental, and

telehealth. Each of these services was provided points with those being deemed as more important having more points. The category of funding was decided on based off what AllianceChicago saw as important but also because of the “infrastructure fundamentals” category in “A Checklist for High-Value Healthcare”. Within this category it was stated that resource utilization is necessary because “providing high-value care requires efficient use of finite resources”. These finite resources can lead to fluctuation in staffing levels, reduced accesses to care, increased staff stress, and lower patient satisfaction (8).

Next the AllianceChicago team decided that infrastructure needed its own category based off the Checklist for High-Value Healthcare and also based on the “Delivery System Design” on the Clinical Readiness Consultation. Within this category the subcategories were team structure, roles and responsibilities of including human resources, clinical, administrative, IT, EMR staff, general staff, and billing staff. These decisions were made based off of what AllianceChicago saw as the categories that would be of best use to their organization. Other subcategories included retention rates of staff, hours of accessibility, and also the locations of care which included where they are geographically, and how many sites exist.

Next, there was a focus on attitudes that each health center has, either positive or negative. The subcategories include willingness to change, willingness to innovate, willingness to own projects, and engagement. These subcategories were then rated on a scale from 0 to 100, 0 meaning weaker and 100 meaning stronger. This category was based off of the “Organization-Level Readiness for Change” (10).

This framework focuses on the different ways that an organization can be ready for change.

The category of operations included the subcategories of quality initiative, patient engagement tools, meaningful use recognition, evidence based guidelines, accreditations, OSHA training plan, and some other aspects. This category was chosen because of the “Care Delivery Priorities” within the High Value Healthcare checklist. It is stressed that this should be of importance because the “core motivation of any health system is to deliver care that is safe, effective, patient centered, timely, efficient, and equitable” (8). Questions that were asked when trying to conclude what to include in this category were “What procedures ensure optical care transitions, both within units of the hospital and between the hospital and the community?” Additionally the question of “How do we define the patient’s care team and ensure that each care step is delivered by the most appropriate team member?”. These questions were discussed while going through the options that would be best to include in the evaluation tool.

One of the most important categories was communication. There were 7 different subcategories defined including interoffice, executive staff to middle management, internal escalation, organizational knowledge base, vendors, patients, and affiliated entities. Within these categories, subcategories were decided upon including a transfer of knowledge plan, personal development, and centralized development. The decision to make this category was not based on the literature review, but was decided based on conversations had during meetings. This illustrates how decisions of importance should be based off what is most important

to the organization that is creating the evaluation tool. Since AllianceChicago is not able to be physically present at all CHCs they see high levels of communication with them as necessary to understand what is taking place.

Lastly, the most highly valued category in the evaluation is technology. It was decided that there are 7 different subcategories of technology which includes Electronic Medical Records, clinical, administrative/practice management, network infrastructure, hosted, self-hosted, and internet service provider. This focus on technology was not directly laid out in one of the checklists that were of focus, but during meetings with the AllianceChicago team it was decided that it is an overarching necessity. If there is not effective technology in the workforce, then none of the previous categories mentioned would be successful.

Data Analysis of Insurance Status Change

In order to further determine why the creation of this evaluation tool was necessary, a data analysis was done on patient insurance status change in community health centers in AllianceChicago's network. Four CHCs were chosen for the data analysis and are the founding members of AllianceChicago, which are based in Chicago, IL. They were picked because they had the most robust data over the past 10 years compared to other CHCs AllianceChicago works with. For the purposes of this paper, the data from the 4 different CHCs was combined to simplify the results, but therefore the data set was very large. This large of a data set led to a determination of significance for all test ran, therefore it was determined for

purposes of this paper a simple descriptive change in percentage would be used to describe change seen.

In order to receive data about insurance change, a request was submitted to the AllianceChicago data team. The AllianceChicago business analyst/epidemiologist worked with the SQL analyst to develop code that extracted data that was of interest. AllianceChicago SQL analyst then ran code to retrieve information from the data warehouse. The data warehouse at AllianceChicago contains standardized information that can be analyzed at both an individual and a population level. Variables pulled to complete the analysis included the year that an individual went to the doctor's office- which was then labeled the encounter year, and also the age, language, gender, insurance type (Medicaid, Medicare, private, uninsured, unknown), race, and ethnicity (Hispanic/Latino/a or not Hispanic/Latino/a). When data was first pulled there were over a million individual data points found. In order to lower this number we only included regular patients at the clinic. This was defined as patients having at least two encounters in one year. After these criteria were met a total of 832,255 individual data points were found. Since patients may have gone to the clinics for multiple years, they would appear in the data more than once, therefore there were less than 832,255 individuals in the data set.

