

Foster, Alania (SAMHSA)

From: Radler, Sharon [RadlerS@chc1.com]
Sent: Wednesday, June 26, 2013 1:20 PM
To: Foster, Alania (SAMHSA)
Cc: Haddad, Marwan; Harding, Kasey; Radler, Sharon
Subject: RE: TI024740 - TCE-TAC - Application Review - Response Requested
Attachments: Response to questions for TI024740.pdf

Dear Alania,

Attached please find the documents requested in response to your email of Friday, June 21, 2013 (below). We want to thank you for giving us the opportunity to respond to these questions.

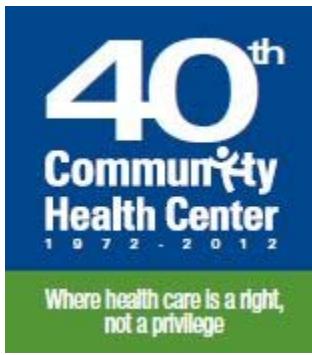
If you have any further questions, please do not hesitate to contact either Kasey or me.

Warmest Regards,

Sharon B. Radler
Grants Office
Community Health Center, Inc
Phone 860-347-6971 ext. 3661
Fax 860-343-7280
www.chc1.com

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RadlerS@chc1.com

From: Foster, Alania (SAMHSA) [<mailto:Alania.Foster@samhsa.hhs.gov>]

Sent: Friday, June 21, 2013 11:01 AM

To: Harding, Kasey

Cc: Flinter, Margaret

Subject: TI024740 - TCE-TAC - Application Review - Response Requested

Dear Kasey,

My name is Alania Foster from the Division of Grants Management at SAMHSA.

Your organization recently applied to the FY 2013 Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need announcement, RFA # TI-13-008. I have started the financial review of your application, and the following items need to be addressed before I can complete the review:

1. It was noted that your organization does not provide an adequate description of existing resources and other support it expects to receive for the proposed project. Provide a detailed description of existing resources and other support you expect to receive for the proposed project.
2. It was noted that your organization did not include evaluation costs in the budget. Please revise the budget to include evaluation costs.

When making changes to the budget you must submit a full revised detailed budget and a revised SF424A. Also, if any changes are made to the budget, please ensure that the bottom line of \$277,208 does not change.

The requested items should be submitted to me via e-mail as one PDF attachment by **COB on June 26, 2013**. If you have questions regarding this request, do not hesitate to contact me.

Please be informed that funding decisions have not been made; however, these are items that needs to be addressed before your application can be further reviewed.

Please note: Any correspondence/response must be sent from the Project Director, Business Official or Authorizing Representative of your organization. If prepared by someone other than those individuals listed above, the correspondence/response must be forwarded to the Project Director, Business Official, or Authorizing Representative then sent to this office with their comments.

Thank you,

Alania Foster

Alania Foster, M.S.
Grants Management Specialist
U.S. Department of Health and Human Resources (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of Financial Resources (OFR), Division of Grants Management (DGM)
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857
(240) 276-1409 (phone)
(240) 276-1430 (fax)
alania.foster@samhsa.hhs.gov
www.samhsa.gov

1. Provide a detailed list of existing resources and other support you expect to receive for the proposed project.

The purpose of this project at its fundamental level is to use technology to expand access to opioid substitution therapy throughout Connecticut while simultaneously linking patients to primary care and behavioral health services. Community Health Center, Inc (CHCI) is uniquely poised to successfully implement this program based on many of our existing resources including complete integration of our electronic health record (EHR), innovative experience implementing the ECHO™ model of training and care, and a sophisticated technology infrastructure already in place to support almost immediate initiation of the program. The following discusses each in more detail:

- Electronic Health Record: CHCI fully implemented our electronic health record eClinical Works (eCW) six years ago. All providers and staff undergo a rigorous training in order to utilize eCW to its fullest capabilities. CHCI has an elaborate system of upgrading and maintaining all our databases, including eCW, and providing security for patient confidentiality, which is supported by a large Information Technology (IT) department. This existing infrastructure will ensure that commencement of this project is immediate and not hindered by a lengthy EHR implementation or training period. All CHCI staff have a strong working knowledge of our EHR which is further buoyed by CHCI's eCW training department, available to employees at all times.
- Project ECHO HIV/HCV: In 2012, CHCI launched the program Project ECHO HIV/HCV which consists of weekly didactic and case presentation sessions conducted via videoconferencing. To date, 16 primary care providers have been trained to successfully manage and treat about 150 patients at CHCI's 12 primary care centers across the state. This program provides weekly consultation with an expert internal HIV/HCV faculty. Case-based learning is enhanced during the sessions since all participants have access to eCW and can review the health records as the patients are being presented and discussed. Communication and care coordination are supported further through both the use of messaging through telephone encounters in eCW to discuss clinical care in between ECHO sessions as well as through the use of instant messaging (IMs), emails, and phone calls if the primary care providers need to communicate with a faculty member more urgently

Weekly Project ECHO HIV/HCV sessions are dynamic and interactive. Primary care providers present clinical cases which are then reviewed with faculty in a telehealth session that begins with a 15-30 minute didactic presentation on a topic related to HIV or HCV care. Clinical recommendations for each case are documented in eCW by the primary care provider in a telephone encounter and patients are co-managed with the guidance of the faculty, which includes physicians, nurse practitioners (NPs), pharmacists, behavioral health providers, and nurses.

CHCI's successful implementation of Project ECHO HIV/HCV demonstrates clearly our ability to utilize technology to enhance patient care. The framework in place for Project ECHO HIV/HCV will make initiation of Project ECHO BMT seamless. Moreover, the experience with the implementation and ongoing management of Project ECHO HIV/HCV will make potential problems that may arise easier to troubleshoot and handle.

- Technology Infrastructure: CHCI currently has 12 locations throughout the state of Connecticut. Each site is already equipped with videoconferencing capabilities including television screens, video cameras, and operating systems. The videoconferencing technology at each site is in a secure conference room. One-to-one as well as group communication throughout the agency is conducted in various effective ways including phone, e-mail, IMs, phone conferencing, and video conferencing. In addition, through the use of the application system Vidyo, participants in Project ECHO can also connect to the video sessions securely through their laptops, iPads, and iPhones/smartphones. CHCI has an excellent and responsive IT department that is always ready and available for technical support whenever needed.
- Community collaborations: CHCI has a long history of providing comprehensive care in the communities we serve. As a result of this we have numerous community partners with whom we work to ensure that all CHCI patients are getting the care they need. With regard to this proposal some of our most important collaborations are with Substance abuse treatment facilities in the communities we serve.

The existing resources which CHCI has detailed above, along with the resources outlined in this proposal for funding make CHCI an ideal candidate for the utilization of technology in enhancing access to Buprenorphine Maintenance therapy. This program will bring much needed substance abuse therapy to hundreds of patients across Connecticut and will provide training to primary care providers that will enable them to provide the most comprehensive care possible.

SAMSHA-Grants to Expand Care Coordination through the Use of Technology Assisted Care in Targeted Areas of Need
 RFA #TI-13-003; CFDA #93.243
 Budget Period: 9/1/13-8/31/14

Community Health Center, Inc.
 Project Period: 9/1/13 through 8/31/16

Personnel	Role on Project	Base Salary	% FTE	Amount on Grant	Justification
Martwan Haddad, MD	Principal Investigator	\$ 179,700	10%	\$ 17,970	The Principal Investigator will ensure that all program goals and objectives are being met and monitor on a regular basis. This position is key personnel.
Kasey Harding	Project Director	\$ 74,963	10.5%	\$ 7,871	The Project Director will directly supervise the staff involved in the project and oversee the implementation, administration, fiscal and programmatic functions of the project. This position is key personnel.
Agi Erickson	Project ECHO Coord.	\$ 65,000	40%	\$ 26,000	The Project ECHO Coordinator will provide specific coordination for project ECHO BMT including monitoring of referrals, case presentations, data collection and communication between providers and faculty. This position is key personnel.
TBH	IT Specialist/Data Coord.	\$ 70,000	35%	\$ 24,500	The IT Specialist will purchase and install IT technology equipment. Continually maintain the system and provide IT support. This person will also collect the data, analyze the data for accuracy and disseminate the data to the program staff.
TBN (1)	Patient Navigator	\$ 37,274	100%	\$ 37,274	The Patient Navigator will provide the outreach, care coordination, enrollment and referral tracking and follow-up as well as other tasks listed in the program narrative.
Primary Care Providers (12) MD/NP	Clinicians	\$ 130,000	5%	\$ 78,000	The Primary Care Providers will participate by providing screenings, assessments and treatment to patients as well as participating in the meetings and case presentations.
Personnel Total				\$ 191,615	
Fringe Benefits					CHCI total fringe benefits rate is @ 25%. The breakout of that 25% total fringe rate for each category that makes up the 25% rate is identified in the left column.
FICA @ 7.65%				\$ 14,659	
Unemployment @ .75%				\$ 1,437	
Workers Comp. @ .82%				\$ 1,571	
Health Insurance @ 11.1%				\$ 21,269	
Pension @ 4.17%				\$ 7,990	
Long term disability @ 5.1%				\$ 977	
Fringe Benefits Total				\$ 47,904	
Supplies					
Incentives	iPads (12)	12* 829 each		\$ 9,948	12 iPads will be used by the providers and staff for participating in videoconferencing and recording data for program
	Gifts cards \$40x50 cards			\$ 2,000	Incentives will be paid for patient surveys completed.
					printing educational materials at an estimated number of 1,000 copies of color at .24 cents per copy and an estimated 9,000 copies of black and white copy at .10 cents per copy. General office supplies such as folders and paper, toner cartridges \$62.
				\$ 1,202	printing educational materials

Supplies Total	\$	13,150	
Travel			
local travel	2000 miles x .565 per mile	\$ 1,130	Total estimated local travel between sites for all staff is 2,000 miles at .565 cents per mile.
Travel for 2 to conference in Washington DC	2160	\$ 2,160	Travel for two staff to travel to Washington for annual meeting at approx. \$300 per person for the flight, \$200 per night for 3 nights per person, and approx. \$60 per day meal allowance per person for 3 days total.
Total Travel	\$ 3,290		
Contractual			
TBN Evaluator	250 hours total @ \$85/hour	\$ 25,000	Evaluator will provide continuous monitoring of quality management goals of the grant. Evaluator will produce a yearly summary document of program including program outcome measures and data.
Total Contractual	\$ 21,250		
Grant total	\$ 277,208		

Dayhoff, Sarah (SAMHSA)

From: Radler, Sharon [RadlerS@chc1.com]
Sent: Monday, June 03, 2013 1:56 PM
To: Dayhoff, Sarah (SAMHSA)
Cc: Flinter, Margaret
Subject: FW: TI024740 TI13-008 TCE-TAC- Community Health Center, Inc.
Attachments: Revised Checklist dated 6.3.13.pdf; Assurances.pdf

Hi Sarah,

I have attached a revised checklist page with the assurances checked off and the date indicated. I have also attached the Assurance form referenced on the checklist form. The page was signed today.

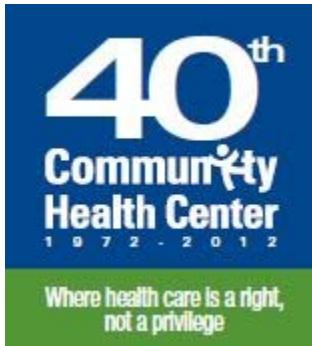
Please do not hesitate to contact me if you need anything else.

Warmest Regards,

Sharon B. Radler
Grants Office
Community Health Center, Inc
Phone 860-347-6971 ext. 3661
Fax 860-343-7280
www.chc1.com

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RadlerS@chc1.com

From: Dayhoff, Sarah (SAMHSA) [<mailto:Sarah.Dayhoff@samhsa.hhs.gov>]
Sent: Monday, June 03, 2013 9:25 AM
To: Flinter, Margaret; Harding, Kasey
Cc: Foster, Alania (SAMHSA)
Subject: TI024740 TI13-008 TCE-TAC- Community Health Center, Inc.

Hello,

My name is Sarah Dayhoff from the Division of Grants Management at SAMHSA.

Please be informed that funding decisions have not been made; however, there is an item that needs to be addressed before your application can be further reviewed.

While reviewing your application, I noticed a discrepancy on the HHS Checklist. Part A, #2 need to be marked completely and have the dates indicated. If your organization has never filed these assurances with an HHS agency please submit them to us at this time. Please submit a revised checklist to me via email no later than C.O.B, Wednesday, June 5, 2013.

Thank you,

Sarah Dayhoff
Grants Technical Assistant
SAMHSA, Division of Grants Management
1 Choke Cherry Road, Room 7-1079
Rockville, MD 20857
Sarah.Dayhoff@samhsa.hhs.gov
240-276-0276 (Office)
240-276-1430 (Fax)

CHECKLIST

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: New Noncompeting Continuation Competing Continuation Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted. Included NOT Applicable

1. Proper Signature and Date on the SF 424 (FACE PAGE)

2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)

- | | |
|-----------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <input checked="" type="checkbox"/> Civil Rights Assurance (45 CFR 80) | <input type="text" value="06/03/2013"/> |
| <input checked="" type="checkbox"/> Assurance Concerning the Handicapped (45 CFR 84) | <input type="text" value="06/03/2013"/> |
| <input checked="" type="checkbox"/> Assurance Concerning Sex Discrimination (45 CFR 86) | <input type="text" value="06/03/2013"/> |
| <input checked="" type="checkbox"/> Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) | <input type="text" value="06/03/2013"/> |

3. Human Subjects Certification, when applicable (45 CFR 46)

PART B: This part is provided to assure that pertinent information has been addressed and included in the application. YES NOT Applicable

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| 2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100) | <input checked="" type="checkbox"/> |
| 3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?..... | <input checked="" type="checkbox"/> |
| 4. Have biographical sketch(es) with job description(s) been provided, when required?..... | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included? | <input checked="" type="checkbox"/> |
| 6. Has the 12 month narrative budget justification been provided? | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 7. Has the budget for the entire proposed project period with sufficient detail been provided? | <input checked="" type="checkbox"/> <input type="checkbox"/> |
| 8. For a Supplemental application, does the narrative budget justification address only the additional funds requested? | <input type="checkbox"/> <input checked="" type="checkbox"/> |
| 9. For Competing Continuation and Supplemental applications, has a progress report been included? | <input type="checkbox"/> <input checked="" type="checkbox"/> |

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Prefix: <input type="text" value="Dr."/>	First Name: <input type="text" value="Margaret"/>	Middle Name: <input type="text"/>
Last Name: <input type="text" value="Flinter"/>	Suffix: <input type="text"/>	
Title: <input type="text" value="SVP/Clinical Director"/>		
Organization: <input type="text" value="Community Health Center, Inc."/>		
Street1: <input type="text" value="635 Main Street"/>		
Street2: <input type="text"/>		
City: <input type="text" value="Middletown"/>		
State: <input type="text" value="CT: Connecticut"/>	ZIP / Postal Code: <input type="text" value="06457"/>	ZIP / Postal Code4: <input type="text" value="2718"/>
E-mail Address: <input type="text" value="Margaret@chc1.com"/>		
Telephone Number: <input type="text" value="(860) 347-6971 ext. 3622"/>	Fax Number: <input type="text"/>	

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: <input type="text"/>	First Name: <input type="text" value="Kasey"/>	Middle Name: <input type="text"/>
Last Name: <input type="text" value="Harding"/>	Suffix: <input type="text"/>	
Title: <input type="text" value="Program Director Int. Care for Special Pop."/>		
Organization: <input type="text" value="Community Health Center, Inc."/>		
Street1: <input type="text" value="635 Main Street"/>		
Street2: <input type="text"/>		
City: <input type="text" value="Middletown"/>		
State: <input type="text" value="CT: Connecticut"/>	ZIP / Postal Code: <input type="text" value="06457"/>	ZIP / Postal Code4: <input type="text" value="2718"/>
E-mail Address: <input type="text" value="Hardink@chc1.com"/>		
Telephone Number: <input type="text" value="(860) 347-6971 ext. 3914"/>	Fax Number: <input type="text"/>	

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: (Agency)

on (Date)

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the

BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:

Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

Debarment and Suspension – Title 2 CFR part 376.

Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.

Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

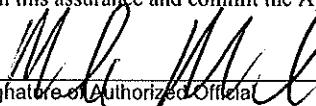
1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

06/03/2013

Date


Signature of Authorized Official

Mark Masselli, CEO/President

Name and Title of Authorized Official (please print or type)

Community Health Center, Inc.

Name of Healthcare Facility Receiving/Requesting Funding

635 Main Street

Street Address

Middletown, CT 06457-2718

City, State, Zip Code

Please mail form to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

Form HHS-690

1/09

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	<input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	<input type="text"/> <input type="text"/>
* 3. Date Received:	4. Applicant Identifier:	
<input type="text" value="04/10/2013"/>	<input type="text"/>	
5a. Federal Entity Identifier:	5b. Federal Award Identifier:	
<input type="text"/>	<input type="text"/>	
State Use Only:		
6. Date Received by State:	7. State Application Identifier:	
8. APPLICANT INFORMATION:		
* a. Legal Name: <input type="text" value="Community Health Center, Inc."/>		
* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="06-0897105"/>		* c. Organizational DUNS: <input type="text" value="0659855740000"/>
d. Address:		
* Street1: <input type="text" value="675 Main Street"/>		
Street2: <input type="text"/>		
* City: <input type="text" value="Middletown"/>		
County/Parish: <input type="text"/>		
* State: <input type="text"/>	CT: Connecticut	
Province: <input type="text"/>		
* Country: <input type="text"/>	USA: UNITED STATES	
* Zip / Postal Code: <input type="text" value="06457-2718"/>		
e. Organizational Unit:		
Department Name: <input type="text"/>	Division Name: <input type="text"/>	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: <input type="text"/>	* First Name: <input type="text" value="Margaret"/>	
Middle Name: <input type="text"/>		
* Last Name: <input type="text" value="Flinter"/>		
Suffix: <input type="text"/>		
Title: <input type="text" value="Senior Vice President/Clinical Director"/>		
Organizational Affiliation: <input type="text"/>		
* Telephone Number: <input type="text" value="(860) 347-6971 ext. 3622"/>	Fax Number: <input type="text"/>	
* Email: <input type="text" value="Margaret@chc1.com"/>		

Application for Federal Assistance SF-424

* 9. Type of Applicant 1: Select Applicant Type:

M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

Substance Abuse & Mental Health Services Adminis.

11. Catalog of Federal Domestic Assistance Number:

93.243

CFDA Title:

Substance Abuse and Mental Health Services_Projects of Regional and National Significance

* 12. Funding Opportunity Number:

TI-13-008

* Title:

Grants to Expand the Use of Technology-Assisted Care in Targeted Areas of Need

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Areas Affected by Project.pdf

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

Technology Enhanced Access to Coordinated Healthcare and Buprenorphine Maintenance Therapy (TEACH BMT)

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="277,208.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="277,208.00"/>

* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?

- a. This application was made available to the State under the Executive Order 12372 Process for review on .
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)

Yes No

If "Yes", provide explanation and attach

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2014

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need	93.243	\$ []	\$ []	\$ 277,208.00	\$ 0.00	\$ 277,208.00
2.	[]	[]	[]	[]	[]	[]
3.	[]	[]	[]	[]	[]	[]
4.	[]	[]	[]	[]	[]	[]
5. Totals		\$ []	\$ []	\$ 277,208.00	\$ []	\$ 277,208.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
	Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need				
a. Personnel	\$ 210,264.00	\$	\$	\$	\$ 210,264.00
b. Fringe Benefits	52,566.00				52,566.00
c. Travel	3,290.00				3,290.00
d. Equipment	0.00				
e. Supplies	11,088.00				11,088.00
f. Contractual	0.00				
g. Construction	0.00				
h. Other	0.00				
i. Total Direct Charges (sum of 6a-6h)	277,208.00				\$ 277,208.00
j. Indirect Charges	0.00				\$
k. TOTALS (sum of 6i and 6j)	\$ 277,208.00	\$	\$	\$	\$ 277,208.00
 7. Program Income	\$ 0.00	\$	\$	\$	\$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program		(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)		\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
		\$ 277,208.00	\$ 69,302.00	\$ 69,302.00	\$ 69,302.00
13. Federal		\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
14. Non-Federal		\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
15. TOTAL (sum of lines 13 and 14)	\$ 277,208.00	\$ 69,302.00	\$ 69,302.00	\$ 69,302.00	\$ 69,302.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16. Grants to Expand Care Coordination through the Use of Technology-Assisted Care in Targeted Areas of Need	\$ 279,971.00	\$ 279,996.00	\$ 0.00	\$ 0.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	\$ 279,971.00	\$ 279,996.00	\$ 0.00	\$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	<input type="text"/>	22. Indirect Charges:	<input type="text"/>
23. Remarks:	<input type="text"/>		

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Community Health Center, Inc. (CHCI) is a private, non-profit Federally Qualified Health Center (FQHC) providing primary medical, behavioral health, and dental care as well as social services. CHCI seeks to reach a total of 375 patients over a three year period, providing them with Buprenorphine Maintenance Therapy (BMT) to treat their opiate addiction using the Project ECHO™ model of care. Project ECHO™ achieves care coordination by utilizing case-based distance learning through videoconferencing and electronic health record technology that links primary care providers with specialists in order to improve health outcomes for underserved patients who have difficulty gaining access to BMT.

The purpose of this groundbreaking project at its fundamental level is to expand access to opioid substitution therapy, particularly buprenorphine, to persons who are opioid-dependent in the state of Connecticut while simultaneously linking them to primary care and behavioral health services. By using innovative videoconferencing technology, this project aims to increase the availability of Buprenorphine Maintenance Treatment (BMT) at 12 of CHCI's primary care sites which practically serve the entire state of Connecticut.

The objectives of this first-of-its-kind project are:

- 1) To utilize novel videoconferencing technology to help educate, train, guide, and support providers in BMT thereby increasing access and access points for patients in all communities served by CHCI.
- 2) To design and implement an innovative program which integrates BMT with primary care, behavioral health and wrap-around support services. Patients who participate in CHCI's program will improve their treatment outcomes related to both their substance abuse as well as their primary health care.
- 3) To engage in a unique multidisciplinary model of substance abuse care through the participation of a comprehensive healthcare team consisting of not only the buprenorphine-prescribing medical provider, but also the nurse, medical assistant, and behavioral health specialists involved in the patients' care in an effort to increase the agency-wide understanding of and reduce stigma surrounding BMT.
- 4) To provide wrap-around support services to patients who participate in BMT at CHCI in an effort to assist them in remaining engaged in care.

Community Health Center, Inc's innovative *Technology Enhanced Access to Coordinated Healthcare and Buprenorphine Maintenance Therapy (TEACH BMT)* project will positively affect the communities we serve throughout Connecticut by opening access to important substance abuse services and sustaining those services by training the providers of the future.

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Section A: Population of Focus and Statement of Need (25 points)

A.1: Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, sexual identity and other relevant factors such as literacy.

In the State of Connecticut, substance use is a major health problem. In 2010, about 2% of the Connecticut population aged 12 or older, or 59,000 people, met diagnostic criteria for illicit drug dependence, and 2.7%, or about 80,000 people, met the criteria for illicit drug abuse. (NSDUH 2010 2011) Moreover, illicit drug use in the past month excluding marijuana was reported by 3.48% of persons aged 12 or older which is higher than the national rate of 3.33%. (NSDUH 2010 2011)

When focusing specifically on opioid abuse, the data show that New England states are affected disproportionately when compared to the rest of the country. From 2000 to 2010, admission rates for heroin treatment were consistently highest in the New England and Middle Atlantic states. (TEDS data) Moreover, when examining the misuse and abuse of opioid prescription medications, it becomes quickly evident that the U.S. is experiencing a dramatic rise in the use of opiates other than heroin, with the New England states leading the unfortunate charge. In 2010, there were 425,247 U.S. emergency department visits secondary to narcotic pain reliever abuse or misuse, an increase of 156% from 2004. Oxycodone and hydrocodone abuse or misuse each accounted for 182,748 and 115,739 visits, an increase of 265% and 149%, respectively, from 2004. (DAWN) The rates of such admissions for opiates other than heroin were consistently highest in the New England states every year in the last decade with the New England rate being more than twice as high as the rates for all other areas in the U.S. for each of those years. (TEDS data)

In looking at the New England state of Connecticut in particular, in 2010, 4.38% of persons age 12 or older reported non-medical use of prescription pain relievers which included 10.73% of 18-25 year olds and 3.32% of all adults 26 years and older; these rates are alarming and quite comparable to the national rates. (NSDUH Report of Non medical use of prescription pain relievers Jan 8, 2013) Furthermore, 27% of the 51,951 substance abuse admissions of people aged 12 or older were due to heroin and other opiates. Examination of the patient demographics reveals that of the heroin admissions, 70.2% were male, 60.2% were White, 20.3% Hispanic, 7.9% Black, and 78.3% were between the ages of 20 and 44. The demographics of admissions for opiates other than heroin, however, demonstrate an increase among females and Whites, showing 62.7% male, 82.6% White, 8.1% Hispanic, 2.8% Black, and 80.4% between the ages of 20 and 44. (TED's data)

The demographics don't change significantly when examining overdose deaths, emergency department visits, and hospitalizations. From 2000 to 2002, 34% of the 1,013 deaths from drug-induced causes, or 341 deaths, were unintentional due to opiates and related narcotics. 84% of these opiate overdose deaths were male, 73% White, 18% Hispanic and 8% Black. The highest death rate was in the 40-44 age group. (State of CT DPH Report 2004) During the same time period of 2000-2002, there were 8,507 emergency room non-admissions that were opiate-

induced and 3,824 opiate induced hospitalizations. The number of non admissions increased by 50% within this timeframe. 71% of all non-admissions and 64% of hospitalizations were men. The 15-49 age group represented 94% of non admissions and almost 90% of hospitalizations. (State of CT DPH Report 2004)

In summary, opioid use in Connecticut predominantly involves persons between the ages of 20 and 44 with more males than females affected, though the use of opiates other than heroin shows a rise in female rates. The majority of opioid use tends to be in Whites, though when compared to the general population's ethnic and racial breakdown, Whites who make up 74.4% of the population (Stratton) are disproportionately underrepresented regarding heroin use and overrepresented regarding opiate use other than heroin. In relation to heroin use, Hispanics, being 11.5% of the Connecticut population, (Stratton) are the ones who are affected in higher proportions.

A.2. Discuss the relationship of your population of focus, including sub populations the overall population in your geographic catchment area and identify sub population disparities, if any, relating to access, use, outcomes of your service providing relevant data.

As summarized in the previous section, opioid use in Connecticut is concentrated among persons between the ages of 20 and 44. Heroin use predominantly affects males and disproportionately affects Hispanics. The use of opiates other than heroin affects women and Whites in higher proportions than with heroin use. Moreover, in general, individuals who are unemployed, live in metropolitan areas have lower education, or who are on probation or parole tend to have higher rates of substance dependence or abuse. (SAMHSA, 2010)

Such demographics and characteristics are reflected quite closely in the population that Community Health Center Inc (CHCI) serves in its communities and hence sets up CHCI as a prime source for the opioid dependent population to receive treatment. CHCI is the largest federally qualified health center (FQHC) network in Connecticut having health centers in 12 cities across the state which offers primary care, mental health, and dental services. In 2012, 80,259 patients generated 422,921 office visits at CHCI. The majority (38%) of these patients were Hispanic, 33% were White and 13% Black. About 41% of all visits were generated by the Hispanic population. About 56% of visits were generated by females and about 46% by patients between the ages of 18 and 49.

Furthermore, CHCI patients endure alarmingly high rates of poverty and unemployment and tend to have State-based or no insurance, which are all unsurprisingly interrelated. 90.8% of the CHCI population is at or below 200% of the federal poverty level. Four of the cities that CHCI serves, Meriden, New Britain, New London and Waterbury, each have more than double the state rate of population living below 200% of the federal poverty level. Regarding unemployment, as of October 2012, the rate in Connecticut is 8.6%. Yet, Connecticut has one of the highest gaps in income disparity. This disparity is reflected in the rate of unemployment among CHCI's service area communities, which is highest in Waterbury, with an unemployment rate of 13.5%, and New Britain and Meriden not far behind with 11.9% and 10.3%, respectively, rates well above the Connecticut average.

In regards to the insurance status of CHCI patients, CHCI operates in cities that have some of the highest rates of people who are uninsured or on Medicaid. The state of Connecticut released data on the insurance status of its population as a whole. These findings include the following:

1. Connecticut's uninsured population is currently 344,000 or about 10%.
2. The majority of the uninsured are male (59%).
3. Two out of five uninsured residents (43%) are between 18-34 years old.
4. The uninsured population is heavily concentrated in a small number of zip codes.
5. The "top 20" zip codes comprise nearly 40% of the total uninsured population.
6. Connecticut's Medicaid population is currently 537,000, projected to increase to 541,000 in 2013.
7. The Medicaid population is also concentrated in a small number of zip codes, and the top 20 zip codes with the largest number of individuals insured by Medicaid is virtually identical to those with the largest numbers of uninsured.

As a federally qualified health center, CHCI is concerned with the disparities and inequities that are found in the communities it serves. Of the twenty "top zip codes" in each county, CHCI operates a primary care site within its scope of project in many of them. In looking at the total visits in the last year, this reality is underscored by the numbers: about 68 % of patients who came in for visits were on Medicaid, 15% were uninsured and 8% were on Medicare.

In summary, given the similarities between those patients at highest risk for heroin and other opiate abuse in Connecticut (Whites and Hispanics, both males and females, those aged between 20 and 44, those unemployed, and those living in metropolitan areas) and the patient population in the cities that CHCI serves (majority Hispanic and White, near half male and half female, majority in the corresponding age group, with high rates of poverty and unemployment, and majority uninsured or on State insurance), CHCI is in an ideal position to reach and engage the opioid-dependent population in the cities it serves and to offer them the opioid abuse treatment they so desperately need.

A.3: Describe the nature of the problem, including service gaps, and document the extent of the need for populations of focus based on data.

In Connecticut, 2.28% of persons aged 12 or older were in need of treatment for illicit drug use but did not receive it in the past year; that amounts to about 68,000 people. (NSDUH 2010 2011) According to the National Survey of Substance Abuse Treatment Services (N-SSATS) in 2011, 25,914 people did receive substance abuse treatment in 188 Connecticut facilities. Of the 188 facilities, 52.7% offered substance abuse treatment services, 39.9% offered a mix of substance abuse and mental health services, and only two offered general health care as their primary focus. 71.3% offered outpatient care. Of the 25,914 people treated for substance abuse, 39.9% received care from the facilities that offered both substance abuse and mental health treatment and only 1.1% or 288 patients received their substance abuse treatment from facilities whose primary focus was general health care. (N-SSATS) Furthermore, each of these

facilities served only a median of 101 clients with the majority (68.5%) serving less than 120 clients.