Results

The average age of the population was 28 years old. Most of the population was White (44%), while 33% was African American, 2% identified as Asian, and

about 20% were Hispanic or Latino. In this population 33% was covered by Medicaid while 22% was uninsured, and 37% had missing insurance data. Of those that were on Medicaid 21% identified as Hispanic or Latino, while 15% of the uninsured population identified as Hispanic or Latino.

Change in Insurance Status

Of the four CHCs analyzed for this paper, each saw an increase in the number of people insured through Medicaid from 2007 to 2016 (Figure 6). In 2007 Medicaid accounted for only 2 percent of the population seen at the 4 founding health centers. By 2009 the number of CHC participants on Medicaid increased to 21%, and only slightly increased in 2010 (25%) and 2011 (27%) which was immediately before and after the ACA was passed. In 2012 the number of people insured by Medicaid increased sharply to 37%. This percentage continues to climb in 2014 (42%) and 2016 (48%). Additionally, the number of people who were uninsured also went up, but at a much slower rate than Medicaid. In 2009 the uninsured rate was at 8% by 2011 it was 17% then jump to 22% by 2015. While these numbers were climbing the percentage of unknown insurance status was going down (2011 51%, 2015 31%).

Since CHC primarily involve treating vulnerable populations, the data set was further analyzed by language spoken. The two most spoken languages in Chicago are English and Spanish, so these two languages were of primary focus. In 2007 a total of 16,818 people spoke English which was 41% of the 4 CHCs population. Additionally, in 2007 24% of the population spoke Spanish which was 9,845 patients being seen at the 4 different health centers. When breaking this down by insurance

type, it was seen that in 2007 5% of the Spanish speaking population was on Medicaid and 31% was uninsured. For the English speaking population only 1% was on Medicaid while 5% was uninsured. By 2009 26% of the population spoke Spanish and 44% spoke English. Of the Spanish speaking population 46% were on Medicaid and 23% were uninsured. When comparing this to the English speaking population only 21% of that population was insured through Medicaid and 4% was uninsured. The number of people who spoke English increased to 65% by 2012, and the Spanish speaking population increased to 31%. The English speaking patients further increased in 2016 to 67%, while the Spanish speaking population stayed at 31%. But even though the percentage of people speaking these languages did not change, there was a change in the percentage of people who spoke each language and were insured or uninsured.

In 2012 those who spoke English and were on Medicaid was 35% and by 2016 it increased to 49%, while the uninsured in this population decreased from 30% in 2012 to 17% in 2016. In the Spanish speaking population the increase was not as drastic. In 2012 the percentage of Spanish speakers who were covered by Medicaid was 44% and it slightly increased to 46% in 2016 while the uninsured rate decreased only slightly from 41% to 39%.

Similar results were seen when choosing to look at the data in terms of ethnicity instead of language spoken. By 2016, of those that identify as Hispanic or Latino/a 49% were on Medicaid and 31% were uninsured. In contrast those that do not identify as Hispanic 45% were insure through Medicaid and only 17% were

uninsured. Additionally in 2016, of those that identified as White 46% were on insured through Medicaid and 27% were uninsured.

Final copy of the evaluation tool can be found in the appendix as figure 10.

Discussion

There are many limitations to the Medicaid data explained above. There were large amounts of missing data because it was based over a 10 year period of time. It seemed that the amount of missing data decreased each year, and this may have explain why there was an increase in the percent of people insured through Medicaid – more recent years have more complete data. Missing insurance data account for 37% of all data obtain, with it accounting for 86% of data in 2007, 51% of the data by 2011, 31% of that data in 2013, and only 13% of the data in 2016. But of the data that was seen, one interesting trend was that overall those who speak Spanish saw a smaller increase in the number of people insured through Medicaid, and also saw a smaller decrease in the amount of people who are uninsured. This may be explained because patients who are undocumented immigrants do not have the opportunity to sign up for the Medicaid expansion. And it further points to how CHCs are necessary to treat vulnerable populations. Additionally, stripping of funding could considerably hurt CHCs- in 2016 providing care for uninsured patients still accounted for almost a quarter of the patients they see (24%).

Furthermore these increases in the number of people covered by Medicaid and increase of those who are uninsured points to the importance of the Medicaid expansion that was been established through the ACA. If this Act was to be

repealed CHCs would not be receiving important funds that are necessary to run the clinic.

Other limitations of these data include that it only focuses on 4 CHCs that are located in the Chicago area. Data were not available for a larger number of CHCs in AllianceChicago network over such a large period of time. If the data were more robust more accurate percentages could have been determined to show how the ACA has affected CHCs. It is possible that the Medicaid and uninsured rates observed may only be occurring in these Chicago CHCs.

Other limitations existed in concerns to creating and piloting the evaluation of the health centers. Main limitations include that many portions are subjective. When talking about operations of the CHCs there are going to be differences between how people that are a part of the CHC and those who are outside of it, and how they perceive the operations (i.e. some people may think that a quality plan is enough, but others would like to know exactly what it looks like). Additionally, choosing what will be included in the evaluation and the deciding on the CHC grade was at times subjective. From piloting the evaluation it was seen that people had different perspectives on aspects such as a CHCs willingness to change. These differences will need to be further corroborated and a decision will need to be made to decide on a final grade.

Additionally, the evaluation tool was only used to evaluate one CHC. Next steps will include piloting it in 4 different health centers at AllianceChicago. Two health centers that are assumed to have a lower grading and 2 health centers that are assumed to have higher grading should be chosen. Piloting the evaluation in this

way will be able to portray how the evaluation tool would differ between CHCs that may have differing levels of needs. Three different auditors will then be chosen from the AllianceChicago teams based off of their knowledge and experience working with the CHC being graded. Even though theses auditors are tasked with the evaluation, they will not evaluate in a vacuum. They will consult with others on the AllianceChicago team, and also the excel sheet that I was tasked with putting together.

After piloting the evaluation it was determined that it may be important to explain why CHCs received certain scores, so that tangible changes could be made. Next steps going forward include having each CHC grade themselves to determine if what the differences may be between how the AllianceChicago team perceives the CHC, and how they perceive themselves.

Conclusion/Impact

In conclusion creating an evaluation tool is essential for AllianceChicago because of the ever changing landscape of the healthcare field. The expansion of Medicaid through the ACA has led to an increase in the number of people having insurance, but funding is still necessary to run clinics. This evaluation will act as a needs assessment of each CHC and allow AllianceChicago to decide where they may need to devote more resources. Specifically it may bring to light lacking skills or resources that are keeping a CHC from running at a fully operational level. AllianceChicago may not be aware of these lack in skill or resources until the evaluation is complete. Additionally, the evaluation may point to how the CHC lacks

resources that may lead to them not being able to take care of their patients at the levels that the AllianceChicago team deems necessary. Futhermore, the evaluation is going to give perspective on what sites need the most attention and help. If a CHC has many moving parts to its operation they may not need more resources but need more help in other ways.

Overall, the evaluation tool still needs to be refined before it can be used to accurately determine the status of all CHCs AllainceChicago works with. This will include testing it in more CHCs and having a more inclusive grading process. But there is no doubt the evaluation tool is essential to help AllianceChicago evaluate CHCs to understand where they need resources now and where they will need resources if there is a lapse in funding.