In regards to treatment of opioid dependence, although 27% of all substance abuse admissions were due to heroin and other opiates, only 9.4% involved outpatient medication assisted opioid therapy. (TEDS data) Only 33 facilities offer opioid treatment programs in Connecticut, which represents 2.8% of all national programs. Methadone maintenance is offered at 30 of those facilities each servicing a median of 381 patients. (N-SSATS) Of the 12,270 clients who received medication-assisted opioid therapy, only 421 clients were on buprenorphine. The rest were on methadone. 434 other clients received buprenorphine from other facilities bringing the total number to only 855 clients who were treated with buprenorphine in Connecticut. (N-SSATS)

There is a very clear need for increased access to opioid substitution therapy in Connecticut. CHCI has the capability through the project being proposed to integrate and offer buprenorphine maintenance treatment (BMT) services to a significant number of persons dependent on opioids and living in CHCI communities. This need is further underscored since the majority of methadone clinics in Connecticut are concentrated in the three largest metropolitan areas of Hartford, Bridgeport, and New Haven making access to opioid substitution therapy extremely difficult for a large proportion of CHCI patients.

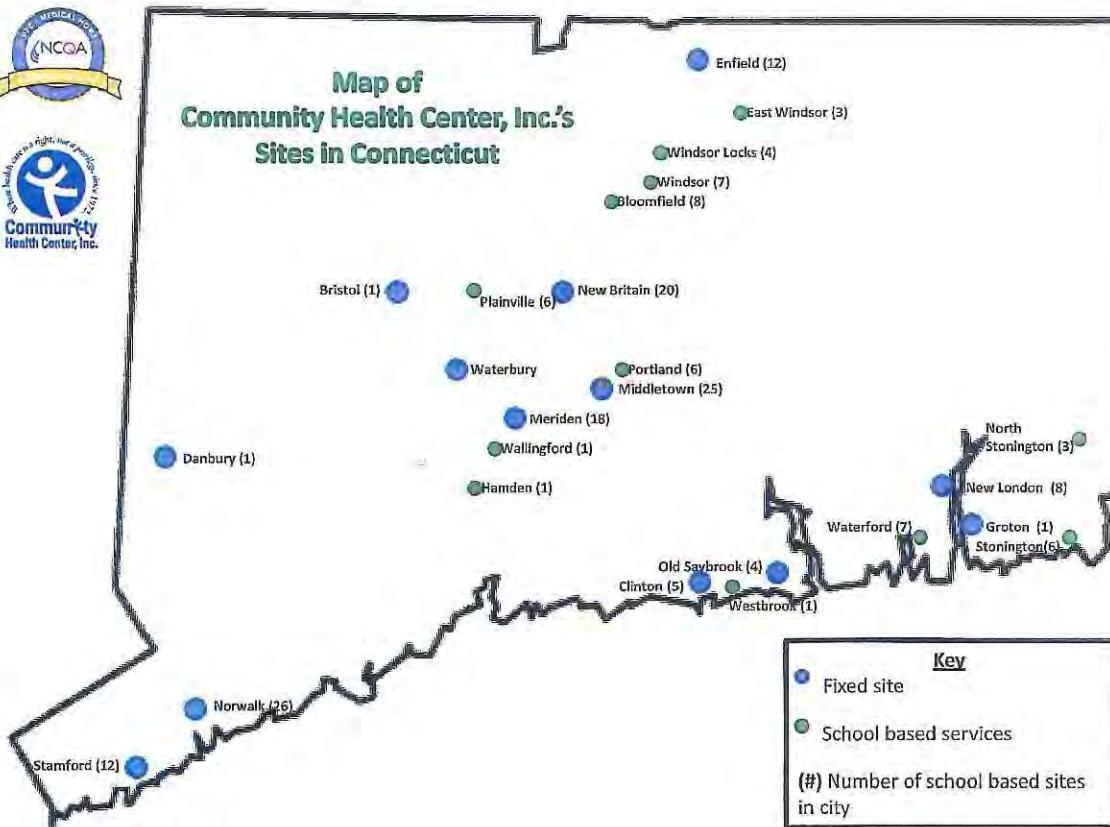
Furthermore, of the facilities offering opioid treatment programs, the majority are state-affiliated, only 7 are certified by the Joint Commission and only 1 is certified by the NCQA. (N-SSATS) Last, 78.7% of facilities accept Medicaid, 50% accept Medicare, 71.3% have sliding fee scales and 55.9% see patients at no charge if they cannot pay. (N-SSATS)

CHCI is a FQHC certified by both the Joint Commission and the NCQA as a patient-centered medical home and operates a primary care health center in 12 cities across the state of Connecticut. CHCI accepts Medicaid, Medicare, has sliding fees and sees uninsured patients. CHCI is uniquely suited to not only offer BMT at all of its sites and engage this patient population in substance abuse treatment but to also deliver integrated primary care and mental health care, which is one of the goals of the Affordable Care Act.

Section B: Proposed Evidence-Based Service/Practice (10 points)

B.1 Describe the purpose of the proposed project, including its goals and objectives. These must relate to the performance measures identified in Section E.

The purpose of this groundbreaking project at its fundamental level is to expand access to opioid substitution therapy, particularly buprenorphine, to persons who are opioid-dependent in the state of Connecticut while simultaneously linking them to primary care and behavioral health services. By using innovative videoconferencing technology, this project aims to increase the availability of Buprenorphine Maintenance Treatment (BMT) at 12 of CHCI's primary care sites which practically serve the entire state of Connecticut.



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- 3) To engage in a unique multidisciplinary model of substance abuse care through the participation of a comprehensive healthcare team consisting of not only the buprenorphine-prescribing medical provider but also the nurse, medical assistant, and behavioral health specialists involved in the patients' care in an effort to increase the agency-wide understanding of and reduce stigma surrounding BMT.
- 4) To provide wrap-around support services to patients who participate in BMT at CHCI in an effort to assist them in remaining engaged in care.

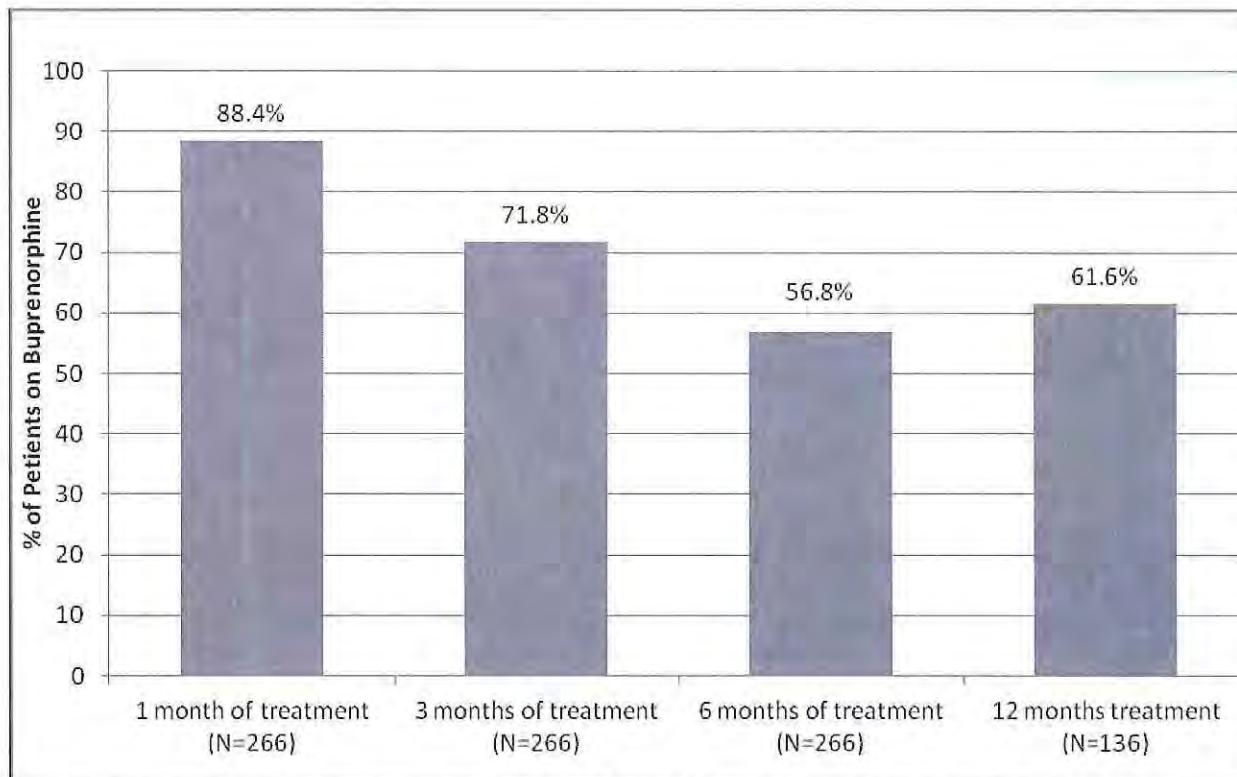
B.2 Describe the evidence based practice that will be used and justify its use for your population of focus, your proposed program and the intent of the RFA. Describe how these practices will address the following issues in the population of focus while retaining fidelity to the chosen

practice; race, ethnicity, religion, gender, age, geography, and socioeconomic status; language and literacy; sexual identity and disability.

This pioneering project found its inception in two published studies. The first study came out of the University of New Mexico by Arora et al demonstrating the effectiveness of the Extension for Community Healthcare Outcomes (ECHO) model in improving access to care for underserved populations. (Arora et al) It demonstrated equivalent Hepatitis C (HCV) treatment outcomes between a university-based HCV specialty clinic and rural primary care clinics and prisons through the use of video-conferencing technology that trained primary care clinicians in HCV treatment. CHCI saw an exciting opportunity to improve patient care and services through the use of such a model.

CHCI has successfully adapted the ECHO model for use both internally and externally to enable patients to receive evidence-based treatment of three complex diseases: HIV, HCV and chronic pain. CHCI's ECHO Pain followed New Mexico's Project ECHO model externally recruiting the Chronic Pain expert faculty from the staff at Integrative Pain Center of Arizona and involving all 12 CHCI health center sites as well as sites from other primary care facilities across the nation. Prior to launching ECHO Pain, however, CHCI demonstrated the feasibility of adapting Project ECHO successfully by replicating the model internally. Through the internal HIV and HCV expertise led by Dr. Marwan Haddad, medical director of HIV, HCV, and Buprenorphine services, Project ECHO HIV/HCV was launched January 2012 in order to expand these services to CHCI patients. Through weekly 2-hour ECHO videoconferencing sessions consisting of short didactic lectures by the HIV/HCV expert faculty and case presentations by the primary care providers, HIV and HCV services were expanded from 3 health center sites to a total of 10 sites as well as the Healthcare for the Homeless Program. The ECHO HIV/HCV program has trained 16 physicians and nurse practitioners who are managing and treating over 150 individual patients to date.

The second study was a groundbreaking one that examined buprenorphine treatment at CHCI demonstrating successful BMT outcomes. It was the first study of its kind examining buprenorphine treatment at a standalone FQHC. The study examined 266 patients who were enrolled in BMT by 3 family physicians and 1 psychiatrist at two CHCI sites. It showed a retention rate of 56.8% at 6 months for all 266 patients and 61.6% at 12 months for those 136 patients who had at least 1 year follow up as can be seen in the figure below.



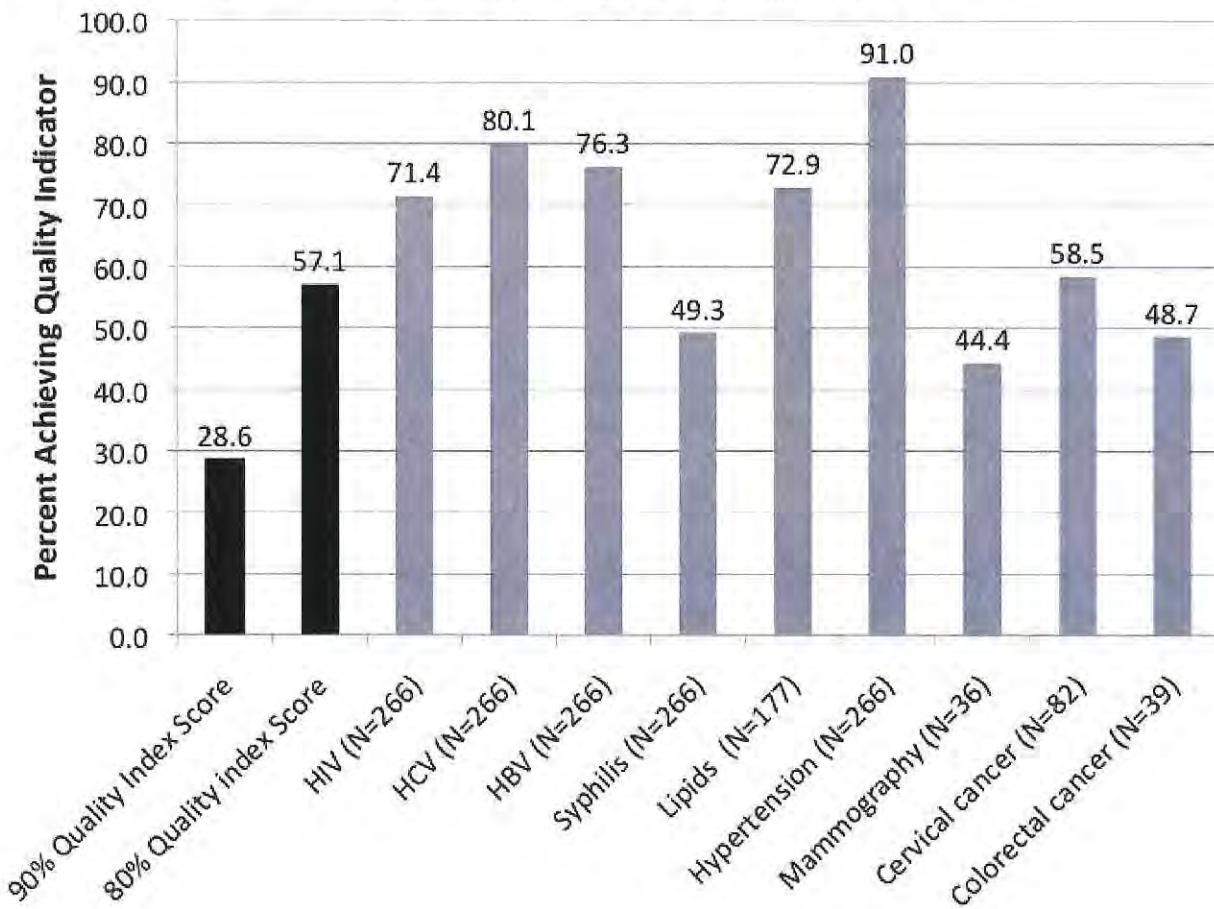
The study also showed that treatment of mental health disorders and receipt of on-site substance abuse counseling was associated with improved retention. (Haddad et al) This finding strongly supports the inclusion of behavioral health specialists as part of the ECHO team.

Given the strong evidence for Project ECHO as a model of care and its success in being adapted at CHCI as well as the novel and encouraging evidence that a successful BMT program can be integrated at a FQHC, this cutting edge project of using the ECHO model to expand BMT access to patients across all CHCI sites to address the unmet need for treatment of opioid dependence in the CHCI communities seems a natural next step.

CHCI as an agency already serves a patient population that is at increased risk for opioid abuse as noted above. Being able to replicate the successful program already demonstrated in the CHCI study throughout the agency by using the ECHO model will help engage those persons most vulnerable in the community and who are in need of opioid substitution therapy but unable to access such treatment. Based on Haddad et al, about 80% of those patients enrolled in BMT at the two CHCI sites actually engaged in care at CHCI because they were seeking treatment for their opioid dependence. (Haddad et al) Being able to offer BMT at all CHCI sites will allow CHCI to better serve its communities.

The biggest advantage of engaging patients in an integrated BMT at a FQHC rather than a substance abuse facility is the linkage to primary care. In the yet-to-be-published data on the 266 patients enrolled in BMT at CHCI, engagement in primary care demonstrated exciting and encouraging rates of health screenings, as seen in the figure below, in a population that

historically has been disenfranchised and disengaged from the healthcare system.



Legend: Quality Index Score= percentage of eligible screenings achieved; N = number of subjects eligible for screening

Integrating BMT into CHCI through the videoconferencing model of Project ECHO BMT will not only serve to improve and enhance access to opioid substitution therapy in cities that generally do not have access to methadone maintenance, thus making treatment easy and convenient for patients to engage in, but will also serve to link patients to a patient-centered medical home where they will receive primary care and mental health services and, as a consequence, engage in health screenings, preventive care, and chronic disease management.

B.3 Explain how your choice of an EBP will help you address disparities in sub populations.

Connecticut, despite being known as one of the richest states in the United States, struggles with health disparities. From 2000 to 2007, the racial and ethnic diversity increased in Connecticut. In particular, the Hispanic population increased by 24.8%. In 2007, whites were 74.4% of the population, Hispanics 11.5%, and Blacks 9.3%. (Stratton) We also know that racial and ethnic minorities are more likely to be poor as compared to whites and are more likely to be

uninsured. In Connecticut, Hispanics are 5.4 times and Blacks 2.7 times more likely than whites to be uninsured.

Not surprisingly, CHCI serves higher proportions of racial and ethnic minorities than in the general Connecticut population. In 2012, 38% of the patients served by CHCI were Hispanic and 13% were Black. With the knowledge that CHCI serves a population more likely to be suffering from health disparities, by expanding the services that CHCI delivers in all its sites which include primary care, mental health and dental to include BMT, CHCI can continue to fulfill its mission of engaging and treating the most vulnerable patients. For example, lower income adults are less likely to obtain recommended screening tests for hyperlipidemia or for cervical and colon cancers as compared to higher income adults. They are also more likely to smoke cigarettes and be overweight or obese. (Stratton) Furthermore, the opioid dependent population is more likely to have injected drugs than the general population and thus is at higher risk for HIV and HCV infections. Through the ECHO model, the fight against health disparities can be one step closer to victory by engaging the poor, uninsured or State-insured, and racial and ethnic minorities in care at CHCI where they can receive not only BMT for their opioid dependence but also their primary care, mental health care as well as HIV and HCV treatment if necessary.

B.4 describe any modifications that will be made, the reasons the modifications are necessary and the implications of these modifications to the fidelity of the EBP.

Modifications from New Mexico's ECHO model have been made in the design of our proposed program Project ECHO BMT in order to incorporate the findings from the CHCI study without compromising the set up or spirit of the ECHO model. Since improved retention at CHCI was associated with treatment of mental health disorders and on-site substance abuse counseling, the proposed program includes a larger multidisciplinary team as part of both the expert faculty as well as the ECHO participants than was part of the original ECHO HCV. This inclusivity of disciplines is also an acknowledgement that there are different challenges in treating HCV and treating substance abuse. When treating the drug using population, buy-in from the whole clinical team is essential to the success of any treatment program. Primary care centers and the healthcare staff that work at such centers rarely have training or experience in addiction medicine or in dealing with treatment and management of substance abuse. In Project ECHO BMT, the expert faculty will include a primary care physician and a psychiatrist both certified to prescribe buprenorphine, a behavioral health clinician with substance abuse experience, and a nurse care coordinator and a medical assistant both who have experience with BMT. The ECHO team from each of the CHCI sites will include the buprenorphine-certified primary care physician or psychiatrist, the nurse and medical assistant for the treating physician as well as the behavioral health therapist who will be running the on-site substance abuse counseling at each of the sites. Although the addition of these disciplines to the ECHO model is a modification, such modification actually takes the original multidisciplinary concept that the model uses for the HCV ECHO faculty and builds on it. This modification in fact is expected not to detract but to enhance the success of the model as it pertains to the implementation and expansion of BMT programs.

B.5 If an EBP does not exist or apply for your program, fully describe the practice you plan to implement, explain why it's appropriate for your focus population and justify its use.

Although strong published evidence may not exist for the use of patient navigators in BMT programs to improve treatment outcomes such as retention in care, the inclusion of patient navigators in the Project ECHO BMT model being proposed was deemed important to the program for two reasons. First, based on the CHCI study, the one measure that was associated with decreased retention was cocaine use. (Haddad et al) In knowing this association, concentrating resources on those patients who do test positive for cocaine may help improve their chances at long term retention. One way of boosting resources for those most in need would be to have patient navigators engage more intensely with these patients and ensure they are following through with medical and counseling appointments. Second, in the previously shown data on buprenorphine patients at CHCI that looked at primary care health screenings, while rates of HIV, Hepatitis B and C, hyperlipidemia, and hypertension screenings were high, the rates for Pap smear, colonoscopy and mammogram screenings tended to be low. Having patient navigators may help increase these rates. Additionally, CHCI has participated in two federal grants over the last 6 years which utilized care coordination specialists such as patient navigators to support the delivery of healthcare. Both of these programs were able to demonstrate increased retention in care and decreases in the barriers to care which might prevent patients from fully engaging in their healthcare. Ultimately, patient surveys and focus groups proved that the patient navigator role and the care coordination that it offered was considered one of the greatest benefits of participation for patients enrolled.

Section C: Proposed Implementation Approach (30 points)

• Describe how you will support SAMHSA's Strategic Initiative #6, Health Information Technology, in treating substance using populations.

As previously described, Project Extension for Community Healthcare Outcomes (Project ECHO) is an evidence-based intervention with health information technology at its core. Project ECHO achieves care coordination by utilizing case-based distance learning through videoconferencing and electronic health record technology that links primary care providers with specialists in order to improve health outcomes for underserved patients who have difficulty gaining access to specialty care. The Project ECHO model has been successfully utilized to provide specialty care to underserved populations in the areas of pain management, HIV, HCV, rheumatology, and cardiology, among others. The recent study of the impact of Project ECHO by Aroro et al, published in the New England Journal of Medicine,(9) found that specialized HCV care delivered by community physicians who participated in Project ECHO was equivalent to care provided by specialists practicing in a state-of-the-art academic health center. Project ECHO seeks to establish “communities of practice” that build expertise among primary care providers, improve access to specialty care for those requiring it, and improve retention of primary care providers in underserved communities through reducing isolation. Project ECHO is a low-cost, reproducible intervention that has the potential to significantly impact health systems and patient outcomes across the country and internationally.

As discussed earlier, CHCI has successfully replicated Project ECHO for HCV and HIV care and has been conducting weekly sessions for this purpose since January 2012. For Project

ECHO Buprenorphine Maintenance Treatment (BMT), we propose to use the ECHO model to extend the much needed support to primary care providers who face the challenge of managing opioid-dependent patients across our statewide health center network. Project ECHO BMT will provide evidence-based opioid substitution therapy education and expert consultation to providers engaging in this important treatment modality. We plan to evaluate the impact of the intervention on a variety of patient and organizational levels. The use of telemedicine, videoconferencing, and our fully integrated electronic health record (eClinicalWorks or eCW) directly support SAMHSA's strategic initiative #6 to enhance Health Information Technology for each of SAMHSA's funded programs.

- Describe your experience using technology for treating substance using populations.**
Describe your organization's current capacity in technology assisted care. Explain how your current infrastructure enhances or limits the quality of care your organization provides. Explain how it enhances or limits your efficiency as an organization.

CHCI uses the electronic health record eCW to capture encounters from any discipline across the agency, including medical, dental, nursing, behavioral health, and substance abuse counseling. Patients being treated for substance abuse or any other condition have a progress note generated in their health record by a clinician after every in-person visit. Detailed electronic notes in the form of "telephone encounters" track any and all patient communications that occur in between visits and any communication between providers and other staff members engaged in the patients' care. Each patient signs a release on an annual basis that is stored in the patient document section of eCW, giving clinicians from other disciplines the ability to track patients' progress in substance abuse and other healthcare treatment. The use of this important and essential technology, the universal electronic health record, allows for an interdisciplinary approach to healthcare in which clinicians from multiple specialties have access to the records kept by the various disciplines and are in communication with each other with the common goal of improving treatment outcomes.

CHCI uses additional technological tools to improve communication between clinicians and enhance the care delivered to patients across the agency. Videoconferencing technology gives providers and staff the opportunity to participate in trainings, meetings and agency-wide grand round presentations without having to travel long distances or leave their home sites or desks even. Staff members could conference into sessions through the television screens set up in the conference rooms at each site using the Polycom bridging system or directly from their mobile devices such as their computer laptops and iPads with the Vidyo© application. This technology increases efficiency and allows for virtual "face-to-face" meetings while still maximizing the amount of time that clinicians and other staff are available for patient visits. Instant messaging (IM) through the Microsoft Lync system and emailing are also extremely valuable technological methods of communication among the clinicians and other staff particularly when there is a need for immediate concerns to be addressed regarding patient care and management.

Through the use of the Patient Portal, patients also have a technological means to reach their providers directly through eCW. The Patient Portal, however, does require patients to have access to the internet and have the desire to communicate to the provider through such means. Overall, a minority of CHCI patients have chosen to use this technology with hardly any patient in substance abuse treatment opting to use this method to communicate with the clinic.

In 2012, CHCI launched the program Project ECHO HIV/HCV which consists of weekly didactic and case presentation sessions conducted via videoconferencing. To date, 16 primary care providers have been trained to successfully manage and treat about 150 patients at CHCI's 12 primary care centers across the state. This program provides weekly consultation with an expert internal HIV/HCV faculty. Case-based learning is enhanced during the sessions since all participants have access to eCW and can review the health records as the patients are being presented and discussed. Communication and care coordination are supported further through both the use of telephone encounters in the electronic health record to discuss clinical care in between sessions as well as through the use of IMs and emails if the primary care providers need to communicate with a faculty member more urgently.

Weekly Project ECHO HIV/HCV sessions are dynamic and interactive. Primary care providers present clinical cases which are then reviewed with faculty in a telehealth session that begins with a 15-30 minute didactic presentation on a topic related to HIV or HCV care. Clinical recommendations for each case are documented in the electronic medical record by the primary care provider in a telephone encounter and patients are co-managed with the guidance of the faculty, which includes physicians, nurse practitioners (NPs), pharmacy, behavioral health, and nursing.

CHCI is proposing to expand the use of these technological methods to increase access to opioid substitution therapy for patients and to enhance their care management and coordination by launching Project ECHO BMT in a similar format. The success of Project ECHO HIV/HCV and the lessons learned from its implementation make CHCI an ideal candidate to use our experience with technology-enhanced care to increase access throughout Connecticut to BMT services.

- **Explain how you will address the following factors influencing the expansion and/or enhancement of technology.**

Organizational factors: (redesign of workflow, capabilities of practice, day to day operations)
CHCI is committed to integrating technology into every facet of healthcare delivery for the benefit of our patients. The day-to-day operations of CHCI are designed around technology currently in place, e.g. electronic health record, IM and email communication, and videoconferencing. Furthering the use of technology by replicating Project ECHO for BMT will simply be a matter of efficiently redirecting the use of current technology to serve new purposes. For instance, as previously described, in 2012 CHCI applied full use of videoconferencing and electronic health records to implement a pilot project using the ECHO model to train CHCI primary care providers to manage HIV and HCV infected patients of the health center. The ECHO model, as explained above, is an innovation in the use of telemedicine which trains primary care providers to deliver specialty care via weekly telehealth consultations with a faculty of experts. The goal of Project ECHO is to open access to care in underserved communities while simultaneously training new providers who will eventually gain the expertise to independently manage their own panel of specialty patients.

In our replication of Project ECHO, CHCI found that the use of technology was seamless. The ECHO model, however, required that participating providers be absent from patient care for two hours per week to attend these sessions creating a potential shortage of appointments for patients that needed to be addressed. To help minimize the shortage, ECHO participants had

generously agreed to use half an hour of their administrative time for the sessions. In return, CHCI ensured that provider time was blocked for the remaining 1 ½ hours of the session time. Patients who needed to be seen were accommodated by giving them available appointments before or after the ECHO sessions with their provider or in available patient slots with other providers at the site if urgency was a concern.

From this experience, we designed Project ECHO BMT to be a monthly instead of weekly program. Once a month sessions would be much less disruptive to patient accessibility and provider and staff workflow. Similarly, providers and the other staff will agree to use a half hour of their administrative time toward the 2 hour ECHO sessions. CHCI will then ensure that provider time is blocked for the other hour and a half once a month during Project ECHO BMT. If the feedback from participants over time is that monthly sessions are not enough, the addition of another session(s) per month will be considered.

Using technology to expand the availability of BMT to patients will positively change capacity. Training and supporting providers and their clinical teams will consequently increase the number of patients enrolled in BMT and the need for available appointments for their opioid dependence therapy. The increase in patients and their subsequent need for clinic appointments will be absorbed by the whole BMT team thus removing the pressure off the provider's time and schedule. Nursing, behavioral health, and substance abuse group and individual counseling visits will be part of the management plan for patients.

The use of videoconferencing allows providers to participate in Project ECHO BMT without having to drive to a central site or even leave their desk, saving critical time for the staff as well as for patient care. CHCI has purchased the “Vidyo ©” mobile teleconferencing platform mentioned earlier which allows ECHO participants to securely join the sessions from any computer with a webcam or from mobile devices like smart phones or tablets.

Using an interdisciplinary approach to substance use treatment ensures that all members of the healthcare team are working collaboratively toward the goals of an individual patient. The Project ECHO BMT team will be designed to mimic CHCI’s existing medical “pod” team with some occasional modifications that will be dictated based on the size and availability of the staff at each of the sites. The BMT team will basically consist of the pod team which includes the provider, nurse, medical assistant, and behavioral health clinician. The pod set-up will assist the Project ECHO BMT teams in providing comprehensive care on a daily basis.

Providing training and competence factors. (Disparity in IT dexterity among providers and staff):

Enhancement of technology will only strengthen CHCI’s already robust training programs for providers and staff. CHCI’s well-trained and experienced Information Technology (IT) department will be responsible for providing on-going training for personnel who participate in Project ECHO BMT. This will be done through a thorough system of on-line trainings, go-to meetings, face-to-face meetings and video conferencing which will link providers and staff with IT staff who can train them on the use of technology. In addition, at the time of each telemedicine session, IT staff will be available to assist with any system glitches or to work with providers and staff to establish connections and linkages. The IT department will ensure on a daily basis that valuable time is not lost due to staff training deficiencies, equipment malfunctions, or transmission issues. CHCI’s IT department will also be responsible for all equipment maintenance and software updates, ensuring that technology enhances the outcomes of the program rather than hinders them.

Relationship factors between providers and persons in treatment.