Appendix

Figure 5

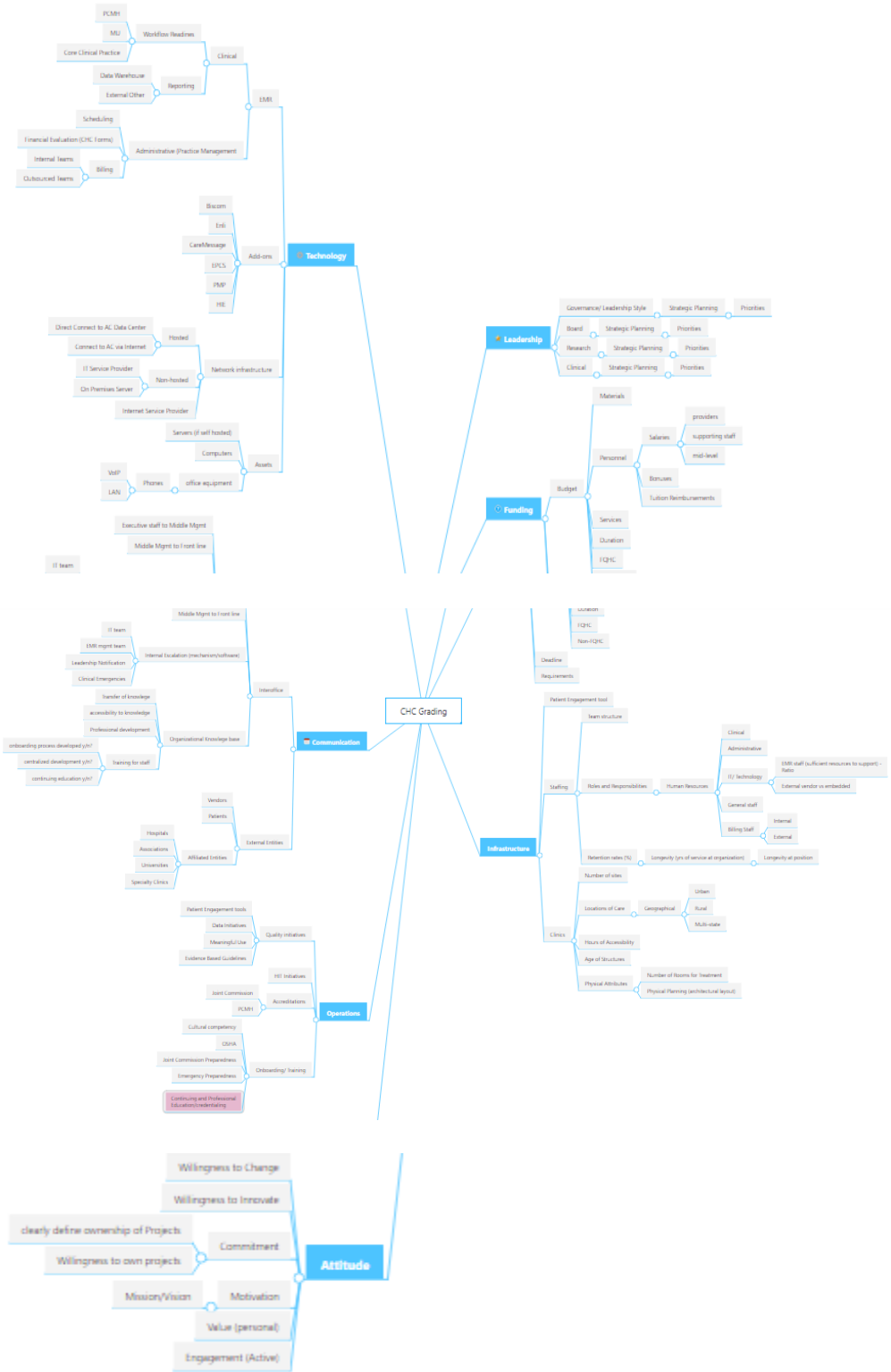

Figure 6

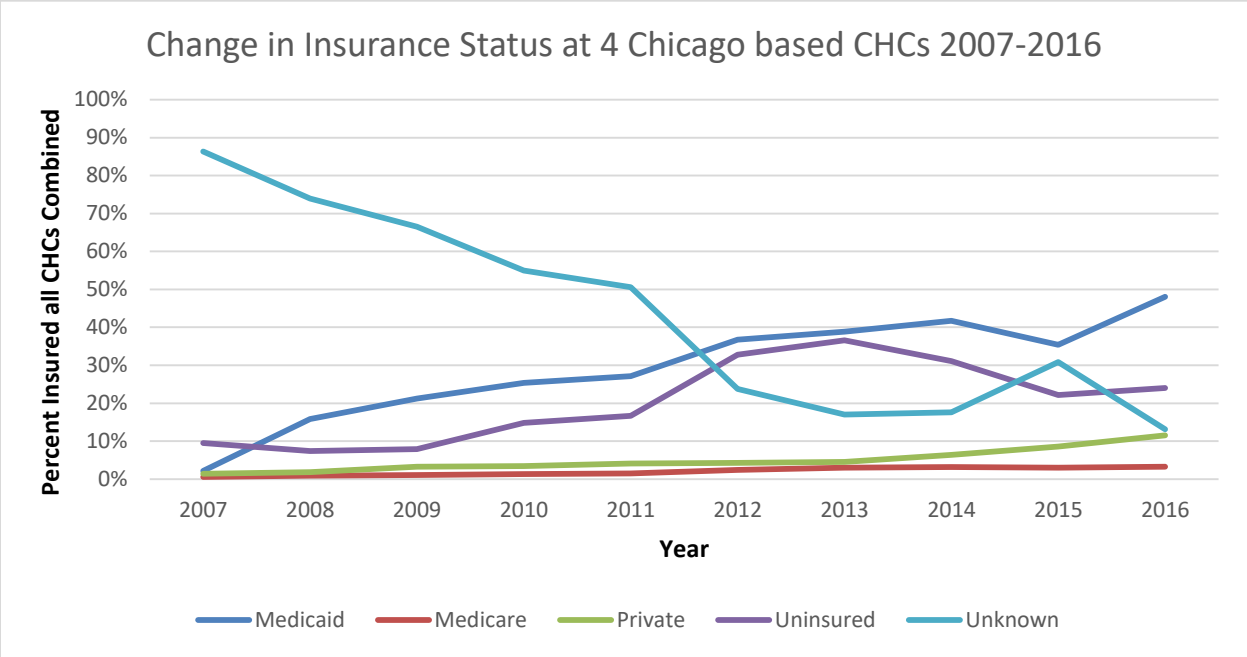

Figure 7

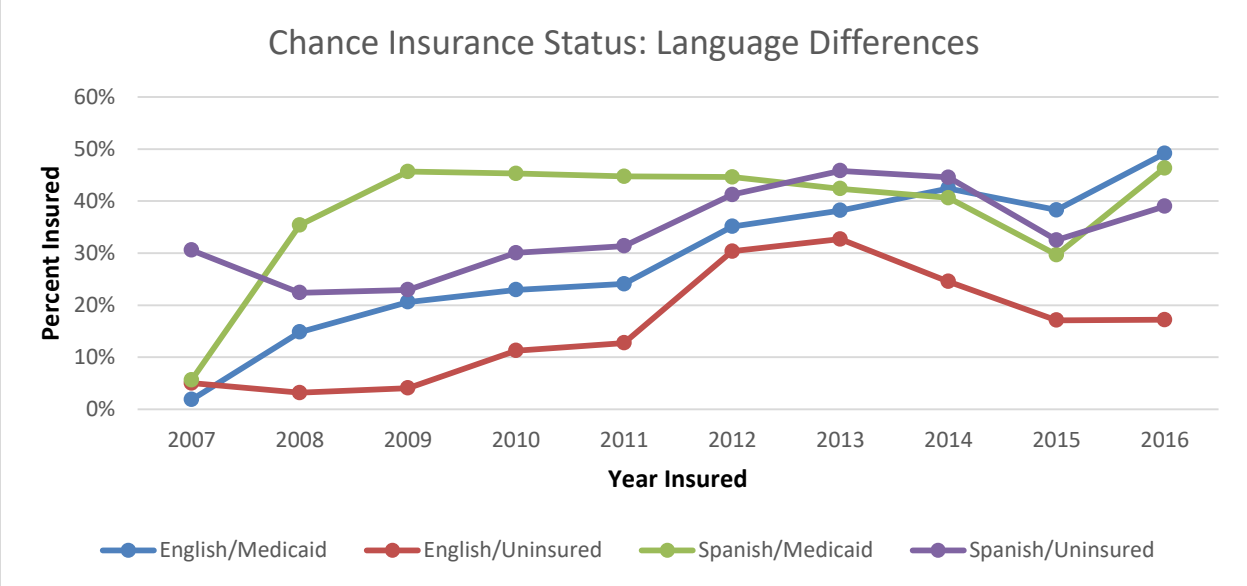

Figure 8

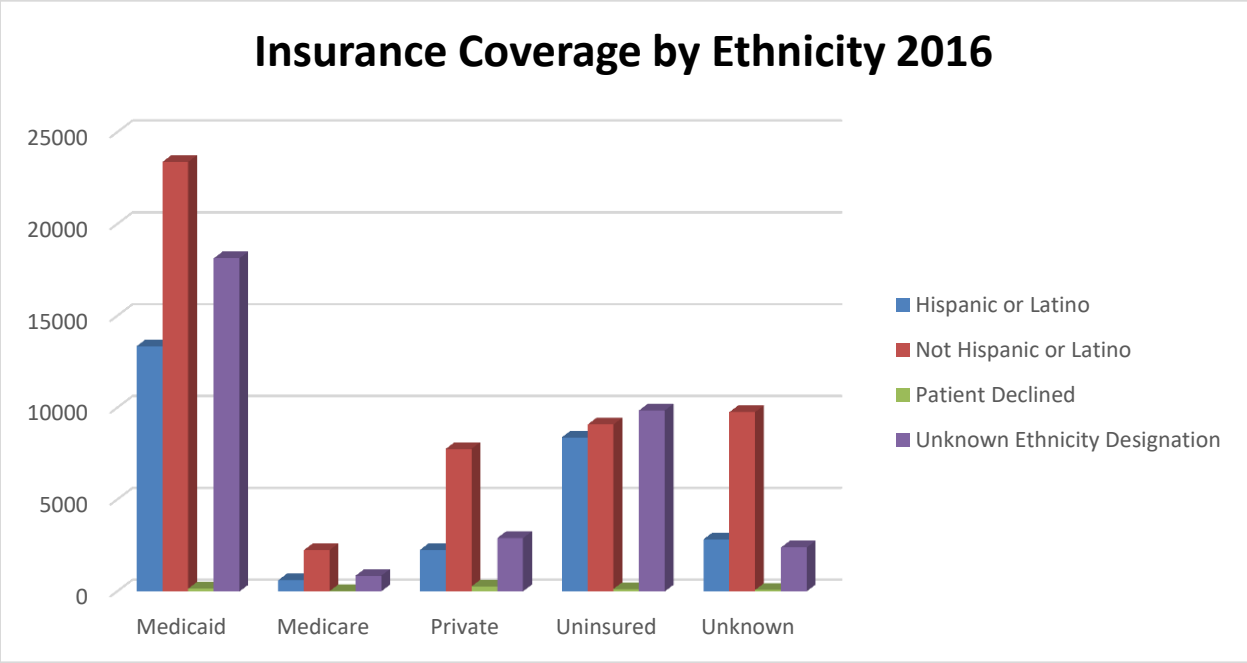

Figure 9

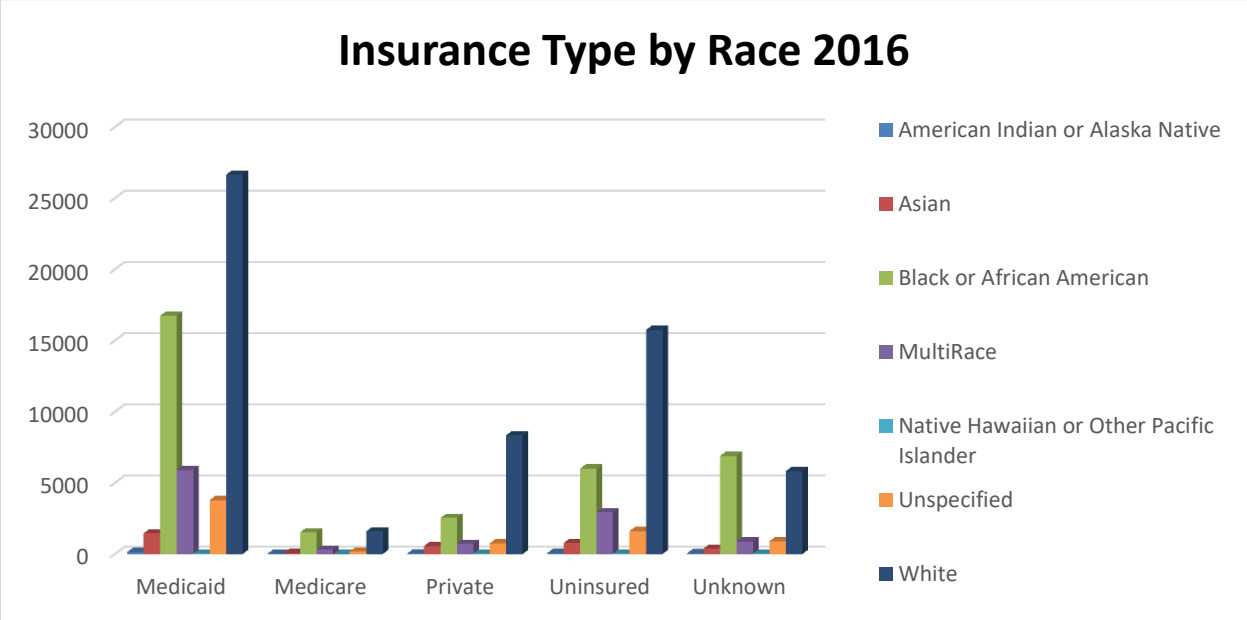

Figure 10

Site CHC 1 Score

Auditors Amy, Sarah, Nan

Leadership - Engaged, Organized		Criteria	Grade	Value 5%
Governance/ Leadership Style		(0-weaker to 100 stronger)	90	
Strategic Planning		(0-weaker to 100 stronger)	90	
Board		0 - No board, 100 - Active board	100	
Research		(0-weaker to 100 stronger)	50	
Clinical		(0-weaker to 100 stronger)	80	
Funding - How site gets funded		**Criteria**	**Grade**	**Value 5%**
Budget		(Finances 0-weaker to 100 stronger)	90	
Personnel				
	Providers	Percentage of billable staff (list as %)	70	
	Mid-levels	Percentage of billable staff (list as %)	30	
Services Provided				
40	Primary Care - Family Care	Percentage of billable encounters (list as %)	60	