CHCI currently provides BMT at only a few select sites with limited capacity. As an agency, CHCI has seen a persistent demand from patients in need of this therapy, both at the sites that have BMT and at sites where BMT is not available and community resources are lacking. Based on the experience of the sites that BMT does currently exist, the capability of increasing access to BMT will lead to interactions between patients and providers and staff that will be both invigorating and challenging.

Several years ago, CHCI implemented a team-based, intercollaborative practice model of care. This model is built around the physical structure of the “pod, a defined physical area in which all members of a healthcare team, including a mental health provider, are physically located in a shared clinical space. This model encourages efficient communication between team members and fosters a more collaborative approach to healthcare delivery. A typical pod includes two primary care providers, their dedicated Medical assistants, an RN care manager, and a behavioralist. Additional pod “seats” are shared by health professions students and team members who support multiple pods such as registered dieticians, certified diabetic educators, psychiatrists, podiatrists, and chiropractors. The pod system benefits both patients and the clinical team. Patients benefit from this by having their care provided by a team of healthcare personnel who have access to all of their health and medical information and can easily collaborate. This will be especially important for those patients receiving BMT because substance abuse treatment requires close monitoring by all members of the healthcare team. A collaborative “pod” approach will ultimately give patients greater access to the care they need. The clinical team benefits from the pod system especially when it comes to the BMT program since the team is in constant contact and can collaborate in real time when fielding patient visits, phone calls, patient requests, pharmacy issues, and so forth. Moreover, CHCI currently uses a voucher system for our BMT patients which allows physicians to provide a prescription to specified area pharmacies for a supply of buprenorphine but requires that the patient present the pharmacist with an embossed, signed voucher in order to have the medication released and dispensed. The voucher may be signed by any member of the clinical team and thus allows team members other than the prescribing physician to participate in the management of patients on buprenorphine. The voucher system allows the healthcare team to monitor attendance at individual and group visits since the voucher is typically handed to patients at the end of their scheduled substance abuse treatment appointments. Monitoring tools such as medication pill counts and urine or saliva toxicology screens are ordered regularly and at the discretion of the prescriber to monitor for progress and success as well as for medication diversion. The BMT program based on the medical pod model and the voucher system empowers the clinical team as a whole and will reinforce the importance of the relationship between the patient and their providers and clinical teams and will hold patients accountable for playing an active role in their own recovery process.

Technical factors requiring additional staff or consultants (support maintenance, operations of the systems):

CHCI has a robust IT department who will play a major role in the success of using technology to enhance care coordination and increased access to substance use therapies for patients at all 12 CHCI medical sites. CHCI is proposing 20 hours per week of IT support to

manage the technology coordination required. This support will include purchasing equipment, installing equipment, installing updates to equipment and software, testing equipment prior to telehealth sessions, maintaining equipment on a weekly basis and working with Project ECHO BMT providers and faculty to ensure appropriate training in the use of all technology. The IT support staff will also be responsible for maintaining the highest level of technology available including upgrades to software or equipment that will promote efficiency. IT support will also be used in the routine data collection and dissemination which will be the backbone of our quality management efforts. Closely monitoring the number of patients screened, assessed, enrolled and retained along with other measurable outcomes will be vital to the on-going improvement of this project.

•How will effective consent be obtained and tracked, including any special conditions:

CHCI currently has an efficient method of collecting informed consent and could seamlessly accommodate additions or revisions to this system. Consent is obtained with a signature obtained at the patient kiosk at the time of check in or on paper consent forms which are then scanned into our electronic health record for storage in the patient documents section if the patient kiosk is not used or not available. The electronic health record sends a yearly alert when consent forms need updating. This is accomplished via a feature which prevents providers from entering a new visit unless the yearly consent is updated. Consent for Project ECHO BMT will be obtained yearly and stored in the patient documents section in eCW along with the patient contract for the BMT program.

• Describe how the goals of the project will provide meaningful and relevant results for your community and support SAMHSA's goals for the program.

The goals of the Project ECHO BMT Program directly correspond to the needs of the communities we serve. Our innovative proposal expands the availability of opioid substitution therapy through the use of enhanced technological methods, making BMT easy and convenient to access by CHCI patients, particularly in the cities where there are no methadone maintenance clinics and very limited if any buprenorphine treatment. Our proposed novel program also serves to link these patients, who historically have been very difficult to engage in healthcare, into primary care since Project ECHO BMT will be established at a FQHC with primary care physicians prescribing the buprenorphine therapy, a goal that is in accordance with the Affordable Care Act. Moreover, once patients are established at CHCI, they will have access to not only BMT, primary care, mental health, and dental services, but they will also benefit from all other services that CHCI offers, including HIV and HCV care which is consistent with the National HIV/AIDS Strategy and the Viral Hepatitis Action Plan.

This exciting project will serve to train and support new providers and their expanded clinical team in BMT and to provide essential care coordination in underserved areas of the state. Initially, CHCI will use expansion and enhancement in technology to train new providers in the use of BMT in an effort to significantly increase the number of providers who will offer this important treatment modality. Over the three year period of the grant, CHCI is proposing to continue adding providers who are delivering BMT in the communities we serve so that by the end of the grant period we will have effectively opened access to hundreds of patients and

trained many new providers who will have the knowledge and expertise to continue providing such valuable services in those communities.

Opening access to BMT is the first priority of the proposed grant but retention in care is a very high priority as well. Based on the findings of the CHCI study by Haddad et al, we incorporated mental health and substance abuse counseling as an integral part of Project ECHO BMT specifically since the results significantly demonstrated that those patients who received mental health treatment or on site substance abuse counseling had higher rates of retention. Managing each patient with an interdisciplinary approach which will also include the nurses and medical assistants of the provider's clinical team will increase the likelihood of their sustained engagement in care while also working toward the goal of helping patients establish medical homes in their own communities. CHCI's model of training primary care providers and their clinical teams to manage opioid dependence through BMT ensures that patients will also receive preventive health screenings and chronic disease management. Screenings and preventive care include mental health services, oral healthcare, tobacco cessation counseling, nutrition, eye care and vaccinations. Chronic disease management includes hypertension, diabetes, asthma, COPD, chronic pain, HIV and HCV among many others as well as referrals to specialty services when needed.

The comprehensive model of care that CHCI is proposing serves to open access to BMT in communities where it is needed while also increasing education around important public health and safety issues for those patients and their families enrolled in services. Communities where BMT is desperately needed but previously unavailable will have increased access to lifesaving services as well as wrap-around support services. By using technology to increase access to these needed services, CHCI will be able to change the healthcare delivery system for substance users and their families.

• Describe your plan to screen and assess clients for the presence of co-occurring mental and substance use disorders and the use of the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

CHCI is committed to providing comprehensive, interdisciplinary care to all patients, and Project ECHO BMT will be no exception. Currently, when a new patient has their initial appointment with a CHCI provider, they are screened for mental health, oral health, substance use and other medical and psychosocial problems. This process will be no different for those patients who initiate treatment with a CHCI provider through Project ECHO BMT. Participants of Project ECHO BMT will receive, at a minimum, annual screenings for co-occurring mental health disorders as well as infections such as HIV/AIDS, hepatitis B, and hepatitis C to ensure that care is comprehensive.



hepatitis C to ensure that care is comprehensive.

Patients who screen positive for a co-occurring mental health disorder during a medical visit will receive a “warm hand-off” to a mental health provider. The “warm hand-off” model is a successful strategy employed by CHCI which enables real-time consults at the time of service with a mental health provider who is already embedded in the medical pod. This consult serves as an entry point into the mental health department, and an appropriate treatment plan is created over subsequent visits with the mental health team. This may include referrals internally to on-site substance abuse counseling and psychiatry or externally to community resources such as intensive outpatient programs or residential drug treatment facilities. When “warm hand-offs” are not possible, patients will be scheduled as soon as possible for intake appointments with mental health clinicians. Furthermore, through Project ECHO BMT, providers and their clinical teams have access to all the ECHO faculty and participants across the agency which includes psychiatrists and behavioral health clinicians who will serve to advise and guide the teams on treatment approaches to the patient cases presented who do suffer from co-occurring mental and substance abuse disorders. See diagram below.

In summary, patients with co-occurring disorders will be followed by a comprehensive healthcare team within which care coordination is paramount. CHCI’s use of a fully integrated electronic health records ensures that every member of the team has a part in coordinated treatment plan decisions and patients receive the best care possible.

• Provide a chart or graph depicting a realistic timeline for the entire project period

	Key Action Steps	Goals	Person Responsible	Date
Technology	<ul style="list-style-type: none">• CHCI’s IT department will purchase technology equipment for use in enhancing Project ECHO to include BMT. This may include Vidyo© licenses or other teleconferencing equipment.• CHCI’s IT department will provide on-going training and support to all providers in the utilization of technology to provide patient care.• CHCI’s IT department will maintain all technology equipment and administer updates on an on-going basis.CHCI’s IT department will aid in facilitating data collection, input, and extraction.	<ul style="list-style-type: none">• Equipment will be purchased, installed and tested to accommodate CHCI’s provider participation in enhanced Project ECHO BMT.• Provider surveys conducted after 6 months and annually will reflect adequate training and support provided by CHCI’s IT department.• All CHCI equipment will be maintained appropriately and will receive updates as necessary by CHCI IT staff.IT staff members will be readily available to help with data in a timely manner.	CHCI IT Staff CHCI IT staff CHCI IT staff CHC IT staff	Immediately and ongoing

Outreach	<ul style="list-style-type: none"> The patient navigators (PN) will conduct outreach to the agencies where potential clients obtain services such as methadone clinics. The patient navigator will work with all CHCI providers, helping them to seamlessly transition new clients to the BMT program. CHCI's Outreach coordinator and Public relations department will utilize social media tools to increase awareness about services and recruit clients from within the health center. . 	<ul style="list-style-type: none"> 300 patients per year will be reached with information about technology enhanced Project ECHO BMT Provider surveys conducted in communities served will reflect basic knowledge of services offered in SA treatment at CHCI. Client surveys conducted at the end of each year of the grant will reflect use of social media in promoting services. 	Patient navigator Project Director PR Department	4 months after NGA Yearly On-going
Recruitment	<ul style="list-style-type: none"> Project ECHO BMT faculty will be recruited. CHCI medical, clinical, and behavioral health providers will be recruited at each CHCI site to participate in Project ECHO BMT. CHCI providers and staff will be trained in the screening for new patients who are in need of BMT. Community providers will make referrals to CHCI sites for Project ECHO BMT where 	<p>A primary care buprenorphine prescriber, a psychiatrist prescriber, a behavioral health substance abuse specialist, a nurse care coordinator and a medical assistant experienced in BMT at CHCI will be recruited to be part of the faculty.</p> <p>Each CHCI site will have an interested physician certified in buprenorphine, his/her pod nurse and medical assistant, as well as the behavioral health therapist interested in running substance abuse groups be part of the ECHO team.</p> <p>CHCI staff will recruit from within the agency for new patients in need of services, specifically at the sites who have not historically provided BMT.</p> <p>Community providers will make CHCI their referral site for BMT.</p>	Principle Investigator Principle Investigator Project Director	4 months after NGA and ongoing

	screening will take place as soon as possible.			
Screening	<ul style="list-style-type: none"> • CHCI patient navigators will utilize community networking opportunities to conduct outreach and Awareness to agencies who can pre screen for people in need of BMT services. • Patients of CHCI providers will be screened for eligibility in Project ECHO BMT on an ongoing basis. • CHCI patients who screen positive for the need for BMT will be referred to the provider on site participating in Project ECHO BMT. 	<ul style="list-style-type: none"> • 300 patients per year will be screened for BMT services. • Patients who screen positive for the need for BMT will be referred directly to their site for services. • Patients who screen negative for eligibility for BMT will be referred appropriately for other services they may require. • All CHCI patients who screen positive for BMT services will receive care from the provider currently trained on site through Project ECHO BMT. 	Patient Navigators CHCI providers	Enrollment will begin 4 months after NGA
Enrollment	<ul style="list-style-type: none"> • CHCI will use patient navigators to enroll patients deemed appropriate for BMT by medical providers at each site. • The patient navigator will ensure that effective consent is obtained for each patient and all new patients are screened for co-occurring disorders. 	<ul style="list-style-type: none"> • 175 patients will be enrolled in BMT in the first year of the grant. • 100% of patients will have effective consent on file in the EHR. • At the time of enrollment all patients will be screened for co-occurring disorders and receive appropriate referrals and care coordination. 	Patient navigator CHCI BMT providers	6 month after NGA 6 months after NGA
Retention	<ul style="list-style-type: none"> • CHCI patient navigator will provide support and care coordination for patients enrolled in the program • CHCI patient navigator will be responsible for working with patients to eliminate barriers to care. • CHCI patient navigator will identify community resources which will help patients eliminate barriers and remain engaged in care. . 	<ul style="list-style-type: none"> • CHCI will retain 150 patients per year in BMT through Project ECHO BMT. • Patient surveys conducted on a yearly basis will demonstrate positive outcomes and behavior changes based on care coordination and elimination of barriers to care. • BMT patients will demonstrate a no show rate of less than 15% each year. 	Patient navigators Patient navigator Patient navigator	Year one and ongoing

Training/Support	<ul style="list-style-type: none"> • CHCI will open access to patients in underserved areas by training new providers in BMT through Project ECHO BMT. • CHCI providers will demonstrate a high level of expertise and comfort in BMT within one year of beginning Project ECHO BMT. • CHCI will sustain the Project ECHO BMT Program after the grant due to the number of providers who will be trained and providing services after the three year period. 	<ul style="list-style-type: none"> • 36 primary care providers will receive training and support through Project ECHO BMT over the three year grant period. • ECHO provider and staff surveys conducted before Project ECHO BMT and 6 months after beginning it will demonstrate an increased level of confidence, comfort, and understanding of BMT. 	PC Providers Project ECHO faculty	Year one and ongoing
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• Describe how you will identify, recruit and retain the population of focus.

CHCI's population of focus includes individuals in our communities who have limited access to buprenorphine maintenance therapy because of their race, ethnicity, income level, insurance status, or location. CHCI will use historically proven outreach strategies to target the populations in each city where the need is the greatest. CHCI proposes to conduct outreach to area service providers, human service agencies, local health departments, and hospitals to ensure that awareness of services provided by Project ECHO BMT is comprehensive and thorough. CHCI also intends to use social media tools to raise community awareness of Project ECHO BMT and recruit patients who utilize such outlets. The need for BMT in the communities served by CHCI is great; in fact, CHCI has already laid the groundwork for recruitment and enrollment with many of our own patients through word-of-mouth networking.

CHCI is committed to providing outreach and care that is culturally sensitive and suitable for all patient populations. To that end, we will follow the successes of our other outreach efforts by targeting agencies that serve the population of focus. We will also guarantee that all written materials are culturally sensitive and at a literacy level that is appropriate for our target populations. Such sensitivity will be carried forward into the care received at our health centers. Once care is initiated at CHCI, patients will experience a highly developed system for ensuring that all patients receive care that is delivered in their first language and by providers and staff who are proficient in cultural competency. Two of the tools that CHCI uses to ensure this are Language Line, which allows staff to obtain a qualified translator in any language over the phone within minutes and a cultural competency training which is required of each employee on an annual basis. CHCI also has all marketing materials printed in the three top languages at each site and requires leadership of all programs to monitor cultural sensitivity on a regular basis. As in our experience with other special populations, we are confident that providing BMT within a patient's medical home, in a culturally sensitive manner, and with a caring, multidisciplinary team will foster patient satisfaction and will ultimately lead to high rates of retention.

•Describe how you will ensure the input of clients in assessing, planning and implementing your project.

CHCI will ensure the input of patients in assessing, planning and implementing the project by conducting yearly patient satisfaction surveys specific to the Project ECHO BMT program. Additionally, patients will be invited to participate in focus groups on a yearly basis. These focus groups will be conducted by the evaluator of the program who will use the feedback to facilitate program improvement. The success of the program will be evaluated on a yearly basis. Patient satisfaction surveys have been highly successful tools for engaging patients in their care and including them in the direction of the program, as seen in our Ryan White HIV/AIDS Program and previous grant awards.

• Identify any other organizations that will participate in the proposed project including their roles and responsibilities.

The agencies listed below have all verbally agreed to provide Intensive Outpatient Services to those patients who require a higher level of care than CHCI can provide with Project ECHO BMT.

Agency Name	City/Town	Service Provided	Type of Relationship
Johnson Memorial Medical Center Chemical Dependency Program	Enfield	Intensive Outpatient Program	Referral Source
Hospital of Central Connecticut Farrell Treatment Center Community Mental Health Affiliates Inc.	New Britain	Intensive Outpatient Program	Referral Source
Central Naugatuck Valley HELP, Inc of Saint Mary's Hospital	Waterbury	Intensive Outpatient Program	Referral Source
Rushford Center, Inc	Meriden	Intensive Outpatient Program	Referral Source
Rushford Center, Inc	Middletown	Intensive Outpatient Program	Referral Source
Connecticut Valley Hospital	Middletown	Intensive Outpatient Program, Inpatient Treatment Program	Referral Source
Southeastern Council on Alcohol and Drug Dependency	New London	Intensive Outpatient Program, Residential Programs, Inpatient Treatment Program	Referral Source
Lawrence and Memorial Hospital	New London	Intensive Outpatient Program	Referral Source
Midwestern CT Council on Alcohol	Danbury	Intensive Outpatient Program	Referral Source

and Drug Addiction			
Rushford Center, Inc	Bristol	Intensive Outpatient Program	Referral Source
Connecticut Renaissance, Inc Norwalk Hospital	Norwalk	Intensive Outpatient Program	Referral Source
Connecticut Renaissance, Inc Stamford Hospital	Stamford	Intensive Outpatient Program	Referral Source

- State the unduplicated number of individuals you propose to serve under the expansion/enhancement project including types and numbers of services to be provided and anticipated outcomes. Also include race, ethnicity and gender.**

The table below is the proposed number of patients to be served by CHCI's Project ECHO BMT Program. The numbers reflect an increase of 100 patients per year and retention of 150 patients per year.

	Number of screenings	Number of assessments	Number of patients enrolled in BMT	Number of patients retained in BMT	Number of patients receiving preventive screenings and chronic disease management
Year One	300	250	175	150	150
Year Two	300	250	275	250	250
Year Three	300	250	375	350	350
Total Project Period	900	750	375	350	350

The table below is the proposed number of patients to be served by CHCI's technology enhancement Project ECHO BMT. These numbers were determined based on historic data from CHCI and the communities we are proposing to serve.

	Total number of patients enrolled in BMT	% of patients Male	% of patients Female	% of patients who self report African American	% of patients who self report Hispanic
Year One	175	65%	35%	25%	35%
Year Two	275	65%	35%	25%	35%
Year Three	375	65%	35%	25%	35%
Total project	375	65%	35%	25%	35%

Period				
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The number of patients served is unduplicated by year.

Provide a per unit cost for this program.

CHCI utilized the example given to demonstrate cost per patient per year.

Total funding – 20% for data and evaluation, divided by the number of patients enrolled in that year = cost per patient per year.

	Year one	Year Two	Year Three
Total grant funding	\$280,000	\$280,000	\$280,000
20% of data and evaluation	-\$56,000 = \$224,000	-\$56,000 = \$224,000	-\$56,000 = \$224,000
# of patients enrolled	175	275	375
Cost per patient/per year	\$1,280	\$814.54	\$597.33

Section D: Staff and Organizational Experience

Discuss the capability and experience of the applicant organization with similar populations.

Demonstrate the applicants linkages to the population of focus and ties to community based agencies rooted in the culture(s) of the focus population.

Community Health Center, Inc. (CHCI) is a private, non-profit Federally Qualified Health Center (FQHC) providing primary medical, behavioral health, and dental care as well as social services. CHCI's quality healthcare services are available to all, and particularly to those who cannot gain access to such services elsewhere. CHCI is building a world class primary health care system that is committed to caring for special populations and that is focused on improving health outcomes for its patients as well as building healthy communities. CHCI's system of care is dedicated to quality service delivery as well as research and development, innovation and training the next generation of healthcare providers. From its origin in 1972 as a volunteer storefront clinic in Middletown, CHCI has grown into a statewide network of care offering services in over 200 locations including homeless shelters, schools, and clinics. CHCI's main primary care sites are located in Middletown (1972), Old Saybrook (1989 dental only), Meriden (1991), New London (1992), Groton (1995), New Britain (1996), Clinton (1999), Norwalk (2005) Stamford (2005), Enfield (2007) Danbury (2008), Bristol, (2009), and Waterbury (2011). In addition to the core competencies of medical, dental and mental health services, CHCI has pioneered a wide range of supportive services such as intensive case management, a homeroom after school program, extensive prenatal education and lactation support services, and family violence prevention and education, including a shelter for battered women. CHCI is now the largest provider of primary health care services to the underserved in Connecticut with over 400,000 visits annually. It is recognized throughout the state for its commitment to clinical excellence, comprehensiveness of scope and management infrastructure. CHCI has a fully integrated electronic health record used across the agency for all services, including medical, behavioral health, and dental care. CHCI is accredited by the Joint Commission and has been recognized as a level III Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA).

CHCI is deeply rooted in the communities we serve creating lasting linkages to those organizations that provide additional services to our patients. CHCI outreach is conducted throughout the cities and towns where we are located with specific focus on those agencies serving the patients in greatest need of healthcare services. For instance, CHCI has developed collaborative relationships with local health departments, community based organizations, human service agencies, government funded programs, health and wellness programs and other organizations and agencies that support the underserved and impoverished in our communities. CHCI participates in all organized community events such as health fairs, outreach projects and awareness campaigns.

- Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.**

Title	Name	Roles, Responsibilities	FTE	Qualifications
Principle Investigator	Marwan Haddad, MD, MPH	<ul style="list-style-type: none"> Continuously monitor comprehensive implementation of proposed grant Ensure that all program goals and objectives are being met on a regular basis 	0.10 FTE	15 years of experience as an HIV Specialist 5 years of experience directing the BMT Program at CHCI Experience in the implementation of successful Project ECHO HIV/HCV at CHCI
Project Director	Kasey Harding - Wheeler	<ul style="list-style-type: none"> Directly supervise the staff in the implementation of the proposed grant Oversee the administrative, fiscal and programmatic functions of the program on a daily basis Ensure that all reporting requirements are made Recruit, hire and train any new staff needed for program 	0.10 FTE	17 years of experience in the field of HIV/HCV field Direct responsibility for the administrative oversight of federal, state, city and local grants. Extensive experience in designing and implementing strategic outreach plans which target populations of need.
Project ECHO Coordinator	Agi Erickson	<ul style="list-style-type: none"> Provide coordination for Project ECHO BMT including monitoring eCW referrals, organizing case presentations, collecting data and maintaining efficient communication between faculty and providers. 	0.50 FTE	6 years of experience as a programmatic director of CHCI's Healthcare for the Homeless Program. 1 year experience as the Coordinator of Project ECHO HIV/HCV 2 years of experience as a coach for CHCI's Clinical Microsystems Program.
Project ECHO BMT faculty	Marwan Haddad MD, MPH Richard Feuer MD Clifford Briggie PsyD, LADC, LCSW Jonathan Arocho LPN Omar Perez MA	<ul style="list-style-type: none"> Provide clinical co-management of BMT patients throughout CHCI through Project ECHO. Provide guidance, recommendations and training to Project ECHO BMT participants. Consistently monitor patient outcomes. 	0.10 FTE each	The two physicians and the behavioral health specialist have a combined 20 years experience in the treatment of opiate addiction. The nurse and MA have 10 years of experience in medication adherence and engaging difficult populations in care. Four of the Project ECHO BMT faculty have served on one of CHCI's other Project ECHO projects.

Project ECHO BMT providers	Dipak Patel,MD Hartmut Doerwaldt,MD Syed Hassan,MD Becky Eleck,MD Lori Weir,MD Doug Olsen,MD Carl Lecce,MD Tachianaa Armah,MD	<ul style="list-style-type: none"> Participate in Project ECHO BMT on a monthly basis, presenting cases when appropriate. Provide screening, assessment and treatment to patients who are in need of substance abuse treatment. 	0.05 FTE each	Primary Care Providers or Psychiatrist with various years of service at CHCI.
Project ECHO BMT Clinical support staff (nurses, mental health clinicians, MA's)	1 RN, 1MA and 1, Behavioral Health clinician from each Project ECHO BMT site.	<ul style="list-style-type: none"> Participate in Project ECHO BMT on a monthly basis and present cases when appropriate. Provide clinical support to patients as needed. Run weekly substance abuse counseling groups	0.05 FTE each	Nurses Ma's and behavioral health specialists with various years of experience at CHCI. Annual Core Competencies completed.
Information Technology Specialist		<ul style="list-style-type: none"> Purchase and install technology equipment. Continuously maintain the systems including upgrades. Provide IT support to providers and faculty participating in Project ECHO BMT. 	0.20 FTE	
Data Coordinator		<ul style="list-style-type: none"> Collect, enter, analyze and evaluate data on a regular basis. Disseminate data to program participants and establish success of measurable outcomes. 	0.20	
Patient Navigator	TBD	<ul style="list-style-type: none"> Conduct outreach and screening to patients at CHCI and in the communities we serve. Provide care coordination for patients enrolled in the Project ECHO BMT Program including the elimination of barriers to care. Efficiently communicate with providers and staff about the needs of patients enrolled in the program. Ensure that all patients enrolled in the BMT Program have updated consent forms and are screened for eligibility on an annual basis. Coordinate referrals tracking and follow up for patient enrolled in the BMT Program. 	1.0 FTE each	The staff hired will possess experience in outreach, case management and working with difficult populations. They will have knowledge of community resources and entitlements.
Program Evaluator	TBD	<ul style="list-style-type: none"> Conduct an annual evaluation of the program including assessment of goals, objectives and outcomes. 		The program evaluator will be detail oriented and have experience conducting successful evaluations for federal grant programs.

- Discuss how key staff have demonstrated experience and are qualified to serve the populations of focus and are familiar with their culture and language.

Dr. Marwan Haddad is the Medical Director of HIV, HCV, and Buprenorphine Services for over 5 years. He is the Medical Director of the RW Part C grant. He is trained in family medicine and public health and has been an HIV specialist for the past 15 years, a Hepatitis C expert for the past 7 years, and he has been certified in buprenorphine treatment since 2006. He has been a champion of these underserved and disenfranchised populations, recognizing the intersecting nature of HIV, Hepatitis C and substance abuse and the importance of integrating the management of these diseases into primary care. He was presented with the 2011 Primary Care Leadership Award by the Connecticut Center for Primary Care for his work in this arena. He has been a leader in expanding this integrated model of care across all sites at CHCI and has taught and lectured at CHCI and at state and national conferences on a variety of topics including buprenorphine and integrated care. He has conducted research at CHCI and published on buprenorphine treatment outcomes at FQHCs as well as on replication of the HCV ECHO model at CHCI. Dr. Haddad has been an integral and essential leader in adapting the ECHO model and launching Project ECHO HIV and HCV at CHCI. He has successfully led the ECHO HIV/HCV program on a weekly basis for the past 15 months since its inception.

Agi Erickson, The Project ECHO Coordinator has 8 years of experience working with populations affected by substance use, first as the Program Director of CHCI's Healthcare for the Homeless Program and now as the Project ECHO Coordinator involved in the overall oversight of Project ECHO HIV/HCV. Ms. Erickson has served on committees aimed at reducing health disparities and ending homelessness in New Britain, Meriden and Middletown. She has directly supervised the substance abuse staff working with the Healthcare for the Homeless Program and was responsible for monitoring appropriate referral to CHCI sites for BMT on a regular basis. As the Project ECHO coordinator Ms. Erickson works in CHCI's Quality improvement Department, utilizing the tools and support of that department to ensure the highest quality measures for Project ECHO.

Kasey Harding – Wheeler, the Project Director, is CHCI's Director of Integrated Care for Special Populations. This department is responsible for the recruitment, care and support of patients in populations like HIV, Hepatitis C and homeless individuals where major health disparities occur and support services are tailored to the specific needs of the populations served. Ms. Harding – Wheeler has worked in the HIV field for over 17 years providing oversight for federal, state, city and local grant funding. In 2005 Ms. Harding – Wheeler completed a 6 week training in the Lewin model of Cultural competency designed around the core value of understanding the communities you serve and the sociocultural influence on individual's health beliefs and behaviors.

As noted above, the key staff involved in the implementation of Project ECHO BMT program have over 40 years of combined experience serving populations hardest hit by substance abuse. Accomplishments include publications about the care of opiate dependent patients, speaking engagements on a variety of related topics, and esteem and respect from patients and colleagues alike. All Project ECHO BMT staff have a commitment to serving the underserved and improving the lives of those suffering with substance abuse and addiction. In addition to having clinical expertise in the arena of opiate dependence, Project ECHO BMT staff have impressive sensitivity to the complex psychosocial needs of this challenging population, as evidenced by the

efforts put into creating a multidisciplinary care team and seeking out funding and assistance to support our efforts to expand BMT whenever possible.

On a larger scale, CHCI has a commitment to providing the care that people need in the most culturally sensitive and comfortable manner possible. All CHCI staff participates in cultural competency training on an annual basis. The training includes issues related to culture, language, gender, sexual orientation, income level and other perceived stigmas. One of the most important tools that CHCI has for ensuring that patients receive care in the language they are most comfortable speaking is the Language Line. Any staff at CHCI can access a qualified medical translation service by using the telephone line in the exam room. The staff person chooses from a list of languages and within minutes is connected to translation services.

Section E: Data Collection and Performance Measurement

- Document your ability to collect and report on performance measures. Describe your plan for data collection, management, analysis and reporting.**

For comprehensive data collection, management, and analysis, CHCI proposes the creation of a research database into which all relevant study information will be entered and tracked.

1. Provider measures
 - a. Demographics: Provider details will be collected and will include provider age, specialty, training, years in practice, and part time/full time status.
 - b. Self-assessment: Project ECHO BMT participants will complete a baseline BMT self-efficacy survey and repeat the survey at six months and one year of participation.
 - c. Pharmacologic management: Data on all medications prescribed will be collected.
2. Patient measures
 - a. Demographics: All relevant patient clinical information will be obtained from the electronic health records and from case presentation forms including patient demographics, co morbid conditions, medication lists, social history, past medical history, and laboratory results relevant to BMT.
 - b. Performance Measures: the number of patients screened, assessed and treated will be collected and assessed indicating our success in reaching our target population. Patients' length of time retained on BMT and in primary care will be evaluated. Opioid, cocaine, and other illicit substance use will be monitored. BMT patients will be monitored for health screenings such as HIV, HCV, and cancer screenings as well as for chronic disease management such as hemoglobin A1C, blood pressure, and lipid targets.
 - c. Complications: We will track all treatment related complications through data collected at each weekly case presentation and, when necessary, through chart reviews
3. Project ECHO BMT implementation: Data on Project ECHO BMT clinics will be collected each week to monitor the number of clinics attended per clinician, the number of cases presented per clinician and the manner in which each participant connects to the conference (conference call, teleconference, personal computer, tablet, smartphone). At a minimum, quarterly focus groups of ECHO participants from different disciplines and sites will elicit

- feedback on the process, content, and organization of the sessions. Adjustments to the sessions will be made on a regular basis if required.
4. Data Analysis: Analysis of data collected will take place through CHCI's Health Data Information department and will include all measures relevant to the success of the program.
 5. Data Reporting: Reporting will take place in two ways. The first is a presentation twice a year to all Project ECHO BMT faculty and participants in order to assess the strengths and weaknesses of current practices. The second will be in federal monitoring reports submitted at regular intervals.
- Describe the data driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed and reduced.