30	Pediatric Care	Percentage of billable encounters (list as %)	30	
19	OB/Gyn	Percentage of billable encounters (list as %)	10	
5	Behavioral Health	Percentage of billable encounters (list as %)	0	
5	Dental	Percentage of billable encounters (list as %)	0	
1	Telehealth	Percentage of billable encounters (list as %)	0	
FQHC		(100 points if an FQHC)	100	
Non-FQHC		(100 points if a Non- FQHC)	0	
Infrastructure		**Criteria**	**Grade**	**Value 10%**
Team Structure		(0-weaker to 100 stronger)	80	
Roles and Responsibilities				
	Human Resources	(0-weaker to 100 stronger)	90	
	Clinical	(0-weaker to 100 stronger)	90	
	Administrative	(0-weaker to 100 stronger)	80	
	IT/Technology			
	* EMR Staff (sufficient staffing)	(0-weaker to 100 stronger)	80	
	* External vendor or embedded	0 = External vendor, Embedded = 100	100	
	General Staff	(0-weaker to 100 stronger)	100	
	Billing Staff			
	* Internal	(0-weaker to 100 stronger)	75	
	* External	(0-weaker to 100 stronger)	0	

Retention Rates	Percentage of turnover (list as %)		
Locations of Care			
Geographical impediment(s)	0-100% (0 closer to difficult, 100 to non-issue)	95	
Urban	Percentage of sites (list as %)	100	
Rural	Percentage of sites (list as %)	0	
Multi-site	0 - single site, 100 - multiple sites	100	
Number of sites	Under 10 sites = 100, Over 10 sites = 0	0	
Hours of Accessibility	Daytime hours only = 0, Late night hours = 100	100	
Attitude - positive, negative (Subjective)	Criteria	Grade	Value 5%
Willingness to change	(0-weaker to 100 stronger)	90	
Willingness to innovate	(0-weaker to 100 stronger)	85	
Willingness to own projects	(0-weaker to 100 stronger)	85	
Engagement	(0-weaker to 100 stronger)	90	
Operations	Criteria	Grade	Value 10%
Qualitiy Initiatives	(0-weaker to 100 stronger)	80	
Patient Engagement tools	(0-weaker to 100 stronger)	85	
Meaningful Use Recognition	Stage 1 = 0, Stage 2 = 50, Stage 3 = 100	50	