The Weitzman Center for Research and Innovation in Community Health and Primary Care, established in 2005 by CHCI, has served as the institutional home of CHCI's research and development. One of the principal elements of the Weitzman Center's research agenda is the study of quality improvement (QI) and system redesign strategies for healthcare delivery. CHCI's quality improvement team is developing and studying a unique quality improvement infrastructure using the latest tools and techniques from both healthcare, and non-healthcare industry. The Project ECHO Coordinator position is under the umbrella of CHCI's Quality Improvement Department, providing access to the tools and training on a daily basis. The data collected will be analyzed and used on a weekly basis to determine if we are reaching our target population and if patients are experiencing the expected outcomes. If at any time the proposed outcomes are not being met, adjustments will be made in outreach, recruitment, assessment and treatment plans. The four measurable outcomes of focus for this proposal are:

- 1) Access to BMT for underserved populations will increase throughout the communities served by CHCI with the continuous training of new providers at CHCI sites through Project ECHO BMT.
- 2) Patient retention in substance abuse treatment will increase as a result of technology-enhanced care coordination and wrap around support services.
- 3) Patient primary care outcomes including routine screenings and chronic disease management will improve with the ultimate goal of increasing the overall health of individuals receiving BMT.
- 4) Patient education on other risk factors associated with substance abuse will be addressed on a regular basis thereby increasing the likelihood of behavior changes.

- Describe your plan for conducting the local performance assessment and document your ability to conduct the assessment.

The research analysis and evaluation of The Project ECHO BMT Program will be done by a subcontractor who specializes in program evaluation and has a successful history working with CHCI. The evaluation will be focused on the primary goals of the program. We will determine the impact of the intervention on a variety of outcomes including provider practice variables, patient outcomes, and organizational outcomes. The Principle Investigator and Project Director will monitor the program and its impact on provider and patient measures. Operational data on Project ECHO BMT sessions will be collected prospectively and reviewed regularly by the

Principal Investigator, with ongoing evaluation and process improvement during the project period.

The evaluation will be guided by questions about the implementation, scope, and impact of Project ECHO BMT, focusing specifically on patient and provider outcomes. Quality of BMT will be evaluated by analyzing both patient and providers measures, as well as, analyzing provider and patient survey tools at specific intervals.

Section F: Electronic Health Record Technology

- Identify your EHR system and include a copy of your EHR vendor contract.

CHCI uses the eClinicalWorks (ECW) Electronic Medical Record (EMR) in conjunction with GE Centricity Practice Solution for billing and scheduling management. All data will be retrieved from these two systems, de-identified, and analyzed by the study team. All data retrieval queries will be validated by random chart reviews of at least 25 records. Data elements will include the patient's primary care provider name and degree, their demographics, patient self-reported pain scores, medication prescribing records, laboratory results, opioid agreement use, and behavioral health and medical referrals. The data will be cleansed extensively to adjust for variation in free text charting, particularly in data fields containing medication frequency and dosages.

SAMSHA Grants to Expand Care Coordination through the Use of Technology Assisted Care in Targeted Areas of Need
 RFA #TI-13-008; CFDA #93.243
 Budget Period: 9/1/13-8/31/14

Community Health Center, Inc.
 Project Period: 9/1/13 through 8/31/16

Personnel	Role on Project	Base Salary	% FTE	Amount on Grant	Justification
Marwan Haddad, MD	Principal Investigator	\$ 179,700	10%	\$ 17,970	The Principal Investigator will ensure that all program goals and objectives are being met and monitor on a regular basis. This position is key personnel.
Kasey Harding	Project Director	\$ 74,963	10%	\$ 7,496	The Project Director will directly supervise the staff involved in the project and oversee the implementation, administration, fiscal and programmatic functions of the project. This position is key personnel.
Agi Erickson	Project ECHO Coord.	\$ 65,000	50%	\$ 32,500	The Project ECHO Coordinator will provide specific coordination for project ECHO BMT including monitoring of referrals, case presentations, data collection and communication between providers and faculty. This position is key personnel.
TBH	IT Specialist/Data Coord	\$ 92,560	40%	\$ 37,024	The IT Specialist will purchase and install IT technology equipment. Continually maintain the system and provide IT support. This person will also collect the data, analyze the data for accuracy and disseminate the data to the program staff.
TBN (1)	Patient Navigator	\$ 37,274	100%	\$ 37,274	The Patient Navigator will provide the outreach, care coordination, enrollment and referral tracking and follow-up as well as other tasks listed in the program narrative.
Primary Care Providers (12) MD/NP	Clinicians	\$ 130,000	5%	\$ 78,000	The Primary Care Providers will participate by providing screenings, assessments and treatment to patients as well as participating in the meetings and case presentations.
Personnel Total				\$ 210,264	
Fringe Benefits					CHCI total fringe benefits rate is @ 25%. The breakout of that 25% total fringe rate for each category that makes up the 25% rate is identified in the left column.
FICA @ 7.65%				\$ 16,085	
Unemployment @ .75%				\$ 1,577	
Workers Comp. @ .82%				\$ 1,724	
Health Insurance @ 11.1%				\$ 23,339	
Pension @ 4.17%				\$ 8,768	
Long term disability @ .51%				\$ 1,072	
Fringe Benefits Total				\$ 52,566	
Supplies	Ipads (12)	12*829 each		\$ 9,948	12 Ipads will be used by the providers and staff for participating in videoconferencing and recording data for program
printing educational materials	1140			\$ 1,140	printing educational materials at an estimated number of 1,000 copies of color at .24 cents per copy and an estimated 9,000 copies of black and white copy at .10 cents per copy.
Supplies Total				\$ 11,088	
Travel	2000 miles x .565 per mile			\$ 1,130	Total estimated local travel between sites for all staff is 2,000 miles at .565 cents per mile

Travel for 2 to conference in Washington DC	2160			\$ 2,160	Travel for two staff to travel to Washington for annual meeting at approx. \$300 per person for the flight; \$200 per night for 3 nights per person, and approx. \$60 per day meal allowance per person for 3 days total.
Total Travel				\$ 3,290	
Grant total				\$ 277,208	

SAMSHA-Grants to Expand Care Coordination through the Use of Technology Assisted Care in Targeted Areas of Need

Community Health Center, Inc.

RFA #T1-13-008

9/1/14-8/31/15

Personnel	Role on Project	Base Salary	% FTE	Amount on Grant	Justification
Marwan Haddad, MD	Principal Investigator	\$ 179,700	10%	\$ 17,970	The Principal Investigator will ensure that all program goals and objectives are being met and monitor on a regular basis. A COLA increase is not included because of the salary cap. This position is key personnel.
Kasey Hardling	Project Director	\$ 77,212	10%	\$ 7,721	The Project Director will directly supervise the staff involved in the project and oversee the implementation, administration, fiscal and programmatic functions of the project. This position is key personnel.
Agi Erickson	Project ECHO Coord.	\$ 66,950	50%	\$ 33,475	The Project ECHO Coordinator will provide specific coordination for project ECHO BMT including monitoring of referrals, case presentations, data collection and communication between providers and faculty. This position is key personnel.
Nick Ciaburri	IT	\$ 95,337	40%	\$ 38,135	The IT Specialist will purchase and install IT technology equipment. Continually maintain the system and provide IT support. This person will also collect the data, analyze the data for accuracy and disseminate the data to the program staff.
TBN (1)	Patient Navigator	\$ 38,392	100%	\$ 38,392	The Patient Navigator will provide the outreach, care coordination, enrollment and referral tracking and follow-up as well as other tasks listed in the program narrative.
Primary Care Providers (12) MD/NP	Clinicians	\$ 133,900	5%	\$ 80,340	The Primary Care Providers will participate by providing screenings, assessments and treatment to patients as well as participating in the meetings and case presentations.
Personnel Total				\$ 216,033	
Fringe Benefits					
FICA @ 7.65%				\$ 16,527	CHCI total fringe benefits rate is @ 25%. The breakout of that 25% total fringe rate for each category that makes up the 25% rate is identified in the left column.
Unemployment @ .75%				\$ 1,620	
Workers Comp. @ 82%				\$ 1,771	
Health Insurance @ 11.1%				\$ 23,980	
Pension @ 4.17%				\$ 9,009	
Long term disability @ .51%				\$ 1,102	
Fringe Benefits Total				\$ 54,008	
Supplies					
printing educational materials	1140			\$ 1,140	printing educational materials at an estimated number of 1,000 copies of color at .24 cents per copy and an estimated 9,000 copies of black and white copy at .10 cents per copy.
Supplies Total				\$ 1,140	
Other Expenses					

Program Evaluation			\$ 5,500	the program evaluation will consist of an annual evaluation that will include an assessment of goals, objectives and outcomes.
Other Expenses Total			\$ 5,500	
Travel	2000 miles x .565 per mile		\$ 1,130	Total estimated local travel between sites for all staff is 2,000 miles at .565 cents per mile
Travel for 2 to conference in Washington DC	2160		\$ 2,160	Travel for two staff to travel to Washington for annual meeting at approx. \$309 per person for the flight, \$206 per night for 3 nights per person, and approx. \$62 per day meal allowance per person for 3 days total.
Total Travel			\$ 3,290	
Grant total			\$ 279,971	

A 3% cost of living increase has been included in years 2 and 3 for all personnel except the Principal Investigator.

The PI's salary does not reflect a cost of living increase due to the salary cap limit.

A 3% increase was calculated into the travel budget to account for marginal estimated increases.

SAMSHA-Grants to Expand Care Coordination through the Use of Technology Assisted Care in Targeted Areas of Need
 Community Health Center, Inc.
 RFA #TI-13-008
 9/1/15-8/31/16
 Project Period: 9/1/13 through 8/31/16

Personnel	Role on Project	Base Salary	% FTE	Amount on Grant	Justification
Marwan Haddad, MD	Principal Investigator	\$ 179,700	10%	\$ 17,970	The Principal Investigator will ensure that all program goals and objectives are being met and monitor on a regular basis. A COLA increase is not included because of the salary cap. This position is key personnel.
Kasey Harding	Project Director	\$ 79,528	10%	\$ 7,953	The Project Director will directly supervise the staff involved in the project and oversee the implementation, administration, fiscal and programmatic functions of the project. This position is key personnel.
Agi Erickson	Project ECHO Coord.	\$ 68,959	50%	\$ 34,479	The Project ECHO Coordinator will provide specific coordination for project ECHO BMT including monitoring of referrals, case presentations, data collection and communication between providers and faculty. This position is key personnel.
Nick Ciaburri	IT	\$ 98,197	35%	\$ 34,369	The IT Specialist will purchase and install IT technology equipment. Continually maintain the system and provide IT support. This person will also collect the data, analyze the data for accuracy and disseminate the data to the program staff.
TBN (1)	Patient Navigator	\$ 39,544	100%	\$ 39,544	The Patient Navigator will provide the outreach, care coordination, enrollment and referral tracking and follow-up as well as other tasks listed in the program narrative.
Primary Care Providers (12) MD/NP	Clinicians	\$ 137,917	5%	\$ 82,750	The Primary Care Providers will participate by providing screenings, assessments and treatment to patients as well as participating in the meetings and case presentations.
Personnel Total				\$ 217,065	
Fringe Benefits					
FICA @ 7.65%				\$ 16,605	CHCI total fringe benefits rate is @ 25%. The breakout of that 25% total fringe rate for each category that makes up the 25% rate is identified in the left column.
Unemployment @ .75%				\$ 1,628	
Workers Comp. @ .82%				\$ 1,780	
Health Insurance @ 11.1%				\$ 24,094	
Pension @ 4.17%				\$ 9,052	
Long term disability @ .51%				\$ 1,107	
Fringe Benefits Total				\$ 54,266	
Supplies					
printing educational materials	264			\$ 264	printing educational materials at an estimated number of 600 copies of color at .24 cents per copy and an estimated 1,200 copies of black and white copy at .10 cents per copy.
Supplies Total				\$ 264	
Other Expenses					

Program Evaluation			\$ 5,100	the program evaluation will consist of an annual evaluation that will include an assessment of goals, objectives and outcomes.
Other Expenses Total			\$ 5,100	
Travel	2000 miles x .565 per mile		\$ 1,130	Total estimated local travel between sites for all staff is 2,000 miles at .565 cents per mile.
Travel for 2 to conference in Washington DC			\$ 2,171	Travel for two staff to travel to Washington for annual meeting at approx. \$318 per person for the flight, \$212 per night for 3 nights per person, and approx. \$64 per day meal allowance per person for 3 days total.
Total Travel			\$ 3,301	
Grant total			\$ 279,996	

A 3% cost of living increase has been included in years 2 and 3 for all personnel except the Principal Investigator.
 The PI's salary does not reflect a cost of living increase due to the salary cap limit.
 A 3% increase was calculated into the travel budget to account for marginal estimated increases.

Section G: Citations:

- (1) Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2010 and 2011 (2010 Data-revised March 2012)
- (2) Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS). Data received through 10.10.11
- (3) Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. (July 2, 2012) The DAWN Report: Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville, MD.
- (4) Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. (January 8, 2013). The National Survey on Drug Use and Health (NSDUH) Report State Estimates of Non-medical Use of Prescription Pain Relievers. Rockville, MD.
- (5) State of Connecticut. Department of Public Health Report to General Assembly. Public Act 03-159. A Report on Fatal and Non Fatal Drug Overdoses in Connecticut. Prepared by MM Hynes, LM Mueller: January 2004.
- (6) Stratton A, Hynes MM, Nepaul AN. The 2009 Connecticut Health Disparities Report. Hartford, CT: Connecticut Department of Public Health, 2009.
- (7) Substance Abuse and Mental Health Services Administration, 2010. The N-SSATS Report: HIV Services Offered by Substance Abuse Treatment Facilities. In: Quality, C.f.B.H.S.a. (Ed.), Rockville, M.D.
- (8) Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2011. Data on Substance Abuse Treatment Facilities. BHSIS Series S-64. HHS Publication No. (SMA) 12-4730. Rockville, MD: SAMHSA, 2012.
- (9) Arora S, Thornton K, Murata G, Deming P, Kalishman S, Dion D, Parish B, Burke T, Pak W, Dunkelberg J, Kistin M, Brown J, Jenkusky S, Komaromy M, Qualls C. Outcomes of treatment for hepatitis C virus infection by primary care providers. N Engl J Med. 2011 Jun 9;364(23):2199-207. Epub 2011 Jun 1.
- (10) Haddad M S, Zelenov A, Altice F L. Integrating buprenorphine maintenance therapy into federally qualified health centers: Real world substance abuse treatment outcomes. *Drug Alcohol Depend.* (2013), <http://dx.doi.org/10.1016/j.drugalcdep.2012.12.008>

Section H: Job Descriptions and Bio sketches

Community Health Center, Inc.

Job Description

I. Heading

Title: Medical Director of HIV/HCV/Suboxone Services

Reports to: Chief Medical Officer

Component: Medical

Date revised: 3/1/2013

Status: Exempt

II. General Responsibilities

The Medical Director of HIV/HCV/Suboxone Services is responsible for providing clinical leadership for the HIV, Hepatitis C and Suboxone Programs at CHC. The clinical director provides direct patient care to a panel of patients with HIV/Hepatitis C and Substance Abuse issues. In addition the Medical Director provides consultation, guidance, training to the clinical provider staff and oversight of the program to ensure that care of the HIV/HCV Suboxone patients meet the latest treatment criteria.

III. Required Qualifications

MD/DO from approved school, Graduate of an accredited residency program in family practice, internal medicine, pediatrics or OB/GYN. Board certified within 24 months of commencing employment at CHC. Maintains appropriate board certification, licensure and professional organizations. Evidence of advanced training and experience in the management of HIV/HCV and Suboxone, as evidenced by clinical experience and CME logs.

IV: Primary Job Functions

1. Provide direct HIV Specialty care to CHC patients including management of ARV therapy, OI prophylaxis and other preventive services.
2. Provide direct HCV specialty care services including management of ARV medications, patient education, preventive services and management of complications.
3. Provide direct specialty care in Buprenorphine Maintenance Therapy to CHC patients including referral and follow up when more intensive treatment is required.
4. Provide agency wide oversight of the HIV/HCV/Suboxone programs and the patients being seen by CHC providers including consultation, precepting, guidance and treatment initiation assistance.
5. Serve as direct supervisor to RW nurse care coordinators.
6. Monitor the performance of all Ryan White, HCV and BMT clinical staff and provide training on a regular basis to ensure that all clinical staff are as updated as possible on the latest treatment guidelines and outcome measures.
7. Define and update the standards of care for all patients receiving care in the HIV/HCV/Suboxone programs.
8. Actively monitor the literature and guidelines for treatment and provide regular updates for all CHC clinicians. This can be accomplished in the form of memos, emails, in-service/education.
9. Develop protocols that define the standards of care for all programs.
10. Review the charts of patients receiving treatment in HIV/HCV/Suboxone on a regular basis to ensure the highest quality of clinical care.
11. In partnership with the HIV Director, conduct quality improvement activities and meeting no less than quarterly. These reviews should include program outcomes, selection of QI Projects, Monitoring of outcomes and education and program development options for staff.
12. Supervise the clinical data collection, analysis and assessment for all programs.

V: Physical Environment

Office Environment and frequent travel to site locations with occasional travel out of state for training.

VI. Work Schedule

Flexible, Exempt position, 40+ hours

VII: Confidentiality

Community Health Center, Inc

Job Description

I: Heading

Title: Director of HIV Services

Component: HIV/HCH

Reports to VP/Clinical Director

Revised: 3/1/2013

Status: Exempt

II: General Responsibilities

The Director of Integrated Care for Special Populations supervises and coordinates all aspects of the agency HIV/HCV and Healthcare for the Homeless Programs. General responsibilities include; overall administrative oversight of grant funding including fiscal, programmatic and administrative support, Coordination of services to promote healthy and stable individuals in the programs served, Data collection and reporting for grants and contracts on a timely basis, and development of community contacts to help carry out the mission of the programs.

III. Required Qualifications

1. BA/BS required, Master's a plus
2. Prior supervisory experience in a health and human service position.
3. In depth knowledge of HIV
4. Understanding of community resources
5. Excellent oral and written communication
6. Prior experience in working with federal, state and local funders including grant reporting and compliance.

IV. Significant Job Responsibilities

1. Recruit, hire, train and supervise staff and evaluate staff on an annual basis.
2. Write, maintain and update policies and procedures as needed and ensure staff compliance.
3. Meet regularly with staff of major service providers in HIV/AIDS, Mental Health, SA and Primary care arenas
4. Monitor productivity on a regular basis using data trends regarding volume and charges.
5. Prepares, oversees, develops quarterly and annual reports for all grant funded programs.
6. Collaborates with site directors and senior health care analyst in preparation of grant application for assigned programs and services.

V. Physical Environment

Office environment and frequent travel to site locations with occasional travel to grant funding organizations to include outside of CT.

VI. Work Schedule

Flexible, Exempt, 40+ hours on a regular basis

VII. Confidentiality

Must remain vigilant and constant confidentiality as part of job function.

**COMMUNITY HEALTH CENTER
JOB DESCRIPTION**

Title: Project ECHO Coordinator
Component/Dept: Administrative

Reports To: VP-CQO
Emp. Status: Exempt

II. GENERAL RESPONSIBILITIES

The Project ECHO Coordinator is responsible for the overall project management of CHC's Project ECHO initiative, an innovative telemedicine program that provides specialty consultation, care management, and education to primary care providers at the Community Health Center, Inc. The project coordinator is responsible for carrying out specific tasks related to conducting Project ECHO sessions as well as overseeing the development, growth, and sustainability of the ECHO model. The coordinator is also responsible for completing tasks related to all current and future grants funding ECHO, including the Vertex Circle of Hep C Care Grant, Mayday Fund Project STEP-ing Out, and the Cox Foundation Community Investment Grant.

Specific responsibilities for this position include coordination of Project ECHO sessions (tasks including but not limited to: blocking provider schedules, booking rooms and video-conferencing equipment, and room set up), coordinating patient case presentations with PCPs and ECHO faculty, coordinating didactics with the ECHO faculty team, attending weekly ECHO sessions, tracking of attendance and participation, monitoring documentation in the EHR, coordinating CME credit, documenting and report running via a web-based program, administering surveys, tallying results, data collection, and other tasks as assigned. The ECHO coordinator is also expected to collaborate with other CHC staff to obtain additional grant funding to support ECHO, develop a financial model for sustainability, and promote growth and sustainability of the ECHO model. To this end the ECHO Coordinator will take a lead role in discussing, publicizing, and presenting the model in a variety of forums. The ECHO coordinator will work collaboratively with other members of the Weitzman Institute for Research and Innovation in Primary Care to conduct research and develop publications about the ECHO model. In order to be expert in CHC's QI methodology, a skill that is vital to ECHO project success, the ECHO coordinator will also be expected to obtain training as a CHC QI coach and to support CHC QI Microsystem teams as part of ongoing training and development for this position.

III. REQUIRED QUALIFICATIONS

- Degree in a related discipline; Proven experience supporting administrative projects
- Strong communication, organizational, time-management, prioritization, multi-tasking, and interpersonal skills; Knowledge of electronic health record systems; Demonstrated proficiency in Microsoft Office and internet related applications; Current Driver's license

IV. SIGNIFICANT JOB RESPONSIBILITIES

- Responsible for Project ECHO session arrangements and maintenance; Attending weekly ECHO sessions; Provide clerical, organizational and technical support for ECHO participants and faculty; Record and maintain ECHO session clinic data: attendance, patient presentations, didactics via web-based program; EHR chart audits/data collection; Administering surveys; Develop financial model for offering ECHO to outside sites; Assist in developing and implementing additional Project ECHO clinics; Obtain training in QI coaching and practice QI coaching skills with active CHC Microsystem teams; Conduct literature reviews; Assist with data collection and analysis; Assist with manuscript development for ECHO research papers; Assistants with preparation of grant applications
- Develop Power Point presentations; Attend CHC's Dartmouth eCoach the Coach trainings; Serve as a QI coach for at least one QI Microsystem team; Professional responsiveness and adaptability to rapid change; Travel between sites;

V. COMMUNICATION SKILLS & CONFIDENTIALITY OF INFORMATION

Excellent oral and written skills are required. This position is highly involved with staff, providers, clients, colleagues, outside vendors and community.

Confidentiality of business information is a requirement. Confidentiality must be maintained according to CHC policies.

Curriculum Vitae

Marwan S. Haddad, M.D., M.P.H., AAHIVS

134 State Street, Meriden, CT 06450

Tel: 203.980.6248; haddadm@chc1.com

Education:

Johns Hopkins School of Public Health, Baltimore, Maryland;
Masters in Public Health-2006-2010

University of Toronto School of Medicine, Toronto, Ontario, Canada
Residency in Family Medicine-1997-99

McGill University School of Medicine, Montreal, Quebec, Canada
Doctor of Medicine-1993-97

McGill University, Montreal, Quebec, Canada
Pre-Medicine Requirements 1991-92

Harvard University, Cambridge, Massachusetts
Bachelor of Arts-1987-91
Concentration in Government and International Relations

Work Experience:

Medical Director of HIV, Hepatitis C, and Buprenorphine Services,
Community Health Center (CHC), Inc, New Britain, Meriden, and
Middletown, Connecticut-2008-present

HIV Specialist & Primary Care Provider, HIV and General Medicine
Community Health Center (CHC), Inc, New Britain, Connecticut-2006 – 2008

HIV Clinical Mentor, International Center for Equal Healthcare Access
& Clinton Foundation HIV/AIDS Initiative, Lesotho, Southern Africa-2006

HIV Specialist & Primary Care Provider, HIV and General Medicine
St. George Medical Arts Center-Toronto, Ontario, Canada-1999 – 2005

Medical Staff, Sexually Transmitted Diseases Hassle Free Community Clinic
Toronto, Ontario, Canada- August 1999 - August 2005

Licenses & Training: American Board of Family Medicine Certification 2007-2014

American Academy of HIV Medicine HIV Specialist Certification
2007-2014

Buprenorphine Licensure and Certification 2006-present

Hepatitis C Educational Symposium

National Association of Community Health Centers (NACHC) Training
Workshop
San Diego, CA, October 15-17, 2006

Primary Care Management of Hepatitis C: Train the Trainer
College of Family Physicians of Canada Workshop
Toronto, Ontario, Canada, November 10, 2002

- Honors:
- Primary Care Leadership Award, 2011
Connecticut Center for Primary Care
 - Cumulative GPA 4.0, Johns Hopkins School of Public Health
 - Chief Resident, Wellesley/St. Michael's Hospital, Family Medicine Program,
University of Toronto School of Medicine
 - Chair, Section of Residents, College of Family Physicians of Canada
 - Dean's Honor List, McGill University School of Medicine
 - Cum Laude*, General Studies, Harvard University
 - Dean's Honor List, Harvard University

- Publications:
- Khushbu K, **Haddad M**, Anderson D. Project ECHO: Replicating a Novel Model to Enhance Access to Hepatitis C Care in a Community Health Center. *Journal of Health Care for the Poor and Underserved*. *In press*
 - Haddad M S**, Zelenev A, Altice F L. Integrating buprenorphine maintenance therapy into federally qualified health centers: Real world substance abuse treatment outcomes. *Drug Alcohol Depend.* (2013), <http://dx.doi.org/10.1016/j.drugalcdep.2012.12.008>
 - Bruce R D, Govindasamy S, Sylla L, **Haddad M**, Kamarulzaman A, Altice F L. Case series of buprenorphine injectors in Kuala Lumpur, Malaysia. *American Journal of Drug and Alcohol Abuse* 2008; 34[4]:511-517.
 - Haddad M**, Inch C, Glazier RH, Wilkins AL, Urbshott GB, Bayoumi A, Rourke S. Patient support and education for promoting adherence to highly active antiretroviral therapy for HIV/AIDS (Cochrane Review). In: *The Cochrane Library*, Issue 3 2002. Oxford: Update Software.
 - Elahi MM, Frenkiel S, Remy H, Just N, **Haddad M**. The development of a standardized reporting proforma for CT scans of the paranasal sinuses. *Journal of Otolaryngology* 1996; 26 [4]:251- 256.

Kathleen Harding
63 Orchard Street
Rocky Hill, CT 06067
(860) 301-1090
hardink@chc1.com

NOTABLE ATTRIBUTES:

- 20 years of experience in the social/human services field, healthcare settings and HIV/AIDS prevention and care.
- Exceptional communication and leadership skills proven in working with people of diverse cultural and socioeconomic settings.
- Commitment to the empowerment of people through organization, education and advocacy.

PROFESSIONAL EXPERIENCE:

Community Health Center, INC. **Meriden, CT**
October 2005 – Present, Director of HIV Services
Responsible for the planning, development and program oversight of three major federal initiatives and several state funded initiatives.
Responsible for the fiscal management of programs using federal, state, local grant funds, as well as, private donations and foundation grants.
Responsible for budget development of CHC's HIV Department; including all grant funded programs and the Oasis Wellness Center.
Developed and implemented Project ECHO – a telehealth based strategy to increase access to care for HIV/Hep C patients throughout Connecticut.
Oversee the Quality Management Team with regard to the 400+ HIV patients in care and the 20+ providers serving them.
Effectively manage the activities and staff of Oasis Wellness Center, a drop-in center for people with HIV that serves 125+ individuals annually.
Developed and implemented DSS funded supportive housing program for people with HIV from the ground up, including writing policy manuals, resident rights and applications.
Responsible for the recruitment, hiring and training of 20+ employees within the HIV Department.
Responsible for providing supervision to case management and outreach staff on a daily basis.
Effectively collaborate with various agencies and service providers in the community to provide service coordination.
Represent CHC on community based planning councils and consortia.
Disseminate information learned through grant funded experience to the public and non-profit sector on behalf of CHC.
Present pertinent information to large audiences at State and National Conferences.

Tabor House, INC
Hartford, CT
January 1998 – October 2005, Program Director

Develop, implement and secure funding for new and innovative projects that assist people with HIV/AIDS in living healthier and more productive lives.

Maintain a current list of donors, corporate funders and businesses that support the mission of the agency.

Generate a proposed budget, actual budgets and financial reports for presentation to the Board of Directors bi-monthly while serving as the liaison between the Board and the agency.

Plan events and recruit volunteers for agency fundraisers, resident activities and recreational outings.

Supervise case managers on a daily basis including compliance with CARC quality standards.

Arriba, INC

La Canada, CA

January 1996 – January 1999, Assistant Director

Supervise the daily running of an agency dedicated to developmentally disabled adults working toward living independently and regaining custody of children in state custody.

Initiate court proceedings on behalf of developmentally disabled adults consumers working toward regaining custody of children from the State of CA.

Presented weekly parenting, budgeting, independent living and vocational education classes to developmentally disabled adults.

Mediated support group for developmentally disabled adult population dealing with the loss of children, lack of family support and the general stress of living with physical and mental limitations.

Responsible for the recruitment, hiring and training of 22 employees as well as conducting employee performance reviews twice a year in collaboration with the Executive Director.

EDUCATION:

University of Connecticut – currently enrolled in Master's of Public Health Program.
(Approximate graduation in December 2012)

Assumption College, Worcester, MA – obtained a BAS in Biology/Human Services – May 1993

CERTIFICATIONS:

- CPR/First Aid Certification – State of CT
- Suicide Prevention Counselor – State of CT
- Medication Administration Certification – State of CT
- HIV/AIDS Education Certification – State of CT

OTHER EXPERIENCE:

- | | |
|-------------------------------------------|----------------|
| • CT AIDS Resource Coalition Board Member | 2009 - present |
| • Licensed Connecticut Foster Parent | 2000 - present |
| • Rape Crisis Counselor | 1999 – present |

REFERENCES FURNISHED UPON REQUEST

Agnes T. Erickson
51 Southfork Circle
Planstville, CT 06479
203-910-1545
karintia@yahoo.com

OBJECTIVE:

Energetic and dedicated project manager with the ability to create strong personal relationships and drive to consistently exceed expectations that will result in complete success of the program or operation.

EDUCATION & TRAINING:

Quinnipiac University, Hamden, CT

Masters Degree in Organizational Leadership – Degree anticipated in 2014

Central Connecticut State University, New Britain CT

Bachelors Degree in Business Management

- Denver Health Lean Academy, Denver, CO
Lean Training – Denver Health Black Belt
- **Advanced Facilitation Training with Ingrid Bens**
- The Dartmouth Institute Microsystems Academy, Lebanon, NH
Coaching Clinical Microsystems
- GE workshop - **Six Sigma, Lean and the Change Acceleration Process**

EXPERIENCE:

1/04 – Present Community Health Center, Inc., Middletown/New Britain CT

Weitzman Center for Research and Innovation in Primary Care – Quality Improvement
Project ECHO Manager (8/12-present)

- Day to day management of CHC's Project ECHO. This is an innovative hi-tech tele-medicine program that uses teleconferencing, electronic health records, disease management, and case-based learning to expand access to specialty care for underserved patients.
- Manage and provide operational leadership for current (Hep C, HIV, and Chronic Pain) and future (Buprenorphine and Care Coordination) initiatives.
 - Project ECHO for Pain Management connecting 13 health centers' primary care medical and behavioral health providers with a specialty team from Arizona
- Manage Project ECHO weekly sessions, patient case presentations with PCP's, and didactics with the faculty team. Track and evaluate operational metrics.
- Collaborate with CHC staff to obtain additional funding and develop a financial model for sustainability and promote growth of the echo model.
- Leadership role in discussing, publicizing and presenting the echo model in a variety of forums.
- **Clinical Microsystems Coach**
 - Coaching Interdisciplinary Clinical Microsystems Team using scientific tools such as 5P's, Process Mapping, Fishbone, Flowcharts, PDSA, SDSA) Focusing on health system improvement work specifically on the design and redesign of small, functional clinical units for a seamless, patient-centered, high quality, safe, and efficient health system.

Program Manager (1/06-8/12)

- Provide operational leadership for achievement of the complex Wherever You Are (WYA) project and its goals with excellence.

- Oversee the daily operation of the WYA program to include fiscal management, program staff supervision, data collection, reporting, oversight of program planning and implementation, and training/in-service coordination.
- Effectively manage five full time and seven part-time clinical and administrative staff (APRN, LADC, RN, LCSW, PsyD, ATC)
- Successfully maintained DPH licensure for seven sites with 21 licenses for medical outpatient, psychiatric outpatient and substance abuse for over six years.
- Develop and maintain positive working relationships with shelter staff and community agencies. Maintain compliance with all contract requirements.
- Participate in local, state and national forums on improvement of health care for the homeless.
- **Clinical Microsystems Coach**

Program/Site Administrator (1/04-1/06)

- Provided technical, clerical, and organizational support to the HCAP Project Director, Site Director, and the HCAP staff.
- Coordinated and organized all administrative aspects of the HCAP project, including data collection and preparation of documentation for grant reporting, agenda and minutes for internal and external meetings, and the creation of promotional materials for the HCAP Project.
- Assisted the Site Director of CHC of New Britain in the administrative functions necessary to support the operation of the site.
- Trained all CHC of New Britain employees on new time and attendance software "NovaTime".

9/01 – 1/04 Kimchuk, Inc., Danbury CT

Administrative Assistant

- Provided a full range of administrative support to the Manager of Human Resources including all aspects of payroll, time keeping and confidential personnel records.

COMPUTER SKILLS:

MSWord (Level 3 Certification)	Excel (Level 3 Certification)
PowerPoint (Level 2 Certification)	QuarkXpress 6.0 (Level 2 Certification)
Outlook (Level 2 Certification)	Publisher (Level 1 Certification)
Photoshop (Level 1 Certification)	E-mail and Internet Research (Expert)
Centricity (Patient Management Software)	E-Clinical Works (EMR)
QuickBooks (Level 1 Certification)	SharePoint (Level 1 Certification)
Project Management (Level 1 Certification)	Visio (Level 1 Certification)

SUMMARY:

Dedicated and effective manager with strong interest in working with my employer to enhance operations and foster a sense of teamwork among staff members. A strong leader who is always willing to teach and mentor peers. Open to constructive feedback and continuous improvement.

Section I: Confidentiality/SAMHSA Participant Protection/Human Subjects Guidelines

CHCI has a thorough policy on the protection of patient confidentiality and operates all of our patient data portals through our own secure server. All data will be collected by CHCI staff that is trained in the confidentiality of patient information and data will be entered directly into our secure database to avoid any breach of confidentiality. CHCI acquires informed consent from all patients at their first visit and proposes to obtain a separate informed consent from patients when they are asked to participate in patient satisfaction surveys or focus groups directly related the SAMHSA grant. The informed consent will contain all potential benefits or risks involved with completing the survey and having individual clinical data attached. Informed consent for participation in the survey portion of the grant will include initials on each page to ensure that each patient has read the consent and understands the information before the final signature.

CHCI ensure the fair selection of participants by setting up criteria for eligibility and enrolling patients in the program on a first come first serve basis if they are eligible. All participation in CHCI programs is voluntary and may be discontinued by patients at any time.

Attachment 1

The identification of at least one experienced, licensed mental health/substance abuse treatment provider organization: Community Health Center, Inc. will serve as the provider organization for the purposes of this grant proposal. Community Health Center, Inc. has been providing mental health and substance abuse services throughout Connecticut for 30 years. All licenses and certifications for professionals working within this field are held by our credentialing specialist, Bain Patrie. The Director of Behavioral Health, Tim Kearney, PhD oversees all providers in this department.

Buprenorphine BHP Survey

***1. Please enter your survey ID number.**

***2. What is your degree?**

- APRN
- Psy.D.
- Ph.D.
- LCSW
- LMFT
- LADC
- Other (please specify)

***3. Have you had any training in addiction medicine?**

- Yes
- No

***4. Have you had training specifically in...**

	Yes	No	N/A
Opioid-dependence?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Buprenorphine BHP Survey

***5. How many hours of Continuing Medical Education focused on addiction treatment have you completed in the last 2 years?**

***6. Have you treated patients with opioid dependence on buprenorphine?**

Yes

No

Buprenorphine BHP Survey

***7. If yes, what was therapy format?**

- Individual
- Group
- Both individual and group
- N/A

***8. If yes, approximately how many total years and months have you treated patients with opioid dependence who are on buprenorphine? Please complete both fields, entering '0' where applicable. If you have not treated these patients, please enter 0.**

Years

Months

***9. If yes, approximately how many patients total have you treated? If you have not treated patients on buprenorphine, please enter 0.**

***10. If you are treating patients who are on buprenorphine, how many patients are you currently treating? Please enter 0 if you are not.**

***11. If you have questions about buprenorphine treatment, where do you get your answers from?**

- Colleagues within CHC
- Colleagues outside of CHC
- Journals
- Online websites
- CME
- Certification course materials
- Course instructor (if taken in person)
- Pharmaceutical company representative
- Pharmacist
- Other (please specify)

Buprenorphine BHP Survey

***12. Are you registered for the Connecticut Prescription Monitoring Program?**

Yes

No

N/A

Buprenorphine BHP Survey

*13. Please pick the appropriate response to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I find the buprenorphine prescriber supportive in helping me manage our mutual buprenorphine patients.	<input type="radio"/>					
I find the other clinical staff (RN, MA) involved in my patients' buprenorphine treatment supportive in helping me manage these patients.	<input type="radio"/>					
I find communication with the buprenorphine prescriber helpful in identifying abnormal or concerning patient behavior.	<input type="radio"/>					
I find communication with other clinical staff (RN/MA) helpful in identifying abnormal or concerning patient behavior.	<input type="radio"/>					
I find CHC psychiatrists/psychiatric APRNs supportive in helping me manage my patients on buprenorphine treatment.	<input type="radio"/>					

*14. Please rate the statements.

	Never	Seldom	About Half the Time	Usually	Always	N/A
How often do you feel you have to refer buprenorphine patients outside CHC to receive higher levels of care such as intensive outpatient programs or inpatient programs?	<input type="radio"/>					
How often do you feel you have to refer buprenorphine patients to outside psychiatrists/psychiatric APRNs for mental health treatment?	<input type="radio"/>					

Buprenorphine BHP Survey

*15. How would you rate your skills regarding the following?

	1 = none or no skill at all	2 = vague knowledge, skills or competence	3 = slight knowledge, skills or competence	4 = average among my peers	5 = competent	6 = very competent	7 = expert, teach others
Ability to recognize opioid-dependence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to understand how buprenorphine treats opioid-dependence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to recognize suitable candidates for buprenorphine maintenance treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to conduct individual therapy to buprenorphine patients effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to conduct buprenorphine treatment groups effectively.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to motivate patients to change behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*16. How would you rate your skills regarding the following?

	1 = none or no skill at all	2 = vague knowledge, skills or competence	3 = slight knowledge, skills or competence	4 = average among my peers	5 = competent	6 = very competent	7 = expert, teach others
Ability to recognize buprenorphine treatment failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to recognize buprenorphine diversion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to interpret urine toxicology results.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to interpret saliva toxicology results.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to use the toxicology results to help manage patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to serve as a consultant on opioid dependence and buprenorphine treatment in my clinic.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Buprenorphine BHP Survey

*17. Please choose your agreement with the following statements.

Strongly Disagree Disagree Neutral Agree Strongly Agree

I understand the principles of harm reduction, which involve pragmatism, humanistic values, focus on harms, balance of costs and benefits to the individual and to society, and hierarchy of goals.

Disagree

Neutral

Agree

Strongly Agree

I apply or will apply harm reduction practices when I manage my patients on buprenorphine.

18. Through Project ECHO Buprenorphine, I would like to learn more about...

Buprenorphine PCP Survey

***1. Please enter your survey ID number.**

***2. What is your specialty?**

- FP
- IM
- Psych

Other (please specify)

***3. Do you have your DEA X license?**

- Yes
- No

***4. If no, are you anticipating getting it in the coming year?**

- Yes
- No
- N/A

***5. Have you completed the buprenorphine certification course?**

- Yes, on-line
- Yes, in-person
- No, not completed

Buprenorphine PCP Survey

***6. How many hours of CME focused on addiction treatment have you completed in the last 2 years?**

***7. If you have questions about buprenorphine treatment, where do you get your answers from? Please pick all that apply.**

- Colleagues at CHC
- Colleagues outside of CHC
- Journals
- Online websites
- CME
- Certification course materials
- Course instructor (if taken in person)
- Pharmaceutical company representative
- Pharmacist
- Other (please specify)

***8. Have you treated opioid dependence with buprenorphine in an office-based setting?**

- Yes
- No

***9. If yes, approximately how many total years and months have you treated opioid dependence with buprenorphine? Please answer both fields, entering '0' where applicable. If you have not treated patients on buprenorphine, please enter 0 in each field.**

Years

Months

***10. If yes, approximately how many patients total have you treated? If you have not treated patients on buprenorphine, please enter 0.**

Buprenorphine PCP Survey

***11. If you are treating with buprenorphine, how many patients are you currently treating? If you are not treating patients on buprenorphine, please enter 0.**

***12. Are you registered for the Connecticut Prescription Monitoring Program?**

- Yes
- No

Buprenorphine PCP Survey

***13. Please pick the appropriate response to each statement.**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I find my medical assistant knowledgeable about buprenorphine treatment.	<input type="radio"/>					
I find my medical assistant helpful in managing my buprenorphine patients.	<input type="radio"/>					
I find my nurse knowledgeable about buprenorphine treatment.	<input type="radio"/>					
I find my nurse helpful in managing my buprenorphine patients.	<input type="radio"/>					
I find communication with my clinical staff (RN, MA) helpful in identifying abnormal or concerning patient behavior.	<input type="radio"/>					

***14. Please pick the appropriate response to each statement.**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I find CHC behavioral health providers supportive in helping me manage my patients on buprenorphine treatment.	<input type="radio"/>					
I find CHC substance abuse groups important in helping me manage my patients on buprenorphine.	<input type="radio"/>					
I find communication with the behavioral health staff helpful in identifying abnormal or concerning patient behavior.	<input type="radio"/>					

Buprenorphine PCP Survey

* 15. Please rate the statements.

	Never	Seldom	About Half the Time	Usually	Always
How often do you feel you have to refer buprenorphine patients to behavioral health providers outside of CHCI?	<input type="radio"/>				
How often do you feel you have to refer buprenorphine patients to substance abuse groups outside of CHCI?	<input type="radio"/>				
How often do you have your buprenorphine patients see your nurse for a buprenorphine nursing visit?	<input type="radio"/>				
How often do you educate your clinical care team on buprenorphine opioid dependence treatment?	<input type="radio"/>				

Buprenorphine PCP Survey

*16. How would you rate your skills regarding the following?

	1 = none or no skill at all	2 = vague knowledge, skills or competence	3 = slight knowledge, skills or competence	4 = average among my peers	5 = competent	6 = very competent	7 = expert, teach others
Ability to diagnose opioid-dependence?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to identify suitable candidates for buprenorphine maintenance treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to induct patients who are using heroin or prescription opioids on buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to induct patients who are switching from methadone maintenance to buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to stabilize patients on appropriate dose of buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to maintain patients on buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*17. How would you rate your skills regarding the following?

	1 = none or no skill at all	2 = vague knowledge, skills or competence	3 = slight knowledge, skills or competence	4 = average among my peers	5 = competent	6 = very competent	7 = expert, teach others
Ability to recognize buprenorphine treatment failure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to recognize buprenorphine diversion?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to interpret urine toxicology results?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to interpret saliva toxicology results?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to use toxicology results to help manage patients on buprenorphine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Buprenorphine PCP Survey

*18. How would you rate your skills regarding the following?

1 = none or no skill at all 2 = vague knowledge, skills or competence 3 = slight knowledge, skills or competence 4 = average among my peers 5 = competent 6 = very competent 7 = expert, teach others

Ability to manage side effects of buprenorphine?	<input type="radio"/>						
Ability to discontinue buprenorphine treatment safely?	<input type="radio"/>						
Ability to treat pregnant opioid dependent women?	<input type="radio"/>						
Ability to educate and motivate patients about/on buprenorphine?	<input type="radio"/>						
Ability to serve as a consultant on opioid dependence and buprenorphine treatment in the clinic?	<input type="radio"/>						

*19. Please choose your agreement with the following statements.

Strongly Disagree Disagree Neutral Agree Strongly Agree

I understand the principles of harm reduction, which involve pragmatism, humanistic values, focus on harms, balance of costs and benefits to the individual and to society, and hierarchy of goals.	<input type="radio"/>				
I apply or will apply harm reduction practices when I manage my patients on buprenorphine.	<input type="radio"/>				

20. Through Project ECHO Buprenorphine, I would like to learn more about...

Buprenorphine RN/MA Survey

***1. Please enter your survey ID number.**

***2. I am a...**

- RN
 MA

***3. How many hours of continuing education or training focused on addiction treatment have you completed in the last 2 years, if any?**

***4. If you have questions about buprenorphine treatment, where do you get your answers from?**

- Colleagues outside of CHC
 Clinical care team at CHC
 PCP
 Journals
 On-line websites
 CME
 Buprenorphine training course materials
 Buprenorphine training course instructor (if taken in person)
 Pharmaceutical company representative
 Pharmacist
 Other (please specify)

***5. Have you worked with patients on buprenorphine?**

- Yes
 No

***6. If you have, approximately how many total years and months have you worked with opioid dependent patients on buprenorphine? Please enter both the year and month fields, putting '0' where applicable. If you have not worked with patients on buprenorphine, please enter 0 in both fields.**

Years

Months

Buprenorphine RN/MA Survey

***7. If yes, approximately how many patients total have you worked with? If you have not worked with these patients, please enter 0.**

Buprenorphine RN/MA Survey

*8. Please pick the appropriate response to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I understand what opioid-dependence is.	<input type="radio"/>				
I understand how buprenorphine works to treat opioid dependence.	<input type="radio"/>				
Buprenorphine is an appropriate treatment for patients with opioid dependence.	<input type="radio"/>				
I understand the principles of harm reduction, which involve pragmatism, humanistic values, focus on harms, balance of costs and benefits to the individual and to society, and hierarchy of goals	<input type="radio"/>				
Harm reduction principles should be applied when managing patients on buprenorphine.	<input type="radio"/>				

*9. Please pick the appropriate response to each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I am comfortable seeing buprenorphine patients.	<input type="radio"/>					
I feel comfortable discussing buprenorphine patients with my provider.	<input type="radio"/>					
I find my provider knowledgeable on buprenorphine treatment.	<input type="radio"/>					

*10. I feel capable of seeing patients for a nursing visit for buprenorphine treatment. (MAs please choose N/A)

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
- N/A

Buprenorphine RN/MA Survey

*11. Please respond to the following questions.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
It is important to offer buprenorphine treatment to our patients.	<input type="radio"/>				
It is appropriate to offer buprenorphine treatment in the primary care setting.	<input type="radio"/>				
Patients on buprenorphine are more disruptive to the clinic than other patients.	<input type="radio"/>				
Patients on buprenorphine are more disruptive to my workflow than other patients.	<input type="radio"/>				
Benefits of treating patients with buprenorphine outweigh the effort involved in managing patients with opioid dependence.	<input type="radio"/>				
Working with opioid-dependent patients on buprenorphine enhances my professional satisfaction.	<input type="radio"/>				

12. Through Project ECHO Buprenorphine, I would like to learn more about...

COMMUNITY HEALTH CENTER, INC.

CLIENT INFORMED CONSENT TO PARTICPATE IN THE PROJECT ECHO BMT PROGRAM

PROTOCOL TITLE: Project ECHO BMT

SPONSOR: Community Health Center, Inc.

PRINCIPAL INVESTIGATOR: Marwan Haddad, MD, MPH

DESCRIPTION OF MHHSC Program

We are participating in an evaluation designed to improve our Substance abuse services. This evaluation is being conducted as part of our involvement with the Substance Abuse and Mental Health Services Administration. We request that you participate in a voluntary survey designed to collect information about clients who receive substance abuse services here at Community Health Center, Inc.

You have been asked to participate in this survey because you are a client of the program. If you agree to the survey, we will ask questions about yourself, marital status, income and employment, HIV risk behaviors, substance abuse, medical health and mental health.

SURVEY PROCEDURES

If you agree to the survey, we will ask you a series of questions directly. Asking you these questions should take about 15 minutes. We will also collect information from some of your medical and mental health records, but only if they are available here through this program. Examples of medical health information we will collect include health outcomes, appointment adherence and lab results. The mental health information we will collect include your mental health diagnoses, mental health medications and discharge status if you decide to leave services here. All of the information you provide is strictly confidential and will be unavailable to anyone outside of the project. You will be one of up to 300 subjects who participate in this survey each year from Community Health Center, Inc. The study will include both males and females of any ethnic and/or racial background.

Survey Participants Initials _____

Date _____

Attachment 3

- Your participation in the survey is voluntary. You do not have to agree to the survey in order to get services here. You may answer questions that are asked of you as you wish, but you can also choose not to answer questions. You may stop the survey at any time.
- If you are still receiving services from this program six months from now, we will contact you and ask you to participate in our survey again. If you decide to participate in the survey now you do not have to do the survey again. We will ask you, but you are free to decide not to.

POTENTIAL BENEFITS OF PARTICIPATION

- The information gathered by the survey will help service providers here learn about ways to improve your services.
- The information gathered by the survey will provide data and evaluation of substance abuse services which may guide future funding.

POTENTIAL RISKS OF PARTICIPATION

- Some of the questions asked may seem personal or make you feel uncomfortable. If this is upsetting you may stop the survey at any time.
- If it feels like the survey is taking too long, you are getting tired, or if for any other reason you wish to stop, you may do so at any time.
- The survey is confidential, but we may want to share the results of our survey with our fellow project colleagues and funding agency (SAMHSA). If we do this, we will protect your privacy by NOT including your name or any information that could identify you.

CONFIDENTIALITY

All of the information that allow us to collect about you as part of this survey will be kept private and will be available only to staff involved with the project, except when required by law. Our project staff includes the health care professionals and evaluators here at this program, as well as at the other SAMHSA programs across the country involved in this evaluation. There are two exceptions to confidentiality: 1) if you reveal that you are a danger to yourself or others; 2) if you reveal that you are committing child abuse, or allowing abuse to be committed against a child. In either of these cases, we are required by law to report it to the appropriate authorities.

By signing this form you are allowing our project colleagues and sponsor (SAMHSA) to review the information from this survey; however, the information available to staff outside of Community Health Center, Inc will not have any of your identifying information attached to it. No one outside of this knows that the information is about you. If anything you share is included in reports it will be written so that no one will know the information is about you.

Attachment 3

VOLUNTARY PARTICIPATION/WITHDRAWAL

Participating in this survey is entirely up to you. You are free to stop at any time. If you decide to stop the survey before it is over, it will in no way affect your services here. If you have any questions about this survey, you can contact Kasey Harding – Wheeler at 860-347-6971 X 3914

CONSENT

By signing this consent form, you are letting us know that you have read it and asked any questions you may have about your participation. You are aware that you can participate or withdraw your participation any time without affecting the care you receive here. By signing this form, you do not give up any rights as a participant. You will receive a signed copy of this consent.

Signing below means that you agree to participate in this survey.

Patients Signature _____ Date _____

Patients Printed Name _____ Date _____

Providers Signature _____ Date _____

Providers Printed Name _____ Date _____

Survey Participant's Initials _____
Date _____

Attachment 4

Not applicable to this application.

SOFTWARE LICENSE AND SERVICES AGREEMENT

This Software License and Services Agreement (the "Agreement") is made this ____ day of May, 2006 (the "Effective Date") by and between Community Health Center, Inc., having its principal place of business at 635 Main Street, Middletown, Connecticut 06457 ("CHC") and eClinicalWorks LLC, having its principal place of business at Westboro Executive Park, 112 Turnpike Road, Suite 200, Westboro, Massachusetts 01581 ("Licensor").

NOW, THEREFORE, in consideration of the mutual promises set forth herein, CHC and Licensor hereby agree as follows:

1. LICENSED SOFTWARE

1.1. License Grant. Licensor hereby grants to CHC and CHC accepts a perpetual, irrevocable, nonexclusive license (the "License") to use its electronic medical records, integrated practice management for front, mid and back office, and patient portal software described in the detailed functional specifications set forth in Schedule A, and related interfaces, including all Updates (as defined in Schedule B) thereto as may be provided pursuant to this Agreement (collectively, the "Programs") and all operator's and electronic user's manuals, training materials, guides, commentary and other materials related thereto (the "Documentation", which collectively with the Programs is referred to herein as the "Software"), subject to the terms and conditions hereinafter set forth in this Agreement and the schedules annexed to this Agreement (the "Schedules").

1.2. Use Limitations. The License hereby granted permits CHC to use the Software in the course of its business operations and for its own business purposes including but not limited to processing its own information and that of its clients as part of its business, as well as for backup, testing and disaster recovery purposes. The Software may be used by any number of users, on any number of computers, and at any number of sites, subject in respect to Providers (defined in Schedule C) to the payment of applicable license fees for Providers as further described in Schedule C. CHC may not sell, license, sublicense, rent or otherwise convey any interest in the Software to any third party, except as otherwise set forth in this Agreement, and may not reverse engineer, de-compile, or disassemble the Software except as allowed by law. CHC's contractors and consultants are authorized to exercise the rights granted to CHC in this Section 1 in furtherance of services provided to CHC. Licensor shall upon request by CHC immediately issue such security codes or other materials necessary for CHC to add additional Providers (defined in Schedule C) to the Program, after receipt of payment in full of the applicable license fees for such additional Providers as set forth in Schedule C.

1.3. Copies. CHC may make such additional copies of the Programs and Documentation as it may deem necessary for its use, backup and disaster recovery purposes, subject to the License use limitations and other terms of this Agreement.

1.4. Training. Licensor hereby commits to supply resources to timely train CHC throughout all applicable phases of the lifecycle of any and all Deliverables, including testing and installation, which at a minimum shall provide training of CHC's personnel on the use and

operation of the Programs as further described in Schedule B hereto. CHC shall have the right to record any training sessions (video or audio) and replay such taped sessions at no additional cost.

1.5. Source Code Escrow. No later than ninety (90) days from Initial Acceptance at the first Site (defined in Schedule A-2), Licensor shall place in escrow with an escrow agent acceptable to CHC ("Escrow Agent") a fully commented and documented copy of the source code form of the Software (the "Source Code"), a listing thereof and all relevant technical specifications and documentation, including, without limitation, flow charts, algorithms and subroutine descriptions, memory and overlay maps and other documentation of the source code, together with all then existing software tools and development aids actually used for development, modification and/or support and maintenance of the Software and a list of all third party products and other materials, including without limitation hardware needed to operate the Software all in sufficient detail to enable a trained programmer through study of such materials to maintain and/or modify the Software without undue experimentation (collectively, "Commentary" and together with the Source Code and listing thereof, the "Source Materials") pursuant to a mutually agreed upon escrow agreement (the "Escrow Agreement"). Licensor will also pay any fees in connection with a deposit of an Update(s) to the Software and the fees required to establish and maintain CHC's status as a beneficiary under the Escrow Agreement; provided, however, that CHC shall reimburse Licensor for Licensor's documented payment of such fees to the Escrow Agent, not to exceed \$500 annually. CHC shall be entitled to receive a copy of the Source Materials upon the occurrence of a Release Condition. If Licensor makes any Update to the Software, Licensor shall promptly furnish the Escrow Agent with a corrected or revised copy of the Source Materials. A "Release Condition" shall include any of the following: (i) Licensor or any successor company ceases to do business in the ordinary course; (ii) Licensor discontinues maintenance and support services for the Software Software or Licensor materially breaches its obligations hereunder, which breach results in CHC terminating this Agreement pursuant to Section 8.2 of this Agreement; (iii) Licensor assigns its maintenance and support obligations under this Agreement, whether through merger, acquisition, or other transfer of its assets, to a company considered by CHC, in its sole discretion, to be unsatisfactory to maintain the Software; or (iv) any proceedings are commenced by or for Licensor under any bankruptcy, insolvency or debtor's relief law, or Licensor becomes insolvent. Licensor hereby grants to CHC and CHC accepts a perpetual, irrevocable, nonexclusive license to modify, enhance, translate, convert, recompile, upgrade and otherwise prepare derivative versions of the Source Materials solely for the purposes of (y) enhancing and making modifications to the Software for its internal use; and (z) maintaining and supporting the Software. In this connection, Customer may provide access to the Source Materials and knowledge of the technology underlying the Software to third parties, provided that any and all such third parties agree that their knowledge of the same will be maintained in confidence and used solely for the above-stated purposes, and not for commercial sale or use by any other persons or entities.

Customer agrees that any such Source Materials and the rights thereto may constitute a marketable asset of Licensor, and therefore will not transfer such materials to any third party, nor allow any third party to duplicate or reverse engineer any software, except as set forth above and as required for Customer's own operations.

1.6. Source Materials Verification and Review. CHC shall have the right to verify the Source Materials upon CHC's request. Additionally, upon CHC's request, Licensor will conduct detailed Source Materials reviews with CHC designees periodically, but no less frequently than twice per calendar year (a "Source Materials Review"). Such Source Materials Reviews shall include a detailed review of Source Code, and detailed discussion of the Source Code design, architecture and coding. Such Source Materials Review shall be detailed enough to enable a reasonably skilled programmer to maintain the Source Code. Notwithstanding the foregoing, in the event of Licensor's material breach of this Agreement, CHC will have the right to have Licensor immediately conduct a Source Materials Review and monthly Source Materials Reviews thereafter. CHC will pay \$70/hour for time spent by Licensor to assist with the review process.

1.7. Section 365(n). All rights and licenses granted under or pursuant to this Agreement by Licensor to CHC (including the License) are, and shall otherwise be deemed to be, for purposes of Section 365 (n) of the United States Bankruptcy Code (the "Code"), licenses to rights to "intellectual property" as defined under the Code. The parties agree that CHC, as licensee of such rights under this Agreement (including the License), shall retain and may fully exercise all of its rights and elections under the Code. The parties further agree that, in the event of the commencement of bankruptcy proceeding by or against Licensor under the Code, CHC shall be entitled to retain all of its rights under this Agreement, including the licenses granted to CHC hereunder.

1.8. Ownership. CHC acknowledges that, as between CHC and Licensor, Licensor is the owner of the Programs and of all intellectual property rights therein. CHC shall not institute or join any action against Licensor alleging facts contrary to the immediately preceding sentence, but shall not be prohibited from doing so in the course of an action instituted against CHC by Licensor or a third party if such action seeks to limit any rights in the Software granted to CHC in this Agreement.

2. PROFESSIONAL SERVICES

2.1. Services. Licensor agrees to perform the services described in this Agreement, including Schedule A and its appendices, of which Schedule A-2 is a statement of work, any other statement of work in a form mutually agreed to and executed by the Licensor and CHC, Schedule C, and Schedule G (collectively, "Services").

2.2. Any mutually executed statement of work (each a "Statement of Work") shall be deemed incorporated into and made a part of this Agreement, and shall include, without limitation, (i) a complete description of the Services to be performed, including any Deliverables (as defined below) to be provided, including all technical and functional specifications applicable thereto; (ii) if the Statement of Work is to be performed on a fixed price basis, the total fees and expenses to be incurred, or if on a time and materials basis, the applicable hourly rates for personnel, expenses to be incurred, and if applicable, maximum fees and expenses; (iii) any reports to be provided by Licensor; (iv) a schedule for completion and delivery of the Services and Deliverables, including any applicable project phases or milestones, and remedies for delays or failure to timely achieve such milestones; and (v) a complete list of all third-party materials to

be provided by Licensor or required to be procured by CHC in order to fully utilize the Services and Deliverables. “**Deliverables**” means those materials and products to be provided by Licensor, including without limitation any Software and other deliverables as described in the applicable Statement of Work. To the extent there is a conflict between the terms of a Statement of Work and this Agreement, the terms of this Agreement shall govern.

2.3. **Work Product.** Notwithstanding any provision in this Agreement to the contrary, all results of any Services performed under this Agreement, including without limitation any and all software, Deliverables, computer system designs, documentation, know-how, trade secrets, inventions (whether or not patentable or reduced to practice), improvements, processes, developments, materials, or data that Licensor makes, conceives, or devises, either solely or jointly, as a result of Services performed under any Statement of Work (whether or not such Statement of Work is completed) or within six (6) months after the termination of such Statement of Work (collectively, the “**Work Product**”), shall be deemed to be a work made for hire and made in the course of the Services rendered hereunder. All right, title, and interest in and to the Work Product shall vest in CHC, and Licensor shall have no right, title, or interest in or to such Work Product. To the extent that title to any Work Product may not, by operation of law, vest in CHC or such Work Product may not be considered work made for hire, all rights, title and interest therein are hereby irrevocably assigned to CHC. All Work Product shall belong exclusively to CHC, with CHC having the right to obtain and to hold in its own name, copyrights, registrations or such other protection as may be appropriate to the subject matter, and any extensions and renewals thereof. Licensor agrees to give CHC and any person designated by CHC, reasonable assistance, at CHC’s expense, required to perfect the rights defined in this Paragraph. Unless otherwise requested by CHC, upon the completion of the Services to be performed under each Statement of Work or upon the earlier termination of such Statement of Work, Licensor shall immediately turn over to CHC all Work Product developed pursuant to such Statement of Work.