Evidence Based Guidelines	(0-weaker to 100 stronger)	90	
HIT Initiatives	(0-weaker to 100 stronger)	85	
Accreditations			
Joint Commission	No = 0 pts, Yes = 100 pts	100	
PCMH	No = 0 pts, Yes = 100 pts	100	
Onboarding/ Training Plan	No = 0 pts, Yes = 100 pts	100	
Cultural Competency Plan	No = 0 pts, Yes = 100 pts	0	
OSHA Training Plan	No = 0 pts, Yes = 100 pts	100	
Emergency Preparedness Plan	No = 0 pts, Yes = 100 pts	0	
Continuing and Professional Ed. Plan	No = 0 pts, Yes = 100 pts	100	
Communications	Criteria	Grade	Value 30%
Interoffice	No = 0 pts, Yes = 100 pts	100	
Executive Staff to Middle Mgmt	No = 0 pts, Yes = 100 pts	100	
Internal Escalation			
IT Team	No = 0 pts, Yes = 100 pts	100	
EMR Mgmt Team	No = 0 pts, Yes = 100 pts	100	
Leadership Notification	No = 0 pts, Yes = 100 pts	100	
Clinical Emergencies	No = 0 pts, Yes = 100 pts	100	
Organizational Knowledge Base			
Transfer of Knowledge Plan	No = 0 pts, Yes = 100 pts	0	