2.4. **Change Control.** CHC may at any time request modification to the scope of the Deliverables and/or Services to be performed under a Statement of Work by written request to Licensor specifying the desired modifications (each, a “**Change Notice**”). Within a reasonable time following receipt of a Change Notice, Licensor shall, at no additional charge to CHC, provide to CHC a written estimate of the impact of the proposed changes on both the schedule contained in the Statement of Work, and the fees and expenses under the Statement of Work (each, an “**Impact Statement**”). Following any negotiation by the parties, Licensor shall deliver a final Impact Statement to CHC, and upon CHC’s execution thereof, the Statement of Work shall be deemed amended thereby.

3. TESTING; ACCEPTANCE; IMPLEMENTATION

3.1. **General.** The parties anticipate that there will be a site-by-site phased installation of the Programs, which shall be initially tested at each Site and tested in an integrated fashion as further described in **Schedule A** and its appendices. Upon installation of any of the Programs or any other Deliverable on CHC’s computer(s) at a Site, and Licensor’s determination that such installation meets all requirements set forth in **Schedule A** and any other applicable Schedule, Documentation, and any other requirements agreed to in writing by the parties, CHC shall have forty-five (45) days (or such other time period set forth in the applicable Schedule) (“**Initial**

Acceptance Testing Period") to conduct initial testing of such Deliverables at individual CHC sites. Licensee's dedicated testing resource(s) shall assist in such testing as requested by CHC at no additional cost; provided, however, that if any delays in such testing occur as a result of the unavailability of such dedicated testing resource(s), the applicable Initial Acceptance Testing Period shall be extended to the extent of any such delays. If the Deliverable passes such tests to CHC's reasonable satisfaction, CHC shall give Licensee written notice of initial acceptance of such Software ("Initial Acceptance"). No Deliverable shall be deemed accepted unless and until CHC provides Licensee such Initial Acceptance.

3.2. Non-Conformance. In the event that any Deliverable does not conform to the acceptance criteria within the Initial Acceptance Testing Period described above, CHC shall give Licensee written notice thereof. CHC shall cooperate with Licensee in identifying in what respects the Deliverable has failed to conform to the criteria. Licensee shall, at no cost to CHC, promptly correct any deficiencies which prevent such Deliverable from conforming to the criteria. Licensee will make a good faith effort on the corrective action using all available resources. For example, a critical support call late on Friday afternoon (normal business hours) would continue to receive the resources and corrective actions necessary until resolved, without interruption due to weekend hours. Upon completion of the corrective action by Licensee, and at no additional cost to CHC, the acceptance test will be repeated until the Deliverable has successfully conformed to the acceptance criteria. If a Deliverable does not conform to the acceptance criteria within ninety (90) days after the commencement of the Initial Acceptance Testing Period described above, CHC may, without limitation of any rights or remedies available to CHC at law or equity, immediately terminate this Agreement or any Statement of Work hereunder without any further obligation or liability of any kind and Licensee shall immediately reimburse the fees paid thereunder.

3.3. Final Acceptance. After Initial Acceptance of Software, and at the completion of installation of all such Deliverables at all Sites, the Deliverables shall operate on an integrated basis at such Sites as set forth in Schedule A and Schedule B-1 for a period of at least ninety (90) days in full compliance with the warranties agreed upon therefor. Acknowledgment by CHC of successful, integrated operation across all Sites of the Deliverables for such ninety (90) day period shall constitute "Final Acceptance."

3.4. Implementation. At no additional cost to CHC, Licensee shall provide a product specialist and project manager at a minimum via video link or web conferencing for the purpose of managing and coordinating all activities in connection with implementation, including testing and training. It is acknowledged and agreed by the parties that these are dedicated personnel that will maintain continuity with CHC throughout the implementation process until Final Acceptance.

4. FEES AND PAYMENT TERMS

4.1. License and One-Time Fees. The fees to be charged by Licensee for all licenses granted hereunder, together with additional one-time fees and related terms, are as set forth in Schedule C hereto.

4.2. Software Maintenance Fees. The fees to be charged by Licensor for Software Maintenance (as defined in Section 7.1 hereof) are as set forth in Schedule C hereto.

4.3. Services Fees and Expenses. The fees to be charged by Licensor for Services are as set forth in Schedule C. Unless otherwise provided in the applicable Statement of Work, CHC shall be obligated to reimburse Licensor only for those reasonable expenses that CHC has approved in writing prior to being incurred.

4.4. Training Fees. The fees to be charged by Licensor for training are as set forth in Schedule C hereto; provided that training shall be provided at no additional cost unless the specifically stated otherwise such Schedule C.

4.5. Invoicing and Payment Terms. Unless otherwise provided in the applicable Schedule or Statement of Work, Licensor shall render monthly invoices for fees and expenses incurred during such month. CHC shall pay undisputed fees and expenses within thirty (30) days of CHC's receipt of invoice, and may dispute fees and expenses at any time. Should an invoice contain undisputed items and disputed items, CHC shall pay undisputed items in accordance with the terms of this Section 4.5.

4.6. Taxes. As CHC is a tax-exempt entity, Licensor agrees that it will not pass through or otherwise charge CHC any amounts representing taxes of any kind.

4.7. Most Favored Customer. Licensor represents that each and all of the prices, terms, warranties and benefits (collectively, "Terms") granted by Licensor hereunder are equivalent to or better than the Terms previously or currently offered by it to its other Community Health Center customers nationwide and to all healthcare provider customers within the state of Connecticut. If, during the first twelve (12) months following the Effective Date, Licensor offers or enters into arrangements with any such customers providing for more favorable Terms, Licensor shall notify CHC of such Terms and this Agreement shall, upon CHC's election and written approval, thereupon be deemed amended to provide the same Terms to CHC effective as of the date such Terms were offered to such third parties. Licensor shall promptly provide CHC with any resulting refund or credits.

5. REPRESENTATIONS AND WARRANTIES

5.1. Licensor's Warranties. Licensor hereby represents and warrants to CHC as follows:

(a) Ownership. Licensor is the owner of the Programs and there is currently no actual or threatened suit by any third party based on an alleged violation of such right by Licensor;

(b) Performance Warranty. From the Effective Date until one hundred and eighty (180) days after Final Acceptance (the "Warranty Period"), the Software (including interfaces) and any other Deliverables shall (i) be free from defects in material and workmanship under normal use and remain in good working order, and (ii) function properly and in conformity with the warranties herein and in accordance with this Agreement and the Documentation, and the Documentation shall completely and accurately reflect the operation of the Software and any other Deliverables;

(c) Interoperability. Licensor represents and warrants that the Software shall be interoperable and compatible with CHC's software (including third party software), hardware and firmware configuration and any such configuration required to run the Software all as set forth in the RFP and herein, as the same may be updated from time to time by the parties during implementation of the Programs. CHC shall use commercially reasonable efforts to identify, within sixty (60) days from the Effective Date, any additional CHC software or 3rd party software with which the Software must interoperate or be compatible;

(d) Additional Software Warranties. The Software shall at all times provide equivalent functionality with respect to Providers and Resources (as defined in Schedule C). While CHC is receiving Software Maintenance, the Software and related Updates shall on a timely basis and at no additional cost to CHC remain compliant with all federal laws and regulations applicable to the Program's functions, including without limitation, those relating to the Privacy Standard (defined in Section 10.3 below), Medicare and Medicaid;

(e) Services Warranty. The Services will be performed and Deliverables provided in accordance with this Agreement, any applicable Statement of Work and all requirements set forth in this Agreement. Each of Licensor's employees or subcontractors assigned to perform any Services or Software Maintenance hereunder shall have the proper skill, training and background so as to be able to perform in a competent and professional manner and Licensor warrants that all such work will be so performed;

(f) Date and Time-Related Functionality. With respect to all date and time-related data and functions, the Software will accept input, perform processes, and provide output in a manner that is consistent with its intended use, prevents ambiguous or erroneous results, does not result in any adverse effect on functionality or performance of the Software or other hardware or software, and is consistent with the time and date dictated by the United States Daylight Saving Time rules then in effect;

(g) Alpha/Beta Site. CHC is not, nor will be, an alpha or beta site for the Software without the prior written consent of CHC. Licensor and CHC agree that CHC will have input to, and shall be advised of, Licensor's future software update and enhancement efforts;

(h) No Viruses. The Programs does not, and will not when delivered, contain any computer code (i) designed to disrupt, disable, harm, or otherwise impede in any manner, including aesthetical disruptions or distortions, the operation thereof, or any other associated software, firmware, hardware, computer system or network (sometimes referred to as "viruses" or "worms"), (ii) that would disable or impair in any way the operation thereof based on the elapsing of a period of time, the exceeding of an authorized number of copies, or the advancement to a particular date or other numeral (sometimes referred to as "time bombs", "time locks", or "drop dead" devices), or (iii) that would permit access by Licensor to cause such disablement or impairment (sometimes referred to as "traps", "access codes" or "trap door" devices), or any other similar harmful, malicious or hidden procedures, routines or mechanism that would cause the Programs to cease functioning or to damage or corrupt data, storage media, programs, equipment or communications, or otherwise interfere with operations;

(i) Open Source Software. Except as set forth in Schedule A, Lessor represents and warrants that the Software shall not include any “open source” code (as defined by the Open Source Initiative) or “Free” code (as defined by the Free Software Foundation), nor operate in such a way that it is compiled with or linked to such open source or free code, without CHC’s prior review and approval of the applicable license agreement, Lessor further represents, warrants and covenants that the Licensed Software shall not interact with CHC’s own proprietary software in such a way: (a) that would impose any requirements on how CHC’s proprietary software, or any portion thereof, is licensed to third parties, (b) that would create, or purport to create, obligations for CHC with respect to its proprietary software, (c) that would grant, or purport to grant, to any third party any rights to or immunities under CHC’s intellectual property or proprietary rights, or (d) that would have the effect of requiring CHC’s proprietary software, or any portion thereof, to be: (i) disclosed or distributed in source code form, (ii) licensed for the purpose of making derivative works, (iii) redistributable at no charge, or (iv) licensed under any open source or free software license or licensing scheme. The inclusion of any open source software in the Software will not affect CHC’s sole and exclusive ownership rights in the output of such Software. As part of its obligations under this Agreement, Lessor will implement a version of MySQL as the operating system on which the Program will run. Although MySQL is available in both open source and proprietary (i.e., non-open source) versions, Lessor shall implement the proprietary version of MySQL. MySQL AB maintains the source code and provides support and updates for its proprietary versions. Lessor will test the new updates of MySQL before releasing it to CHC and insure that updated versions fully complies with security, performance, and system configuration requirements as set forth in RFP and herein, as the same may be updated from time to time by the parties during implementation of the Programs; and

(j) Hardware; Third Party Systems. Lessor represents and warrants that there is no hardware or third party software or system required for CHC’s use of the Software except as set forth in Schedule A. At CHC’s election, Lessor will serve as CHC’s liaison with any hardware or software vendors (e.g., Windows, Citrix) such that any issues due to such items will be promptly isolated, reported on and managed to resolution by Lessor.

5.2. Lessor Representation. In Lessor’s response to CHC’s Request for Proposal dated January 9, 2006 (the “**RFP Response**”), Lessor has not materially misrepresented the functional capabilities of the Program. The RFP Response is attached hereto as Schedule A-1.

6. LIMITATION OF LIABILITY; DISCLAIMER OF WARRANTIES

6.1. LIMITATION OF LIABILITY. LICENSOR’S LIABILITY TO CHC FOR ANY DAMAGES, IN CONTRACT, TORT OR OTHERWISE, ARISING OUT OF THE SUBJECT MATTER OF THIS AGREEMENT SHALL BE LIMITED TO THOSE ACTUAL AND DIRECT DAMAGES INCURRED BY CHC AND SHALL NOT EXCEED THE SUM OF ALL LICENSE FEES PAID BY CHC DURING THE TERM OF THE AGREEMENT AND ALL OTHER FEES PAID BY CHC TO LICENSOR OVER THE TWELVE (12) MONTH PERIOD PRIOR TO THE DATE IN WHICH LIABILITY OCCURRED. CHC’S LIABILITY TO LICENSOR FOR ANY DAMAGES, IN CONTRACT, TORT OR OTHERWISE, ARISING OUT OF THE SUBJECT MATTER OF THIS AGREEMENT SHALL BE LIMITED TO THOSE ACTUAL AND DIRECT DAMAGES INCURRED BY LICENSOR AND SHALL

NOT EXCEED THE UNPAID FEES DUE AND OWING BY CHC TO LICENSOR UNDER THIS AGREEMENT.

6.2. NEITHER PARTY WILL BE LIABLE TO THE OTHER PARTY FOR: SPECIAL, PUNITIVE, INDIRECT, INCIDENTAL, EXEMPLARY OR CONSEQUENTIAL DAMAGES OR LOSS OF DATA, LOST PROFITS, OR LOSS OF GOODWILL IN ANY WAY ARISING FROM OR RELATING TO THIS AGREEMENT, EVEN IF IT HAS BEEN NOTIFIED OF THE POSSIBILITY OF SUCH DAMAGES OCCURRING.

6.3. THE LIMITATIONS SET FORTH IN SECTION 6.1 AND SECTION 6.2 SHALL NOT APPLY WITH RESPECT TO (I) A PARTY'S OBLIGATIONS UNDER SECTION 9; OR (II) A PARTY'S BREACH OF ITS CONFIDENTIALITY OBLIGATIONS UNDER THIS AGREEMENT.

6.4. No Additional Warranties. Except as otherwise provided in this Agreement, Licensor and CHC disclaim and waive all warranties, expressed or implied, in fact or by operation of law or otherwise, including without limitation, implied warranties of merchantability or fitness for a particular purpose.

7. SOFTWARE MAINTENANCE AND SUPPORT; AVAILABILITY

7.1. Software Maintenance. As set forth in Schedule C hereto, Licensor shall provide support and maintenance services in connection with the Software, including interfaces, and any other Deliverables ("Software Maintenance"), as further provided in this Section 7 and Schedule B hereto. Licensor shall make Software Maintenance for the Programs available to CHC under the terms of this Agreement for a period of no less than seven (7) years from Final Acceptance, and shall support its most current major version release of the Programs, in addition to the prior two major version releases. CHC may terminate Software Maintenance effective on thirty (30) days notice to Licensor, and shall receive a pro-rata refund of any prepaid fees therefor as of the effective date of such termination.

7.2. Notice of Errors. During the Warranty Period and for the term of any Software Maintenance, Licensor shall promptly notify CHC of any defects or malfunctions in the Programs or Documentation which it learns from any source that could be reasonably expected to affect CHC. If requested by CHC, Licensor shall promptly correct at no additional charge any defects or malfunctions in the Programs or Documentation discovered during such Warranty Period and the term of any Software Maintenance as provided in Schedule B.

7.3. Software Availability. Licensor shall cause the Software to be available for use by CHC in accordance with the requirements set forth in Schedule B-1.

8. TERM AND TERMINATION

8.1. Term. The Agreement shall be in effect in perpetuity unless earlier terminated in accordance with its express terms.

8.2. **Material Breach.** In the event that Licensor materially breaches any of its obligations hereunder, CHC may, without limitation to any other right or remedy, terminate all or a portion of this Agreement and/or any Statement of Work.

8.3. **Termination for Convenience.** CHC shall have the right, but not the obligation, to terminate for convenience this Agreement or, from time to time, one or more Statements of Work or one or more categories of Services under a Statement of Work, without liability. CHC shall exercise its termination right by delivering to Licensor written notice of such termination identifying the scope of the termination and the termination date (which shall be at least thirty (30) days after the date of such notice).

8.4. **Termination for Insolvency.** CHC shall have the right, but not the obligation, to terminate this Agreement in its entirety (including all Statements of Work) without payment of any termination fees if Licensor (i) becomes insolvent or is unable to meet its debts as they mature, (ii) files a voluntary petition in bankruptcy or seeks reorganization or to effect a plan or other arrangement with creditors, (iii) files an answer or other pleading admitting, or fails to deny or contest, the material allegations of an involuntary petition filed against it pursuant to any applicable statute relating to bankruptcy, arrangement or reorganization, (iv) shall be adjudicated a bankrupt or shall make an assignment for the benefit of its creditors generally, (v) shall apply for, consent to, or acquiesce in the appointment of any receiver or trustee for all or a substantial part of its property, and any such receiver or trustee shall be appointed and shall not be discharged within thirty (30) days after the date of such appointment, or (vi) has suffered a Material Adverse Change to its business or financial condition (including but not limited to termination or resignation of all or a material portion of the employees providing Services). A “**Material Adverse Change**” means any event or circumstance which in CHC’s reasonable judgment has or could be expected to have a material adverse effect on (1) the property, business, operations, financial, condition, prospects or liabilities of Licensor or (2) the ability of Licensor to perform any of its obligations under this Agreement, including, without limitation, the timely provision of any source code.

8.5. **Termination.** The parties may terminate this Agreement only as expressly authorized herein. Unless otherwise expressly provided herein, such termination shall not relieve CHC of its obligation to pay charges incurred for that time period prior to the effective date of termination, and Licensor shall refund to CHC a pro-rata portion of any prepaid fees as of the effective date of such termination.

8.6. **Survival.** The provisions of Sections 1, 2.3, 4.6, 5, 6, 8, 9, 10 and 11 of this Agreement, and Schedule E shall survive the termination of this Agreement. The licenses granted in Section 1 hereof may be terminated only as expressly authorized in this Agreement.

9. INDEMNITIES

9.1. **Intellectual Property Indemnity.** Licensor, at its own expense, shall defend, indemnify and hold harmless CHC, its subsidiaries, affiliates or assignees, and their directors, officers, employees and agents and defend any action brought against same with respect to any claim, demand, cause of action, debt or liability, including attorneys’ fees and costs, to the extent that it is based upon a claim that the Software or any Work Product, or any portion thereof,

infringes, violates any patents, copyrights, trade secrets, licenses, or other property rights of any third party. In the event that the Software, Work Product or any portion thereof is held to constitute an infringement, Licensor shall have the obligation, at its expense, to (i) modify the infringing Software or Work Product without impairing in any material respect the functionality or performance, so that it is non-infringing, (ii) procure for CHC the right to continue to use the infringing Software or Work Product, or (iii) replace said Software or Work Product with equally suitable, non-infringing software or work product.

9.2. Personal Injury and Property Damage Indemnity. Licensor, at its own expense, shall defend, indemnify and hold harmless CHC, its subsidiaries, affiliates or assignees, and their directors, officers, employees and agents and defend any action brought against same with respect to any claim, demand, cause of action, debt or liability, including attorneys' fees and costs, to the extent that it is based upon a claim for personal injury or property damage (i) arising out of the furnishing or performance of the Software or the Services provided hereunder or (ii) arising out of the fault or negligence of Licensor, its employees, subcontractors or agents.

9.3. Notice and Participation. CHC, or any of its related indemnified parties hereunder may, at its own expense, assist in the defense of any such claim if it so chooses, provided that, as long as it can demonstrate sufficient financial resources, it shall control such defense and all negotiations relative to the settlement of any such claim, and further provided that any settlement intended to bind it shall not be final without its written consent, which shall not be unreasonably withheld.

10. CONFIDENTIALITY AND PROPRIETARY RIGHTS

10.1. Confidential Information. In the course of their relationship, each party (the "Receiving Party") has been and may be exposed to or acquire information regarding the business, projects, operations, finances, pricing, activities and affairs of the other party (the "Disclosing Party") or its directors, officers, employees, agents or clients, including, without limitation, any idea, proposal, plan, procedure, technique, formula, technology, or method of operation (collectively, "Confidential Information"). Without limiting the foregoing, Confidential Information shall also include all written or oral information relating to Disclosing Party and its directors, officers, employees, agents or clients, that given its nature or the context of disclosure should reasonably be understood to be confidential. As of January 1, 2006, the Receiving Party agrees to hold Confidential Information of the Disclosing Party in strict confidence, to use such information for no purpose other than as necessary for the performance of its obligations hereunder, and to make no disclosure of such information except in accordance with the terms of this Agreement. The Receiving Party may disclose Confidential Information of the Disclosing Party only to those personnel of the Receiving Party who have an absolute need to know such Confidential Information in order to fulfill the Receiving Party's obligations hereunder and who have previously executed a written confidentiality agreement imposing confidentiality obligations no less restrictive than those applicable to the Receiving Party hereunder. The Receiving Party shall promptly notify the Disclosing Party of any actual or potential violation of the terms of this Section 10, and shall reasonably cooperate with the Disclosing Party in relation thereto.

10.2. Exceptions. Confidential Information shall not include information that the Receiving Party can demonstrate (i) was, at the time of its disclosure, or thereafter becomes part of the public domain through no fault of the Receiving Party or its personnel, (ii) was known to the Receiving Party as of the time of its disclosure from a source other than the Disclosing Party, (iii) is subsequently learned from a third party not under a confidentiality obligation to the Disclosing Party, or (iv) is required to be disclosed pursuant to subpoena, court order, or government authority, provided that the Receiving Party has provided the Disclosing Party with sufficient prior written notice of such requirement to enable the Disclosing Party to seek a protective order or other appropriate remedy, and further provided that during the pendency of such request, the parties shall cooperate to determine whether such disclosure may be permissibly limited, and to the extent authorized by applicable law and in accordance with the parties' agreement, the Disclosing Party shall accordingly seek to limit such disclosure.

10.3. HIPAA. Licensor will as of the Effective Date execute and be bound by the business associates agreement set forth as Schedule E. All of the patient demographics and medical records created by the Programs will be solely owned by the CHC. To the extent required by the Health Insurance Portability and Accountability Act of 1996 and regulations related to privacy promulgated there under (the "Privacy Standard"), and notwithstanding anything to the contrary herein (including Section 10.2), Licensor will maintain the confidentiality of Protected Health Information or PHI (as defined by the Privacy Standard) made available to or obtained by Licensor as a result of this Agreement, such information shall constitute Confidential Information and Licensor will comply with applicable requirements of the Privacy Standard. Specifically, Licensor will:

- a. Not use or further disclose PHI other than as permitted or required by this Agreement or as required by law (as such term is defined by the Privacy Standard);
- b. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement;
- c. Report to CHC any use or disclosure of PHI not provided for by this Agreement of which Licensor become aware;
- d. Ensure that any agent, including a subcontractor to whom Licensor provides PHI received from, or created or received on behalf of the foregoing, agrees in writing to the provisions of this Agreement; and
- e. Mitigate the harmful effect of any use or disclosure of PHI not permitted by this Agreement.

10.4. Return of Confidential Information. Promptly upon termination of this Agreement, or at any time upon the Disclosing Party's request, the Receiving Party shall promptly, at the Disclosing Party's option, either return or destroy all (or, if the Disclosing Party so requests, any part) of the Confidential Information, and all copies thereof and other materials containing such Confidential Information, and the Receiving Party shall certify in writing its compliance with the foregoing.

10.5. Injunctive Relief. The Receiving Party acknowledges that in the event of a breach of this Section 10, damages may not be an adequate remedy and the Disclosing Party shall be entitled to injunctive relief to restrain any such breach, threatened or actual, in addition to any other rights and remedies available to the Disclosing Party under this Agreement or at law or in equity.

10.6. Publicity. Licensee shall not, without the prior written consent of CHC in each instance, refer to the existence or subject matter of this Agreement, state that CHC or any CHC affiliate is a CHC or potential or former customer of Licensee, or use the name or any trade name, trademark, or service mark of CHC or any CHC affiliate in any press release, advertising or promotional materials, its CHC list or on its website or represent that any product or service has been endorsed or approved by CHC or any CHC affiliate. In any event that CHC provides any such approval, it shall have the right to revoke such approval at any time by written notice to Licensee.

11. GENERAL

11.1. Assignment. CHC may assign this Agreement without Licensee's consent to any of its subsidiaries or affiliates, and shall provide Licensee with notice of any such assignment. CHC may not otherwise assign this Agreement without Licensee's prior written consent, not to be unreasonably withheld. Licensee shall not assign this Agreement without CHC's prior written consent, not to be unreasonably withheld. The rights and obligations of the parties hereunder shall be binding upon and inure to the benefit of their respective successors and permitted assigns.

11.2. Notice. All notices required or permitted to be given by one party to the other under this Agreement will be sufficient if sent by certified mail, return receipt requested, or by FedEx or similar overnight delivery service, receipt signature required, to the parties at the respective addresses set forth below, or to such other address as the party to receive the notice has designated by notice to the other party pursuant to this Section 11.2.

To Licensee: eClinicalWorks, LLC
Attn: Girish Navani, President
114, Turnpike road
Westborough, MA 01581

To CHC: Community Health Center, Inc.
Attn.: Mark Masselli, President
635 Main Street
Middletown, CT 06457

11.3. Subcontracting. Licensee may not subcontract all or any portion of the Services without the prior written consent of CHC. Licensee shall remain fully responsible for the performance of the Services by such subcontractor, its compliance with all terms of this Agreement, and for the acts and omissions of its personnel.

11.4. Governing Law; Venue. This Agreement shall be governed by and construed under the laws of the State of Connecticut, without regard to principles of conflicts of laws. Any claim or action brought by one party against the other party shall be brought only in the applicable state or federal court located in the county in which the other party resides (Hartford

County, Connecticut for CHC, Worcester County, Massachusetts for Licensor), and the parties hereby agree that all actions or proceedings relating to this Agreement and any Statement of Work may be litigated in only such courts, and each of the parties waives any objection which it may have based on improper venue or forum *non conveniens* to the conduct of any such action or proceeding in such court.

11.5. Severability. If any provision of this Agreement is held invalid or otherwise unenforceable, the enforceability of the remaining provisions of this Agreement will not be impaired thereby.

11.6. No Waiver. The failure by any party to exercise any right or remedy provided for herein will not be deemed a waiver of any right or remedy hereunder.

11.7. Complete Agreement. This Agreement, which incorporates by reference the attached Schedules and any Statements of Work executed by the parties, supersedes all prior agreements and understandings between the parties and constitutes the complete agreement of the parties with respect to the subject matter hereof. No modification of or amendment to this Agreement shall be valid unless in writing and signed by an officer of both parties. Terms contained in any invoice, purchase order, order form or similar transactional document issued by either party shall not be deemed to modify or amend the terms of this Agreement, regardless of whether the receiving party has signed such document.

11.8. Remedies. Except to the extent otherwise expressly set forth herein, the rights and remedies of the parties set forth in this Agreement are not exclusive and are in addition to any other rights and remedies available of law or in equity.

11.9. Insurance. Licensor will secure, and maintain in force during the term of this Agreement, the insurance coverage set forth on Schedule F. Licensor will provide CHC with insurance certificate(s) in evidence of such coverage. The insurance certificate(s) will provide that CHC be given not less than thirty (30) days prior written notice of any cancellation, non-renewal, or modification of coverage.

11.10. Relationship. The relationship between the parties created by this Agreement is that of independent contractors and not partners, joint venturers or agents, and neither party shall have the power to bind the other party.

11.11. Interpretation. The term "including" shall be deemed to mean "including without limitation" even if such text is not set forth at length. The word "day" shall mean a calendar day, not a business day, unless specifically designated to be a "business day."

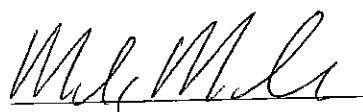
11.12. Counterparts. This Agreement may be executed in two or more counterparts each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

11.13. Section Headings. The Section headings used in this Agreement are for convenience of reference only and are not to be considered in construing or interpreting this Agreement.

11.14. Originals. Any copy of this Agreement made by reliable mechanical means, such as photocopy or facsimile, shall be deemed an original.

IN WITNESS WHEREOF, authorized representatives of parties have executed this Agreement as of the Effective Date.

By:



Name: Mark Masselli

Title: President & CEO, Community Health Center, Inc.

By:



Name: Girish Navani

Title: President, eClinicalWorks LLC

5/26/2006

SCHEDULE A
FUNCTIONAL SPECIFICATIONS

Copy of eClinicalWorks user specifications and manual is provided online at support.eclinicalworks.com.

In addition to online content, a complete copy of eClinicalWorks EHR and PM (version 7.0) Product Manual(s) (incorporated herein by this reference) will be provided prior to the Effective Date to supplement the specifications listed below.

Products	Functionality
eClinicalWorks 7.0 Product Suite	EMR Package and Integrated Practice Management Package to manage the Front Office, Mid Office and Back Office
1. Front Office Package	<ul style="list-style-type: none"> • Appointment Scheduling • Telephone Triage • Referral Management • Office Messaging and Workflow • Patient Management <ul style="list-style-type: none"> ◦ Demographics ◦ Insurance • Document Generation <ul style="list-style-type: none"> ◦ Letters creation and Microsoft Word Mail Merge ◦ Document Scanning and Archiving • Integrated Scan, Digital Image, Digital Audio file interface
2. EMR Package (Mid Office)	<ul style="list-style-type: none"> • Electronic Medical Records (S.O.A.P.) • Prescription Management • Protocol Alerts <ul style="list-style-type: none"> ◦ Immunization and Reminders ◦ Lab and Diagnostics Imaging Reminders • Physician Order Entry <ul style="list-style-type: none"> ◦ Prescriptions, Labs, Diagnostics Imaging • Growth and clinical analysis Charts • E&M Coding Advisor • Bubble sheets • Clinical Analysis Reports • Super Bill, Reports
3. Billing Package (Back Office)	<ul style="list-style-type: none"> • Claims scrubber • Batch management • Clearing house connectivity • Patient statements • Collection management • Financial and management reports • ERA
4. Document Management Package	<ul style="list-style-type: none"> • Scan and manage documents • Lab Reports • Consult Notes • Referrals • All Patient Documents • HIPAA letters, etc

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EHR Functionalities

EHR, Practice Management, and Patient Portal are Programs that provide clinical and administrative functionality for the transmission and documentation of electronic health records, clinical and financial reporting and treatment protocols. Lessor guarantees that Providers have full access and rights of use of the Programs. Lessor's product also leverages and accesses data from other databases and applications. As Lessor provides these functionalities, it will also provide full and seamless access to patient data that will be converted from Centricity Practice Management system. All Providers will be relying on data that is imported/exported from other systems. This includes the timely availability of data that must be integrated, accessed, and easy to use by CHC clinicians and other medical and administrative staff. This is not limited to Lessor's EHR, but refers to the transmission and capturing of data from other proprietary systems as deemed necessary for continuity of CHC patient records. By using the E-HR product, CHC will be able to use all data pertaining to EHR not only as a software application, but as a communication broker that interfaces between different data sources that constitute the Software.

EHR includes: Electronic Medical Records (S.O.A.P.), Prescription Management, Protocol Alerts, Immunization Reminders, Lab and Diagnostic Imaging Reminders, ACPOE, Prescriptions, Labs, Diagnostics Imaging, Growth and clinical analysis Charts, E&M Coding Advisor, Clinical Analysis Reports, Super Bill, and Reports. In addition, EHR comprises of Document Management Package that provides the following functionalities: Scanning and archiving of documents, Lab Reports, Consult Notes, Referrals, All Patient Documents, HIPAA and other compliance letters and correspondence. All new enhancements/upgrades will be automatically included as part of the base offering.

Ryan White and HIV Reports

Lessor will provide application functionality and report capabilities for Ryan White and HIV clinical specialties. This includes presorted lists, six-stage reports, separate HIV laboratory screen, registry capabilities, customization of HIV flow sheets, and other fields, reports, and functions.

Interfaces

The requirements relating to the interfaces between the Program and other databases and clinical systems (as currently described in Schedule I) shall be deemed to be part of the functional specifications.

Disaster Recovery

At CHC's request, Lessor shall provide offsite disaster recovery services pursuant to terms and conditions to be agreed upon by the parties.

SCHEDULE A-1

ECLINICALWORKS RFP PROPOSAL

SEE ATTACHED



eClinical Works RFP
Proposal

A-1-1

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SCHEDULE A-2
STATEMENT OF WORK NUMBER 1

1.1 Work to be Performed; Acceptance Testing and Go-Live of Each Site.

A "Site" means one or more facilities associated with the referenced town or city (i.e., not only a city's principal facility but also other facilities such as school based health centers), as may change and be increased or decreased from time to time. For reference purposes only, a listing of the facilities associated with each Site as of the Effective Date is set forth in Section 1.4 below.

Sites:

- (1) New Britain: Initial Acceptance and Go-Live (defined below) by October 31, 2006
- (2) Middletown: Initial Acceptance and Go-Live by November 30, 2006.
- (3) Remaining Sites are: New London, Meriden, Clinton, Groton and any other designated by CHC, in an order to be determined by CHC.

Milestones:

Sites will be up no more than thirty (30) days apart from one another, i.e., Lessor will bring each Site to implementation and successful testing such that Initial Acceptance and Go-Live with respect to a Site has occurred by no later than thirty (30) days after the prior Site has reached such milestones and such that Final Acceptance occurs by November 30, 2007.

As indicated above, Lessor agrees that all Software will undergo integration and unit testing at each Site and in an integrated manner for all Sites. The coding and data quality is verified by multiple layers of testing via CHC's acceptance testing. Only after the data has been verified at each level of testing is the final product approved for production implementation. Lessor's ongoing verification of data through this process is necessary for testing to be deemed complete by CHC. This will include remote monitoring across interfaces, servers, and application and may include onsite testing. All testing will be under guidance and approval of CHC. "Go-Live" means all Providers and Resources (defined below) successfully and fully accessing the Software in live productive use on a stable and fully-implemented system. Access is not limited to users logging on to EHR, it pertains to a fully functional and stable application and system environment that conforms to agreed upon uptime and downtime measures as set forth in Schedule B-1. Lessor will train all Providers and Resources to be proficient in using the Software in a clinical and administrative setting and pertaining to their role and responsibilities. Go-live at each Site (and enterprise-wide) shall not interrupt or downgrade CHC's standards of clinical care.

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1.2 Custom Report Development. Lessor will develop for CHC custom reports that will provide registry and reporting capability for all designated report functionality outlined in Schedule G at no additional cost. Custom report development will include currently identified reports as well as reports that have yet to be identified. Such reports include: Asthma Collaborative, Diabetes Collaborative, Cardiovascular Collaborative, Prenatal, Depression Collaborative. UDS reports are already under current development and CHC requires that all currently identified reports and reports in development are to be made available at no additional charge. Such reports in development are to be available as soon as they are tested and proven to have full functionality (no later than 30 days after general release). Notwithstanding the foregoing, if all such custom reports are not delivered by December 1, 2006, Lessor shall pay to CHC a credit equal to 5% of the license fees that have been paid to Lessor by CHC prior to December 1, 2006; and if such customer reports are not delivered by February 28, 2007, Lessor shall pay to CHC a credit equal to 10% of the license fees that have been paid to Lessor by CHC prior to February 28, 2007.

1.3 System Testing. System testing includes two (2) site visits to test system viability, bandwidth utilization and network performance at no additional cost. This includes LAN and WAN validation. The initial onsite visit will be conducted to verify system viability prior to hardware purchase. During this visit a network sniffer or protocol analyzer will be utilized to evaluate and monitor for network usage, bottlenecks and/or opportunities for network optimization. The second onsite visit will follow the same procedure, and will take place after all hardware is installed and operational as part of acceptance testing. There will be no additional cost for any visits not prompted by a solely CHC-caused issue. Online tests of network will be provided at no additional charge. The initial two (2) visits will be billed at \$500/day not to exceed \$2,000 in the aggregate for both visits. Lessor will provide a Network and System Evaluation Report as part of each site visit and/or remote test. This report will contain findings including: network traffic, network performance, system configurations, packet and bandwidth utilization, that meet or fail to meet Lessor's specification within each Site and across relevant network switches. Report will contain network and system recommendations and determine current performance levels. Lessor will verify that application runs successfully over Citrix and dark fiber environments and networks. All Lessor Network Check procedures included in Lessor's Welcome Pak as of the Effective Date (attached to the Agreement as Schedule I) (the "Welcome Pak") shall be included as part of System Testing.

1.4 List of Sites as of Effective Date

SITE #1	SITE #2
<input checked="" type="checkbox"/> Year-Round <input type="checkbox"/> Seasonal <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of hours per week services are available at the site: <u>32</u> Date site was opened: <u>4/2001</u> Name of service site: New Britain High School Based Health Center Physical Address: 110 Mill Street City New Britain State CT Zip (9 digit required) 06051-3413 Phone No. 860-826-8845 Fax No. 860-826-8846 Congressional District: Fifth County Name: Hartford Service Area: New Britain Urban/Rural/Sparsely Populated: rural Other HRSA Funding Sources: None	<input checked="" type="checkbox"/> Year-Round <input type="checkbox"/> Seasonal <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> <input type="checkbox"/> Part-Time # of hours per week services are available at the site: <u>32</u> Date site was opened: 3/2000 Name of service site: Keigwin School Based Health Center Physical Address: 99 Spruce Street City Middletown State CT Zip (9 digit required) 06457 Phone No. 860-632-8103 Fax No. 860-632-0376 Congressional District: Third County Name: Middlesex Service Area: Middletown Urban/Rural/Sparsely Populated: Rural Other HRSA Funding Sources: None
SITE #3	SITE #4
<input checked="" type="checkbox"/> Year-Round <input type="checkbox"/> Seasonal <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of hours per week services are available at the site: <u>40</u> Date site was opened: <u>5/1992</u> Name of service site: Community Health Center of New London Physical Address: One Shaw's Cove City New London State CT Zip (9 digit required) 06320-4902 Phone No. 860-447-8304 Fax No. 860-443-8720 Congressional District: Second County Name: New London Service Area: 6901-6905, 6907-6909 Urban/Rural/Sparsely Populated: urban Other HRSA Funding Sources: none	<input checked="" type="checkbox"/> Year-Round <input type="checkbox"/> Seasonal <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> <input type="checkbox"/> Part-Time # of hours per week services are available at the site: <u>40</u> Date site was opened: <u>11/1991</u> Name of service site: Community Health Center of Meriden Physical Address: 134 State Street City Meriden State CT Zip (9 digit required) 06450-3293 Phone No. 203-237-2229 Fax No. 203-686-1677 Congressional District: Fifth County Name: New Haven Service Area: 1701-1703, 1707-1710, 1714-1715 Urban/Rural/Sparsely Populated: urban Other HRSA Funding Sources: Title III

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SITE #5	SITE #6
<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: <u>7/1996</u></p> <p>Name of service site: Community Health Center of New Britain</p> <p>Physical Address: One Washington Square</p> <p>City: New Britain State: CT Zip (9 digit required) 06051-1848</p> <p>Phone No. 860-224-3642 Fax No. 860-224-2760</p> <p>Congressional District: Fifth</p> <p>County Name: Hartford</p> <p>Service Area: 4159-4163, 4166, 4171-4175</p> <p>Urban/Rural/Sparingly Populated: urban</p> <p>Other HRSA Funding Sources: Title III, HCAP</p>	<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: <u>9/2000</u></p> <p>Name of service site: Community Health Center of Clinton</p> <p>Physical Address: 114 East Main Street</p> <p>City: Clinton State: CT Zip (9 digit required) 06413-2112</p> <p>Phone No. 860-664-0767 Fax No. 860-664-1982</p> <p>Congressional District: Second</p> <p>County Name: Middlesex</p> <p>Service Area: 6101-6104, 6301, 6701-6702, 6801, 6501, 6601.01-02</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: Title III</p>
SITE #7	SITE #8
<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the sites: <u>40</u></p> <p>Date site was opened: <u>4/1993</u></p> <p>Name of service site: Rita Hayes Wellness Center</p> <p>Physical Address: MacDonough Elementary 66 Spring Street</p> <p>City: Middletown State: CT Zip (9 digit required) 06457-2262</p> <p>Phone No. 860-344-9821 Fax No. 860-347-0135</p> <p>Congressional District: Third</p> <p>County Name: Middlesex</p> <p>Service Area: Middletown</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: None</p>	<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: <u>6/1980</u></p> <p>Name of service site: New Horizons Battered Women's Shelter</p> <p>Physical Address: Undisclosed, part of Middletown MUA</p> <p>City: State: Zip (9 digit required)</p> <p>Phone No. 860-344-9599 Fax No. 860-344-9953</p> <p>Congressional District: Third</p> <p>County Name: Middlesex</p> <p>Service Area: Middlesex County</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: None</p>

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SITE #9	SITE #10
<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: 9/1995</p> <p>Name of service site: Community Health Center of Groton</p> <p>Physical Address: 333 Long Hill Road</p> <p>City Groton State CT Zip (9 digit required) 06340-3823</p> <p>Phone No. 860-446-8858 Fax No. 860-405-2140</p> <p>Congressional District: Second</p> <p>County Name: New London</p> <p>Service Area: 7022-7023, 7025, 7027-7028</p> <p>Urban/Rural/Sparingly Populated: urban</p> <p>Other HRSA Funding Sources: none</p>	<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: 3/1995</p> <p>Name of service site: Woodrow Wilson School Based Health Center</p> <p>Physical Address: 1 Wilderman's Way</p> <p>City Middletown State CT Zip (9 digit required) 06457-2172</p> <p>Phone No. 860-343-0333 Fax No. 860-343-0402</p> <p>Congressional District: Third</p> <p>County Name: Middlesex</p> <p>Service Area: Middletown</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: None</p>
SITE #11	SITE #12
<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: 5/1972</p> <p>Name of service site: Community Health Center of Middletown</p> <p>Physical Address: 635 Main Street</p> <p>City Middletown State CT Zip (9 digit required) 06457-2718</p> <p>Phone No. 860-347-6971 Fax No. 860-347-2043</p> <p>Congressional District: Third</p> <p>County Name: Middlesex</p> <p>Service Area: 5411,5415-5418</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: Title III</p>	<p>X Year-Round G Seasonal X Full-Time <input type="checkbox"/> Part-Time</p> <p># of hours per week services are available at the site: <u>40</u></p> <p>Date site was opened: 1/1980</p> <p>Name of service site: Family Wellness Center</p> <p>Physical Address: 635 Main Street</p> <p>City Middletown State CT Zip (9 digit required) 06457-2718</p> <p>Phone No. 860-347-6971 Fax No. 860-347-2043</p> <p>Congressional District: Third</p> <p>County Name: Middlesex</p> <p>Service Area: Middletown</p> <p>Urban/Rural/Sparingly Populated: Rural</p> <p>Other HRSA Funding Sources: None</p>

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SITE #13	
X Year-Round G Seasonal Full-Time <input checked="" type="checkbox"/> x Part-Time # of hours per week services are available at the site: <u>8</u> Date site was opened: <u>2/1/06</u> Name of service site: <u>Eddy Shelter</u> Physical Address: <u>Labella Circle</u> City <u>Middletown</u> State <u>CT</u> Zip (9 digit required) <u>06457-XXXX</u> Phone No. Fax No. Congressional District: <u>second</u> County Name: <u>Middlesex</u> Service Area: <u>6101-6104, 6301, 6701-6702, 6801, 6501, 6601, 01-02</u> Urban/Rural/Sparsely Populated: <u>rural</u> Other HRSA Funding Sources: <u>None</u>	

IN WITNESS WHEREOF, authorized representatives of parties have executed this Statement of Work as of the Effective Date of the Agreement.

By: _____

By: _____

Name: Mark Masselli

Name: Girish Navani

Title: President & CEO, Community Health Center, Inc.

Title: President, eClinicalWorks LLC

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SCHEDULE B
MAINTENANCE SERVICES AND TRAINING

1. Support.

1.1 Telephone Support Staffing.

(a) A group of no less than seven and no more than twelve CHC representatives, who are certified by Licensor as having passed its then-current test for Software proficiency, will provide first-line support to CHC staff on Software issues. Should the number of such representatives fall below seven, CHC shall have sixty (60) days to replace such representatives. CHC shall from time to time provide an updated list of such staff to Licensor, and Licensor shall not be obligated to provide support to any other personnel. If the issue is beyond the scope of knowledge of a CHC representative or cannot be promptly remedied by a CHC representative, Licensor will promptly provide assistance by telephone or e-mail to CHC in resolving such issue. CHC shall provide Licensor remote access to the Software via VPN and the Internet, or such other means of connectivity as is mutually agreed to by the parties in writing. Licensor shall be relieved of its obligations hereunder to the extent CHC's failure to provide such access affects Licensor's ability to resolve Software issues.

(b) Licensor will maintain at all times a designated and dedicated product specialist resource that retains knowledge of the EHR implementation process at CHC, retains knowledge of the organization, such that knowledge of such implementation and CHC's system environment is not lost after the transition from Go-Live to support, and keeps current on all aspects of outside report development at other community health centers and make data available to CHC. Such product specialist who will participate in the EHR implementation process is required to continue to guide, draw together resources, track, and resolve software support issues after Go-Live. The product specialist will ensure an 'integrated' resource coordination within Licensor's own organization and full support based on CHC's needs and agreed upon development initiatives over time.

(c) Hours of Operation. Licensor shall provide support by telephone (via toll-free number) and e-mail on a 24 x 7 basis for the resolution CHC issues, including technical questions and Software errors. The normal business hours for support are from 8:00 A.M. ET to 6:00 PM ET. The Annual Support Fees (defined in Schedule C) cover unlimited support via telephone and email within the normal business hours. After hours support will be billed at \$70/incident; provided, however that any after hours support relating to backup-related issues shall be provided by Licensor at no cost for a period of one (1) year from Final Acceptance. Licensor shall work with CHC in good faith to resolve support issues during the normal business hours. Critical issues identified during regular business hours that run into weekend hours will continue to receive timely, full and necessary resources for resolution in accordance with the service levels, response times, and escalation procedures set forth in this Schedule B.

1.2 Support Issue Classification. Support issues shall be categorized as follows:

(a) High Priority: An issue that results in complete non-functionality of the Software or that otherwise prevents Software users at all CHC locations from entering or

retrieving scheduling information, accessing patient information, or entering encounter data. Licensee will respond to CHC's initial report of a High Priority issue within thirty (30) minutes. Issue resolution shall occur within one (1) hour or a time frame mutually agreed to by the parties. Such resolution time period defined with respect to each priority definition, running from the time the issue is reported to Licensee, is referred to herein as the "**Resolution Period**".

(b) **Medium Priority:** An issue other than a High Priority (Critical) issue that prevents Software users at one or more CHC locations from entering or retrieving scheduling information, accessing patient information, entering encounter data, electronically transmitting claim information, or any issue that unless promptly remedied is likely to impose a substantial additional clerical burden on CHC. Licensee will respond to CHC's report of a Medium Priority issue within two (2) hours. Issue resolution shall occur within one (1) business day or a time frame mutually agreed to by the parties.

(c) **Low Priority:** An issue that interferes with the effective use of the Program, but which can be easily avoided by a workaround reasonably acceptable to CHC, an issue that is unlikely to pose more than a minor inconvenience to a Software user in the performance of his or her job functions, or any other issue that does not constitute a High or Medium Priority issue. Licensee will respond to CHC's report of a Low Priority issue within four (4) hours. Issue resolution shall occur within four (4) business days or a time frame mutually agreed to by the parties.

(d) **Functional Enhancement:** An issue that would improve the functionality of the Program but does not cause unscheduled downtime, affects Software performance, or prevents users at any CHC locations from entering or accessing patient information is considered a Functional Enhancement. Licensee will respond to CHC's report of a Functional Enhancement within 5 business days. Issue resolution will be resolved in next upgrade release. Licensee shall create a community health center steering team (the member of which will be determined by the parties and reasonably acceptable to CHC) to allow CHC to provide input and direction on Functional Enhancements. The steering team shall meet online or onsite every quarter for the first two (2) years following Final Acceptance and thereafter as mutually agreed by the parties.

1.3 **Resolution of Issues.** CHC may log support cases by telephone or through Licensee's case management system accessible through Licensee's secure Web site. Licensee shall respond to the initial report of an issue and begin efforts to diagnose and resolve the issue no later than the response time indicated with respect to each priority level. A temporary workaround, including a patch, restriction or bypass, that does not require CHC to use substantial additional efforts to compensate for any impaired functionality shall be considered a correction of any such failure as of the date the same is provided by Licensee to CHC, provided that Licensee continues its efforts to resolve the underlying issue and does so within a time period agreed to by the parties.

1.4 **Support Service Credits.** Should Licensee fail to resolve an issue within the applicable Resolution Period set forth above, CHC shall receive a refund of the Software Support fees as follows: (i) for High Priority issues, a refund equal to three (3) times the prorated portion of the applicable Annual Support Fees paid by CHC for number of complete or partial days during which the issue remained unresolved plus two (2%) of applicable Annual Maintenance

Fees (defined in Schedule C) paid by CHC; (ii) for Medium Priority issues, a refund equal to the prorated portion of the applicable Annual Support Fees for the number of complete or partial days during which the issue remained unresolved plus (2%) of the applicable Annual Maintenance Fees. The refunded Annual Support Fees and Annual Maintenance Fees during any month in which an issue occurred will not exceed the total Annual Support Fees and Annual Maintenance Fees paid attributable to such month.

2. Maintenance.

2.1 Updates and Corrections. Lessor shall make available to CHC all lessor developed interfaces, modifications, updates, enhancements, corrections and new version releases to the Software as are made available to other users of the Programs or are otherwise required to correct Programs errors reported by CHC (collectively, "Updates"). For each Update, Lessor represents and warrants that the installation of such Update shall not give rise to any additional charges by Lessor and the installation of the Update shall not adversely affect Software performance as warranted in this Agreement. CHC may decline to utilize any such Update, which shall not relieve Provider of any of its warranty or Maintenance Services obligations under the Agreement.

2.2 Known Issues and Program Bugs. All Updates are to provide a full list of known Program incapability including functionality loss, conflicts with MS OS, IE, antivirus incompatibilities with McAfee and Norton antivirus software, and all known issues regarding Citrix and Dark Fiber impact from upgrades and update patches. Fixes for Program bugs and coding errors that have the potential to affect Program performance and user experience are to be released to CHC sixty (60) days prior to general release of Updates to allow CHC the opportunity to test and verify prior to accepting such Updates.

2.3 Additional Terms. CHC reserves the right to reject all Updates, which shall not relieve Provider of any of its warranty or Maintenance Services obligations under this Agreement. Lessor must provide CHC with the ability to manually reject/deny Update packages.

3. Software and My-SQL Versions: The Program will be 7.0 or later version and will be implemented with My-SQL 5.0 version or later by October 2006. No other earlier versions will be accepted after Go-Live for the first Site. Lessor will make available the Program available for use on the Microsoft SQL platform by March 2007 should CHC determine to switch to this platform. Lessor insures full functionality to all CHC's users. CHC will be responsible for buying required licenses for Microsoft SQL.

4. Training.

4.1 Initial Train-the-Trainer. Twelve (12) seats at full train-the-trainer sessions at Licensor's Corporate offices. Licensor recommends a minimum of 3-5 day training sessions with an option to have additional follow-up sessions. Licensor shall provide a Beta server during and after this training session until the first Site is Go-Live.

4.2 Train Providers. Program and Training Specialists are to be onsite at CHC during Provider training. They will assist CHC's expert trainers with hands-on application training. All training criteria set forth in the Welcome Pak is included in Provider training.

4.3 Training Format. Training Format as set forth in the Welcome Pak will be reviewed by CHC prior to CHC's staff participation. This review will provide the opportunity for Licensor and CHC to shape curriculum and timing of training to meet the needs of CHC's clinical and administrative staff schedule and competencies.

4.4 Administrative Training. Licensor will provide detailed 'backend' application training as is Licensor's standard procedure indicated in RFP response, Functional Requirements and Welcome Pak. This will include, but is not limited to:

- (a) APL, Ad Hoc, and Crystal Report generation.
- (b) Application, error log and interface monitoring
- (c) All aspects of customization of templates and forms including text and field editing, embedding links, establishing all coding protocols relevant to the transmission and continuity of electronic patient records
- (d) Setting of security levels and access protocols
- (e) All application functions including: OB/GYN Flow sheet, Lab and Test Management, Progress Note Customization, Progress Note Heading modification based on preferences, fax and email management.

4.5 Beta Server for Training. A Beta Server will be made available to CHC expert trainers who, after returning from training sessions, will apply their knowledge immediately to application use and experimentation. A Beta Server is to be installed and ready for use by CHC expert trainers within two weeks of the Effective Date.

4.6 New Release Training. Four seats at 5-day train-the-trainer program in a location to be determined by CHC for any of two subsequent Program releases to be selected at CHC's discretion: training provided at \$500 per day plus reasonable, documented travel expenses. CHC can reserve a training slot at the Licensor's training facilities at \$150 per day per person. Licensor will also offer Web based training sessions. CHC can sign up for any online Web sessions for \$50 per session. Web training schedule is provided at support.eclinicalworks.com. The scheduling of such training shall be subject to the mutual agreement of the parties. CHC is entitled to one (1) New Release Training, free of charge, per year.

4.7 Interview/Selection of Trainers. CHC reserves the right to interview and select all trainers that Licensor provides. Licensor is to provide seasoned and knowledgeable trainers who

have experience in CHC implementation and training and/or have experience in large-scale implementations and training with healthcare sites of 60+ providers.

4.8 Customizations. CHC reserves the right to design and make modifications to Licensor's training project to customize training to CHC's needs. At CHC's election, training will not commence until such customizations are made.

4.9 My-SQL and Application Server Training. Licensor will provide My-SQL and application server documentation to CHC's IT staff (3-5) at no additional charge. CHC requires that Licensor training include a resource who possesses expert knowledge of My-SQL and eClinicalWorks Application Server set up and configuration to train CHC's IT staff to install and troubleshoot relevant server, backup procedures, and log file maintenance. Such procedures shall follow Licensor's installation guide, attached hereto as Schedule K. CHC will also make available any knowledge deemed beneficial to Licensor's own trouble shooting of My-SQL in a similar system environment.

SCHEDULE B-1

AVAILABILITY SERVICE LEVEL

Services Measured: Availability of the Software and any related system (collectively "System")

Defined: The amount of time that the System is Available.

Service Level Guarantee: For the purpose of allocating a discount as a service credit under this Schedule B-1, as set forth below, the System will be available at least 99.9% from 8:00 A.M. to 6:00 P.M. ET Monday through and including Friday (although the System will also be Available weekends and evenings) other than Scheduled Downtime (the "Designated Time"). "Scheduled Downtime" is mutually agreed upon, pre-scheduled weekend and evening downtime for regular preventative maintenance and system (version) upgrades, backups, re-boot and restart. CHC is responsible for any and all hardware and hardware downtime, which will be excluded from the "Available" service level unless such downtime was caused by Software corruption or failure. Hardware failure examples: Hard drive failure, network card failure, etc. "Available" means available for actual access and use by all relevant Providers and Resources and providing all functions and features in accordance with Schedule A. In addition, Licensor shall at its own expense immediately furnish remedial services as needed so that the Software functions properly.

Measurement: Availability will be calculated as the amount of time (in hours) the System is Available during the Designated Time during the Measurement Period divided by the total amount of time (in hours) during the Designated Time during that Measurement Period. System Availability shall be measured in 'total round-trip' manner, i.e., a system is considered 'Available' if all patient information including patient demographics, schedules, chart/progress notes, and reports (patient information) is available to the hardware server within 3 seconds and that same patient information is fully accessible and functional to users within 5 seconds provided all sites have broadband access (768KBs/sec) of the initial data entry and/or data query.

Measurement Period: Every 3 consecutive calendar month period commencing after the Initial Acceptance of the first Site.

Measurement Reports: Measurement reports will be provided quarterly and on an as-needed basis at CHC's request.

Availability

The following discount shall apply to fifteen percent (15%) of all Annual

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Support Fees and Annual Maintenance Fees attributable for the period due during the Measurement Period for Availability in the specified category, except if the lack of Availability was due to CHC's fault

<u>System Availability</u>	<u>Discount</u>
99.9%≤ x < 100%	0%
99.5%≤ x < 99.9%	12%
99.0%≤ x < 99.5%	25%
98.5%≤ x < 99.0%	37%
98.0%≤ x < 98.5%	50%
97.5%≤ x < 98.0%	62%
97.0%≤ x < 97.5%	75%
96.6%≤ x < 97.0%	87%
x<96.6%	100%

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SCHEDULE C

FEES

This Schedule C sets forth all fees under the Agreement. No other fees shall be payable under the Agreement.

1. Provider License Fees

The following fees are in respect to the License as it relates to use of the Software by Providers ("License Fees"). CHC is not responsible for paying these fees other than on a one-time, non-recurring basis.

Providers As of Effective Date

This Section 1 sets forth the fees payable for Provider use of the Software on the Effective Date. On the milestones set forth in the timetable set forth in Table 2, below, if reached, and subject to the terms of the Agreement, CHC shall pay Lessor the applicable one-time per-Provider license fees set forth in E-HR column in Table 1 below multiplied by the number of Providers as of the Effective Date in such categories (i.e. 73 Providers), totaling \$181,550. (A "Provider" shall mean any individual determined by CHC to be a licensed independent Provider, including without limitation physicians, nurse practitioners, licensed clinical social workers and psychologists. Because of the significant variation in the numbers of visits generated and ancillary staff required by Providers in the primary care medical specialties relative to the behavioral health specialties, separate categories of license fees are established for these two major groups. A Provider may only fall into one numbered category, which is based on hours as described below, and one subject matter category, i.e., medicine or behavioral health.) An additional License Fee (designated below) is assessed if Providers require a license to the Practice Management and/or Patient Portal, as elected by CHC in its sole discretion. Such licenses shall be subject to the same license rights set forth in the Agreement. Once elected by CHC, the License Fee payment schedule for Practice Management shall be agreed upon by the parties but shall be consistent with the payment schedule in Table 2 below if such election is made during Software implementation.

Table 1
One-Time Per Provider License Fee

Provider Category	Average hours per week Provider works for CHC (determined on a quarterly basis)	E-HR		Practice Management	
		Medicine	Behavioral Health	Medicine	Behavioral Health
1	30 or more	\$4,100	\$2,250	\$500	\$250

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Provider Category	Average hours per week Provider works for CHC (determined on a quarterly basis)	E-HR		Practice Management	
		Medicine	Behavioral Health	Medicine	Behavioral Health
2	16 or more, but fewer than 30	\$2,250	\$1,125	\$500	\$250
3	5 or more, but fewer than 16	\$1,500	\$550	\$500	\$250
4	Fewer than 5	\$500	\$250	\$500	\$250

Patient Portal

The Patient Portal will be licensed, at CHC's election, for use by CHC's entire patient, Provider and Resource population during an 18 month pilot period that will commence at CHC's discretion, which license shall continue beyond the pilot period if elected by CHC. This 18 month period will be used for the co-development of new features, research, remote monitoring and access, and Full Adoption. During the co-development period, the parties shall work together to further develop and test the Patient Portal to meet specific CHC requirements. At any time (whether during or after pilot period), CHC may terminate the Patient Portal license and receive a refund of a pro-rata portion of the pre-paid license fees (if any). In consideration of such license, CHC shall pay the following License Fees during the applicable periods set forth below, which fees shall be calculated on a monthly basis as agreed upon by the parties and invoiced quarterly by Lessor.

Phase One of co-development commencing on the date determined by CHC and continuing for a six (6) month period thereafter @ \$25/per month per Provider.

Phase Two of co-development commencing at the end of Phase One and continuing for a six (6) month period thereafter @ \$50/per month per Provider.

Phase Three of Patient Portal Full Adoption commencing at the end of Phase Two and continuing for a six (6) month period thereafter @ \$65/per month per Provider.

Phase Four of Patient Portal Full Adoption commencing at the end of Phase Three and continuing for so long as CHC elects @ \$75 per Provider.

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Table 2
Timing of License Fee Payments for Providers as of the Effective Date

Criteria	License Fee Payment
Agreement Effective Date	50% of \$181,550 (i.e., \$90,775)
Initial Acceptance at a Site	30% of that portion of the \$181,550 License Fee attributable to the Providers at such Site
Final Acceptance	20% of \$181,550 (i.e., \$36,310)

Changes in Number of Providers after Final Acceptance (If Required)

After Final Acceptance, on a quarterly basis, CHC shall compare the number of Providers in each quarter against the number of Providers in the previous quarter. If CHC determines that the number of Providers in such quarter exceeds the number of Provider licenses purchased by CHC, then CHC shall purchase as a one-time expenditure the corresponding number of incremental licenses, if any, subject to the terms of the Agreement and Table 1 (as hours are applicable for the applicable quarter). If CHC determines that the number of Providers in such quarter are less than the number of Provider licenses purchased by CHC, then CHC may retain such unused licenses and may apply them in the future to any Providers added by CHC. Notwithstanding anything to the contrary set forth herein, CHC may freely reassign licenses among Providers (including reassigning one Provider license to multiple Providers so long as the total average hours or such multiple Providers are no greater than the average hour limitations of the reassigned license) without any requirement of an additional purchase.