Accessibility to knowledge	No = 0 pts, Yes = 100 pts	0	
Personal Development	No = 0 pts, Yes = 100 pts	100	
Professional Development	No = 0 pts, Yes = 100 pts	100	
Centralized Development	No = 0 pts, Yes = 100 pts	0	
Vendors	No = 0 pts, Yes = 100 pts	100	
Patients	No = 0 pts, Yes = 100 pts	100	
Affiliated Entities			
Hospitals	No = 0 pts, Yes = 100 pts	0	
Associations (state)	No = 0 pts, Yes = 100 pts	100	
Universities	No = 0 pts, Yes = 100 pts	0	
Specialty Clinics	No = 0 pts, Yes = 100 pts	100	
Technology	Criteria	Grade	Value 35%
EMR	No = 0 pts, Yes = 100 pts	100	
Clincal			
Workflow Readiness	(0-weaker to 100 stronger)	80	
PCMH	(0-weaker to 100 stronger)	90	
Meaningful Use	(0-weaker to 100 stronger)	90	
Core Clinical Practice	(0-weaker to 100 stronger)	90	
Reporting	(0-weaker to 100 stronger)	90	
Data Warehouse	(0-weaker to 100 stronger)	85	
External Other	(0-weaker to 100 stronger)	90	
Administrative / Practice Mgmt			
Scheduling	(0-weaker to 100 stronger)	90	
Financial Evaluation	(0-weaker to 100 stronger)	90	
Billing	(0-weaker to 100 stronger)	85	
Internal teams	No = 0 pts, Yes = 100 pts	100	
External teams	No = 0 pts, Yes = 100 pts	0	
Network Infrastructure	No = 0 pts, Yes = 100 pts	100	
Hosted	No = 0 pts, Yes = 100 pts	100	
Self - Hosted	No = 0 pts, Yes = 100 pts	0	
Internet Service Provider	No = 0 pts, Yes = 100 pts	0	

References

1. Health and Human Resources and Services Administration. *Health Center Program: Impact and Growth.* (2017). Last access date March 10, 2018. Available at: https://bphc.hrsa.gov/about/healthcenterprogram/index.html

2. Paradise, Julia, Rosenbaum A., Markus, A., Sharac, J., Tran, C., Reynolds, D. and Shin, P. Kaiser Family Foundation. *Community Health Centers: Recent Growth and the Role of the ACA.* (January 18, 2017). Last access date March 25, 2018.
Available at: https://www.kff.org/medicaid/issue-brief/community-health-centers -recent -growth-and-the-role-of-the-aca/

3. AllianceChicago, *Health Care Collaboration.* (2018). Last access date February 25, 2018.
Available at: http://alliancechicago.org/hcc/

4. Kaiser Family Foundation, *Medicaid Expansion Enrollment*. (2018). Last access date March 30, 2018.
Available at
https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?activeTab=map&currentTimeframe=0&selectedDistributions=expanded-medicaid-by-september-30-2016&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

5. US Centers for Medicare and Medicaid Services. *Medicaid Expansion and What it Means for You*. (2018) Last access date April 10, 2018.

Available at: https://www.healthcare.gov/medicaid-chip/medicaid- expansion-and-you/

6. Kaiser Family Foundation. *Interactive Maps: Estimates of Enrollment in ACA Marketplace and Medicaid Expansion*. (Oct 2017). Last access date April 1, 2018.
Available at: https://www.kff.org/interactive/interactive-maps-estimates-of-enrollment-in-aca-marketplaces-and-medicaid-expansion/

7. The Commonwealth Fund. *Repealing Federal Health Reform: Economic and Employment Consequences for States.* (2018). Last access date January 10, 2018.
Available at: http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform

8. Cosgrove, D. A CEO *Checklist for High Value Healthcare.* Institute of Medicine June 2012

9. Hayward, M. N., Mequanint, S., Paquette-Warren, J., Bailie, R., Chirila, A., Dyck, R., Orcutt, M. (2017). The FORGE AHEAD clinical readiness consultation tool: a validated tool to assess clinical readiness for chronic disease care mobilization in Canada's First Nations. *BMC Health Services Research*, *17*, 233. http://doi.org/10.1186/s12913-017-2175-6

10. Benzer, J., Charns, M., Hamdan, S., Afable. (2016)The role of organizational structure in readiness for change: A conceptual integration *Health Services Management Research*. 30, 1, pp. 34 - 46