Resources

Any individual whom CHC determines does not fall within the above definition of "Providers" shall be deemed to be a "Resource" and shall have full access and use of the Software at no additional cost, including nurses, medical assistants, case managers and other staff.

2. Other One-Time Fees.

There are no fees in connection with Schedules A or B other than as set forth below. After the following fees are accrued, Licensor shall pay all other amounts it may incur in connection with the corresponding description without reimbursement, regardless of work required, notwithstanding any provision in the Agreement to the contrary.

Project Management Fee (up to \$7,500): Includes project management as the application of knowledge, skills, tools, and techniques to project activities, to meet project requirements, and draw together key resources, including kick off call, project planning and tracking, scheduling communication, coordination of resources and third parties for timely delivery of interfaces, regardless of the amount.

Installation (up to \$5,000): Includes all aspects of Program loaded into test and production. Installation may take place both remotely and onsite, regardless of number of Sites.

Training (up to \$50,000): Includes all training of CHC trainers and Providers, as described in the Agreement and Schedule B, Section 4 for up to 100 man days of training (billed at \$500/day). CHC will assign Super Users trained and certified in eClinicalWorks to augment Licensor's onsite trainers. This training will be used to train the trainers and Site Super Users. Any additional training required by CHC shall be provided by Licensor and billed at \$500/day.

Travel and accommodations (estimated \$10,000): Includes all Licensor installation, site survey, and project direction. These funds will be held in an account and will be drawn upon as needed and subject to CHC's written approval in each instance. If travel and accommodations are less than this amount the remainder will be returned to CHC. Additional travel expenses billed at \$225 per diem.

Interface Development: Licensor's development of the 16 interfaces set forth in Schedule I shall be performed at no cost. Any additional custom interfaces other than those listed in Schedule I that CHC requires that Licensor develop will be billed at \$5000 per interface.

Interface Configuration (\$280 per interface x 16 = Up to \$4,480): No additional interface configuration charges are to be incurred by CHC regardless of the complexity or number of additional interfaces in excess of the 16 interfaces referenced in Schedule I. Where applicable, any such interfaces are to be charged to attendant hospitals and clinics. Licensor shall work with reference and hospital labs to implement lab interfaces within 16 weeks of the Effective Date. As part of such endeavor, Licensor shall, within two weeks of the Effective Date, initiate a kick off meetings in collaboration with CHC to bring together the relevant hospital and reference labs on a Site by Site basis. This tuning is based on receiving timely and committed resources from the reference labs and the hospital labs.

Interface to Centricity Practice Management System (up to \$5,000): Including interface and configurations charges. This interface includes charges and codes (ICD-9 and CPT codes), patient demographics, schedules, and insurance data instantaneously and bi-directionally populates Licensor's EHR and Centricity PM system, regardless of amount. Licensor will provide this interface before Go-Live occurs at the first Site.

Data Migration (up to \$12,500): Includes data migration of patient demographics, schedules, and insurance from Centricity Practice Management System to eClinical's Electronic Health Record, not to exceed \$2,000. Data conversion will be included as a core installation service. Data Conversion includes Lab Tracker data conversion, CDEMS, and report and template testing, not to exceed \$8,000. CHC's Access to Care Data Base will require conversion to EHR, billed at \$500/day for estimated 5 days.

RightFax Integration: At no charge to CHC, Licenser will make a good faith effort to integrate RightFax or find a compatible faxing solution for CHC. Such an integrated solution must conform to all Software versions, performance levels and system specifications set forth in the Agreement.

3. **Software Maintenance Fees.**

Annual Maintenance Fees

The annual fees for Maintenance (as described in Section 2 of Schedule B) (the “**Annual Maintenance Fees**”) shall total eighteen percent (18%) of License Fees. These are the sole fees for Maintenance.

Annual Support Fees

The annual fees for Support (as described in Section 1 of Schedule B) are \$400 per Provider per year (the “**Annual Support Fees**”); provided, however, that if CHC’s IT staff goes through the training and certification processes described in Schedule H to the Agreement, and CHC agrees to provide Tier1 and Tier2 support, the Annual Support Fees shall be reduced to \$200 per Provider per year effective on the day that CHC commences the provision of Tier 1 and Tier 2 support with 30 day advance notice to Licensor. The Annual Support Fees shall be reconciled on a quarterly basis based on the actual volumes of Providers in the prior quarter, with appropriate payments to be made by CHC or credits to be issued to CHC by Licensor.

Additional Terms

CHC’s shall commence paying Annual Maintenance Fees and Annual Support Fees on a Site-by-Site basis. When Initial Acceptance occurs at a Site, Licensor may commence invoicing CHC for the applicable Annual Maintenance Fees and Annual Support Fees attributable to such Site (i.e., if Initial Acceptance occurs at a Site with 5 Providers, Licensor would invoice CHC: (1) with respect to Annual Maintenance Fees, 18% of the License Fees that CHC paid so that such 5 Providers could use the Software; and (2) with respect to the Annual Support Fees, $5 \times \$400 = \$2,000$). The Annual Maintenance Fees and Annual Support Fees may not be increased for any additional Providers during the first three (3) years following Final Acceptance, and thereafter, such fees may be increased no more than once annually, and any such increase may not exceed the percentage change in the most recent Consumer Price Index for All Urban Consumers, All Items (without seasonal adjustment) as published by the Bureau of Labor Statistics of the U.S. Department of Labor (the “**CPI-U**”) compared with that index published 12 months earlier.

SUMMARY OF FEES

Software License Fees for Clinical Works

eClinical Works - Medical - 30 Hrs	28	4,100	114,800
eClinical Works - Medical - >16 Hrs <30 Hrs	1	2,250	2,250
eClinical Works - Medical - >5 Hrs <16 Hrs	6	1,500	9,000
eClinical Works - Medical - <5 Hrs	11	500	5,500
eClinical Works - Behavioral Health - 30 Hrs	20	2,250	45,000
eClinical Works - Behavioral Health - >16 Hrs <30 Hrs	2	1,125	2,250
eClinical Works - Behavioral Health - >5 Hrs <16 Hrs	5	550	2,750
eClinical Works - Behavioral Health - <5 Hrs	0	250	-

Total License Fees: \$181,550

Interfaces (not to exceed)	16	280	4,480
Interface - Practice Management (not to exceed)	1	5,000	5,000
Site Survey (not to exceed)	2	1,000	2,000
Project Management (15 days- \$500/day) (not to exceed)	15	500	7,500
Installation (10 days - \$500/day) (not to exceed)	10	500	5,000
Training (\$500/day per trainer - 100 Days) (not to exceed)	100	500	50,000
Travel (estimated)	1	10,000	10,000
Data Migration (not to exceed)	1	12,500	12,500

Total One-Time Fees: \$96,480

Software Maintenance Fees for eClinical Works

Annual Maintenance Fees (18% of the License Fee)	1	32,679	32,679
Annual Support Fee per Provider	73	400	29,200

Total Software Maintenance Fees: \$61,879

Source Code Escrow Costs (annual cap) 1 500 \$500

SCHEDULE D
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SCHEDULE E

BUSINESS ASSOCIATES AGREEMENT

This Business Associate Agreement, effective _____, 200____ ("Effective Date"), is entered into by and between _____ (the "Business Associate") and _____ (the "Covered Entity") (each a "Party" and collectively the "Parties").

This Business Associate Agreement ("Rider") shall serve as an addendum to the Agreement dated _____, 200____ between the Parties (the "Agreement") under which the Business Associate will have access to and use Protected Health Information (as that term is defined in the Health Insurance Portability and Accountability Act of 1996 and its related regulations, 45 CFR Part 164 ("HIPAA"), in its performance of the services described below and/or in the Agreement.

Business Associate hereby acknowledges that Covered Entity is a "covered entity" and that Business Associate is a "business associate" as those terms are defined in HIPAA.

The Parties agree that each of them and all of their employees, agents and contractors shall comply with all provisions of the Standards for Security and Privacy of Identifiable Health Information ("Security and Privacy Regulations") under HIPAA as currently written and as amended from time to time. Business Associate will instruct its employees, agents and subcontractors in the requirements of this Rider, and will ensure their compliance with this Rider.

1. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE OF PROTECTED HEALTH INFORMATION

Pursuant to the Agreement, Business Associate provides services for the Covered Entity that will involve the use and/or disclosure of Protected Health Information. Except as otherwise specified herein, the Business Associate may use Protected Health Information to the extent necessary to perform its obligations under the Agreement. Business Associate may disclose Protected Health Information, for the purposes authorized by this Rider only, (i) to its employees, subcontractors and agents, in accordance with Section 2.1(e) below; (ii) as directed by the Covered Entity, or (iii) as otherwise permitted by the terms of this Rider or as required by law. All other uses and disclosures not authorized by this Rider are prohibited.

2. RESPONSIBILITIES OF THE BUSINESS ASSOCIATE WITH RESPECT TO PROTECTED HEALTH INFORMATION

- 2.1 With regard to its use and/or disclosure of Protected Health Information, the Business Associate hereby agrees to do the following:

- a. ***Use and Disclosure.*** Use and/or disclose the Protected Health Information only as permitted or required by this Rider or as otherwise required by law.
- b. ***Reporting.*** Report to the Covered Entity in writing any use and/or disclosure of the Protected Health Information that is not permitted or required by this Rider or any breach of security of electronic Protected Health Information of which Business Associate becomes aware within three (3) business days.
- c. ***Safeguards.*** Maintain the security of the Protected Health Information and to prevent unauthorized use and/or disclosure of such Protected Health Information; and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Covered Entity.
- d. ***Subcontractors and Agents.*** Require all of its subcontractors and agents that receive or use, or have access to, Protected Health Information under this Rider to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to the Business Associate pursuant to this Rider.
- e. ***Audit and Inspection.*** Make available all records, books, agreements, policies and procedures relating to the use, disclosure, and safeguarding of Protected Health Information to the Secretary of Health and Human Services for purposes of determining the Covered Entity's compliance with the Privacy and Security Regulations, provided that Business Associate will notify Covered Entity in writing promptly upon receiving any requests for such documents and information from the Secretary of Health and Human Services or his/her representative.
- f. ***Maintenance of Disclosure Records.*** Maintain sufficient information (including date of disclosure, name of receiver and address (if known), description of Protected Health Information disclosed and the purpose of disclosure) to permit a complete accounting of all disclosure of Protected Health Information within the previous six (6) years (and subsequent to April 14, 2003), excluding disclosures made for treatment, payment and health care operations, as part of a limited data set, pursuant to the patient's authorization, for national security or intelligence purposes or other purposes excepted under 45 C.F.R. Section 164.528 (or equivalent); and provide to the Covered Entity notice of each such disclosure promptly, in order to permit the Covered Entity to respond to requests by individuals for an accounting of the disclosures of the individuals' Protected Health Information in accordance with 45 C.F.R. Sections 164.528 and 164.314.

- g.* ***Access for Patient Inspection and Amendment.*** To the extent that Business Associate is maintaining a “designated record set” for Covered Entity, within 15 days of receiving a written request from Covered Entity or directly from a patient or authorized patient representative, provide to Covered Entity such records and information as is requested to permit Covered Entity to timely respond to an individual’s request to (i) inspect and/or copy Protected Health Information within the designated record set in accordance with 45 C.F.R. Section 164.124; and/or (ii) amend Protected Health Information in accordance with 45 C.F.R. Section 164.526 (or equivalent).
- h.* ***Return or Destruction.*** To the extent feasible, return or destroy the Protected Health Information within its possession upon termination of the Agreement. If it is not feasible to immediately return or destroy the Protected Health Information because of other obligations or legal requirements, the protections of this Rider shall apply until the Protected Health Information is returned or destroyed, and no other uses or disclosures may be made except for the purposes which prevented the return or destruction of the Protected Health Information.
- i.* ***Mitigation and Injunction.*** Establish procedures for mitigating, and cooperate with Covered Entity to mitigate, to the greatest extent possible, any deleterious effects from any improper use and/or disclosure of Protected Health Information, regardless of its cause. To the extent that Business Associate breaches its obligations under this Rider, Business Associate shall promptly cure such breach and take any necessary steps, at its own expense, to mitigate any harm caused. Notwithstanding the foregoing, Covered Entity maintains the right to intervene and, in addition to any other remedies available to Covered Entity at law or in equity, to an injunction or other decree of specific performance to effectuate a cure of any breach of Business Associate’s duties under this Rider. Business Associate agrees that any breach of this Rider will result in irreparable harm to Covered Entity.
- j.* ***Indemnification.*** Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from or relating to the acts or omissions of Business Associate in connection with a breach of the representations, duties and obligations of Business Associate under this Rider.

3. TERM AND TERMINATION

- 3.1 ***Term.*** This Rider shall become effective as of the Effective Date and shall continue in effect until all obligations of the Parties have been met. The terms

and conditions of this Rider shall survive the expiration or termination of the Agreement.

- 3.2 ***Termination by the Covered Entity.*** The Covered Entity may immediately terminate the Agreement and any related agreements if the Covered Entity makes the determination that the Business Associate has breached a material term of this Rider, or if a finding or stipulation that Business Associate has violated any standard or requirement of the Privacy and Security Regulations or other security or privacy laws is made in any administrative or civil proceeding in which Business Associate has been joined.

4. MISCELLANEOUS

4.1 ***Amendment.*** The Parties agree to enter into a mutually acceptable amendment to this Rider as necessary to comply with applicable federal laws and regulations governing the use and/or disclosure of individually identifiable health information. Such amendment shall be entered into on or before the date on which compliance is required. Covered Entity may terminate the Agreement upon thirty (30) days' written notice in the event that Business Associate does not promptly enter into an amendment that Covered Entity, in its sole discretion, deems sufficient to ensure Covered Entity's compliance with such laws and regulations.

4.2 ***State Law.*** Nothing in this Rider shall be construed to require Business Associate to use or disclose Protected Health Information without a written authorization from an individual who is a subject of the Protected Health Information, or written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

4.3 ***No Third Party Beneficiaries.*** Nothing express or implied in this Rider is intended or shall be deemed to confer upon any person other than Covered Entity, Business Associate, and their respective successors and assigns, any rights, obligations, remedies or liabilities.

4.4 ***Conflicting Terms.*** To the extent that there is any conflict between the terms of the Agreement and the terms of this Rider, the terms of this Rider shall prevail.

4.5 ***Defined Terms.*** Terms used in this Rider that are not defined in this Rider shall have the meanings ascribed to them under HIPAA.

IN WITNESS WHEREOF, each of the Parties has caused this Business Associate Agreement to be duly executed in its name and on its behalf effective as of the date first written above.

COVERED ENTITY

By: Mark Massell
Print Name: Mark Massell
Print Title: PRESIDENT/CEO
Date: 5/26/2006

BUSINESS ASSOCIATE

By: Girish Navani
Print Name: GIRISH NAVANI
Print Title: PRESIDENT
Date: 6-2-06

SCHEDULE F
INSURANCE
SEE ATTACHED

F-1

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ACORD CERTIFICATE OF LIABILITY INSURANCE				DATE (MM/DD/YYYY) 5/1/2006	
PRODUCER (978) 696-0007 FAX (978) 345-6811 Employers Insurance Group, Inc. 281 Main Street Suite 7B Fitchburg MA 01420		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERNS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.			
INSURED aClinical Works, LLC Westboro Executive Park 114 Turnpike Road Westboro MA 01581		INSURERS AFFORDING COVERAGE NAIC # INSURER A Evanston Insurance INSURER B INSURER C INSURER D INSURER E			
COVERAGES THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION IN ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.					
TYPE OF INSURANCE <input type="checkbox"/> GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> GENERAL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJ. <input type="checkbox"/> LOC	POLICY NUMBER Policy Number:		POLICY EFFECTIVE DATE (MM/DD/YY) Date (MM/DD/YY): 5/10/2005	POLICY EXPIRATION DATE (MM/DD/YY) Date (MM/DD/YY): 5/10/2006	
	EACH OCCURRENCE \$ <input type="checkbox"/> EACH AUTO \$ <input type="checkbox"/> EACH BUSINESS (Ex. excess limit) \$ <input type="checkbox"/> MED EXP (Any one claim) \$ <input type="checkbox"/> PERSONAL & ADV. INJURY \$ <input type="checkbox"/> GENERAL AGGREGATE \$ <input type="checkbox"/> PRODUCTS - CONCIP AGG \$ COMBINED SINGLE LIMIT (Ex. excess limit) \$ <input type="checkbox"/> BODILY INJURY (Per person) \$ <input type="checkbox"/> BODILY INJURY (Per accident) \$ <input type="checkbox"/> PROPERTY DAMAGE (Per incident) \$ AUTO ONLY - EA ACCIDENT \$ <input type="checkbox"/> OTHER THAN EA ACC \$ <input type="checkbox"/> AUTO ONLY: AGG \$ EACH OCCURRENCE \$ <input type="checkbox"/> AGGREGATE \$ <input type="checkbox"/> \$ <input type="checkbox"/> \$ <input type="checkbox"/> \$ INC. STABL. TOTY (TARS) 12TH <input type="checkbox"/> EL EACH ACCIDENT \$ <input type="checkbox"/> EL DISEASE EA EMPLOYEE \$ <input type="checkbox"/> EL DISEASE POLICY LIMIT \$				
	Each claim \$3,000,000 Annual Aggregate \$3,000,000				
	DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENTS/SPECIAL PROVISIONS Coverage for professional services rendered				

CERTIFICATE HOLDER	CANCELLATION
FOR RECORD PURPOSES ONLY	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.
AUTHORIZED REPRESENTATIVE 	

ACORD 25 (2001/05)

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SCHEDULE G
LIST OF REPORTS

Licensor shall provide CHC with the following reports on a timetable designated by CHC as set forth in Schedule A and Schedule A-2.

Clinical Reports	**all reports designed by eclinical for CHC shall be in Crystal Reports	Report Name	Report Description	Data	Notes
PREGNATAL					
Monthly EDC Dates	Report pulls patients with a due date in the specified month by site	Prenatal Database			Site was not a filter in the registry reporting during our demo. We need to make sure this is available for go live. **not all ob users - has to be pulled by preg drag code.
Total Users	Pregnant Users by specified date range and site	Prenatal Database			
Total Deliveries	Deliveries by specified date range and site	Prenatal Database			
Total Deliveries By Teen Mothers	Deliveries by specified age range, date range and site	Prenatal Database			
Total Deliveries by Race/Ethnicity	Deliveries by specified ethnicity, date range, and site	Prenatal Database			Need to check if the race filter is available in the registry reporting.
Total Intakes	Intakes by site (New Pregnant Patient Count by specified date range)	Prenatal Database			*has to be first visit with Preg diagnosis in date range. Not anyone with preg diag.) ** could be an OB patient and not pregnant
Prenatal Patients Age	Users by age (pie graph)	Prenatal Database			Preg users only
Prenatal Patients By Ethnicity	Users by ethnicity (pie graph)	Prenatal Database			Preg users only
Prenatal Patients by Week entering care	All pregnant users with intake date in specified range, by site, by week entering care	Prenatal Database			*we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)

Prenatal Patients with defined risk factor	All users by specified date range, by site by risk factor	Prenatal Database	**we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)
Prenatal Birth weights	All Deliveries by birth weight by site by date range - Scatter Chart	Prenatal Database	**we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)
Birth weights by mothers with defined risk factors	All Deliveries by date range and site including mothers with specified risk factor (Bar Graph)	Prenatal Database	**we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)
Birth weights by mothers week of entering care	All births in specified date range by weight and by week mother entered care	Prenatal Database	**we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)
Delivery Type	All Deliveries by date range and site by type of delivery - Bar Graph	Prenatal Database	**we will want a chart and a csv file for this report to load into SPSS (unique ID - mothers chart number)
Discontinued Care	All Pregnant users who discontinued care by reason, date range, and site	Prenatal Database	
All births by type of feeding program at 6 week PP visit	Birth by Feeding program, by date, by site	Prenatal Database	
All births by type of feeding program at birth	Birth by Feeding program, by date, by site	Prenatal Database	
UNDS	9 tables needed for report, tables 3, 4, 5, 6, and 7 can be pulled from Elinical alone	part of 4, part of 5, part of 6, and 7 can be pulled from Elinical alone	
Table 3	Patients by age and sex	Access	
Table 3	Patients by race/ethnicity	Access	need to confirm this comes over from centricity
Table 3	Patient best served in a language other than English	Access	
Table 4	Total Homeless users, Total SBHC Users	Access	? need to look into how this data will be held.
Table 5	Visits by component	Access	
Table 6	Visits/Users by Diagnosis/Procedure Grouping	Access	*report includes dental - will be pulled from centricity
Table 7	Prenatal Summary Report	Access	

HIV Department Reports	Current chart forms: need to verify all data is on template	will have to collect data on Patient specialty care from outside
All Patients with HIV that have not had a flu shot with in the last year	List of Patients by chart ID, by site, that have not refused and do not have egg allergy	Labtracker
All Patients with HIV that have not had GC/Chlamydia with in the last year	List of Patients by chart ID, by site,	Labtracker
All Patients with HIV that have not had HCV Ab with in the last year	List of Patients by chart ID, by site, if no diagnosis of HCV	Labtracker
Patients who are HCV ab + who have not had a confirmatory lab	List of Patients by chart ID, by site, not done	
Patients who have never had HBsAb Total & HBsAb	Who have never had Diag of HBV and no diag of sAB+ or HBs AG+	Labtracker
Patients who have never had a chest xray		Labtracker
Patients who have never had toxo IgG	with no Diag of Toxo	Labtracker
Patients who have CD4<200 and no toxo IgG in past year	with no Diag of Toxo	Labtracker
Patients with out a PPD in the last year or ever	if not diag of LTBI or any M.TB or Prior PPD >5mm	Labtracker
Patients with no RPR or VDRL	By any date range	Labtracker
Patients with out a pneumovax	in specified date range	Labtracker

Patients with out a tetanus or DPT or DT	In specified date range	Labtracker
Patients with out a HBV Immunization	In specified date range, if no prior HBV Immn, no Dx of HBV and HBsAb is Neg/NR or HBsAg or HBeAg is not positive	Labtracker
HAV immunization	In specified date range, if no prior HAV Immn, no Dx of HAV and HAV ab Total is Neg/NR	Labtracker
Patients with CD4 either <200 or <14% who are not using medications of SMX-TMP, dapsona, atovaquone		Labtracker
All Patients with HIV that have not had PAP Smear with a year or ever	List of Patients by chart ID, by site, By site, by providers, dx filters, date filter, demographics filters, by medications, by viral load, Total and percent	Labtracker
Listing of patients with Total and percent		
HRSA Report	CADR Report - currently push button out of labtracker.	**need to recreate - load..
P & T Reports	P & T committee	**must have multi select on medications as part of registry reporting or the ability to create "Groups" in list
Mental Health Reporting	**Im doing list of reports for grants including criteria	**need to review use of sure scripts -

Safeguarding Report	Patients with DV seen by therapist by date, by provider, by group or individual, by age	Manual Chart Pull	*must use DV Diag
Child Guidance			
TFP			
DMHAS			
TIP			
Parent Aide			
Parent Education			
SAMHSA			
Foster Care			
	***Gladys is pulling together packet of all assessment data collection forms for me		
Other Reporting			
Panels			
Patients with Chronic Disease by provider			
Clinical Outcome			
Peer Review Lists			
Coding Reports			
Pediatric Peer Review	Report by provider, with a well procedure code, by site, visit date range, birth date range, up to date on AAP vaccines rec, nutrition assessment, developmental screen, lead assessment.		**detail, then aggregated results.
CDEMS	USED FOR DIABETES, ASTHMHA AND CANCER COLLABORATIVES		

CANCER COLLABORATIVE	Measure	Definition	Data Gathering Plan
	1. Percent of patients having documentation of self-management goal setting	Number of patients (women ≥ 21 years of age and men ≥ 51) in the registry who have documentation of self-management goal setting (Self management goal setting can and is recommended to include documented shared decision-making* discussion about cancer screening and follow-up when appropriate) in the last 12 months divided by the total number women ≥ 21 years of age and the number of men ≥ 51 in the registry. Multiply by 100 to get percentage.	On the last workday of the month, find all patients (women ≥ 18 years of age and men ≥ 50) who have had at least one visit in the prior three years. Within this population identify those women ≥ 21 and those men ≥ 51 with documentation of self-management goal setting. At the same time, count the number of women >21 years of age and the number of men >51 .
	2. Percent of women ≥ 42 years of age who have had a mammogram in the previous 2 years	Number of women ≥ 42 years of age who have had a mammogram in the previous 2 years divided by the total number of women ≥ 42 years of age in the registry. Multiply by 100 to get percentage.	On the last workday of the month, the registry will be searched for all women ≥ 42 years of age who have had a mammogram in the previous 2 years. At the same time the total number of women ≥ 42 years of age in the registry will be counted.
	3. Percent of women age ≥ 21 who have had a Pap smear within the prior 3 years	Number of women age ≥ 21 who have had a Pap smear within the prior 3 years divided by the total number of women ages ≥ 21 . Multiply by 100 to get percentage.	On the last workday of the month count the number of women age ≥ 21 who have had a pap smear within the prior 3 years. At the same time, count the number women age ≥ 21 in the registry.
	4. Percent of adults age ≥ 51 who have been appropriately screened for colon cancer	Number of adults ages ≥ 51 have been screened with at least one of the following:	On the last workday of the month, the registry will be searched for all adults ≥ 51 who have been screened with at least one of the following:

-FOBT within one year	-FOBT within one year
-Sigmoidoscopy within 5 years	-Sigmoidoscopy within 5 years
-Colonoscopy within 10 years divided by the total number of adults ages ≥ 51 . Multiply by 100 to get percentage.	-Colonoscopy within 10 years. At the same time, count the total number of adults ≥ 51 years of age in the registry.
5. Percent of patients having documented notification of mammogram, PAP and colon cancer screening results within 30 days	<p>The number of women (age ≥ 42) having documented notification of mammogram results within 30 days of test completion plus the number of women ≥ 21 having documented notification of PAP smear results within 30 days of test completion plus the number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of test completion plus the number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of test completion [these counts are for screenings that have occurred in the last 12 months], divided by the total number of women age ≥ 42 having a mammogram plus the total number of women ≥ 21 having PAP plus the total number of adults ≥ 51 having colon cancer screening. [These counts are for screenings that have occurred in the last 12 months]</p> <p>Multiply each by 100 to get percentage.</p>

6. Percent of patients requiring additional evaluation and/or treatment completing that assessment/treatment within appropriate time frame.	<p>Number of women ≥ 42 years of age having additional required evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram plus the number of adult adults (≥ 51) with positive fecal occult blood testing having sigmoidoscopy and BE) within 60 days of the date of the positive result plus the number of women (≥ 42) with invasive cancer or ductal carcinoma in situ having initial treatment documented within 90 days of diagnosis plus the number of women (≥ 21) who require colonoscopy** having been evaluated within 90 days of the date of the abnormal test plus the number of women (≥ 21) with CIN 2 & 3 or invasive cervical cancer having initial treatment documented within 90 days of diagnosis plus the number of adults (≥ 51) with polyp or colon cancer having initial treatment documented within 90 days of lab confirmation of the diagnosis [these counts are for screenings and diagnoses that have occurred in the last 12 months] divided by the total number of women ≥ 42 years.</p> <p>[On the last workday of the month, find all women >42 years of age who have documented required additional evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram. At the same time, the number of women >42 years of age who have had an abnormal mammogram will be counted. On the last workday of the month count the number of women (≥ 42) with invasive cancer or ductal carcinoma in situ having initial treatment documented within 90 days of diagnosis. At the same time, count the number of women (≥ 42) with invasive cancer or ductal carcinoma in situ in the registry. Documentation could include Type of surgery (lumpectomy, mastectomy, other), use of chemotherapy (yes, no), radiation therapy (yes, no), hormonal therapy (yes, no). Refusal of care should be documented as well with reasons for refusal.]</p>
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	<p>On the last workday of the month count the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer who have their initial treatment documented within 90 days of diagnosis. At the same time count the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer.</p>	
	<p>On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with positive fecal occult blood testing having colonoscopy (or sigmoidoscopy and BE) within 8 weeks of the date of the positive FOBT. At the same time, count the number of adults (age ≥ 51) who have had a positive FOBT.</p>	<p>On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with polyp or colon cancer who have their initial treatment documented within 90 days of lab confirmation of the diagnosis. At the same time, count the number of adults (age ≥ 51) with polyp or colon cancer. [These counts are for screenings and diagnoses that have occurred in the last 12 months]</p>
7. Percent of patients having documented shared decision-making* discussion about cancer screening and follow-up in the last 12 months	<p>Number of patients (women ≥ 21 and men ≥ 51) in the registry who have documented shared decision-making discussion of cancer screening and its follow-up in the last 12 months divided by the total number women ≥ 21 years of age and the number of men ≥ 51 in the registry. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month, find all patients (women ≥ 21 and men ≥ 51) who have a documented shared decision-making* discussion about cancer screening and follow-up. At the same time, count the number of women ≥ 21 years of age and the number of men ≥ 51.</p>
8. Percent of women (age ≥ 42) having documented notification of mammogram results within 30 days of mammogram date, divided by the total number of women (age ≥ 42) having a mammogram [these counts are for mammograms that have occurred in the last 12 months]. Multiply by 100 to get percentage.	<p>Number of women (age ≥ 42) having documented notification of mammogram results within 30 days of mammogram date, divided by the total number of women (age ≥ 42) having a mammogram [these counts are for mammograms that have occurred in the last 12 months]. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month count the number of women (age ≥ 42) with documented notification of mammogram results within 30 days of the mammogram date [these counts are for mammograms that have occurred in the last 12 months]. At the same time, count the number of women (age ≥ 42) who have had a mammogram within the last 12 months.</p>

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<p>9. Percent of women (age ≥ 21) having documented notification of Pap smear results within 30 days</p>	<p>Number of women (age ≥ 21) having documented notification of Pap smear results within 30 days of lab date, divided by the total number of women (age ≥ 21) having Pap smears [these counts are for pap smears that have occurred in the last 12 months]. At the same time, count the number of women age ≥ 21 who have had Pap smears within the last 12 months. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month count the number of women age ≥ 21 with documented notification of Pap smear results within 30 days of the lab date [these counts are for pap smears that have occurred in the last 12 months]. At the same time, count the number of women age ≥ 21 who have had Pap smears within the last 12 months.</p>
<p>10. Percent adults (age ≥ 51) screened for colon cancer having documented notification of results within 30 days of screening</p>	<p>Number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of screening date divided by the total number of adults (age ≥ 51) having screening [these counts are for screenings that have occurred in the last 12 months]. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month, the registry will be searched for the number of adults age ≥ 51 who have had colon cancer screening and have received documented notification of colon cancer screening results within 30 days of screening date [these counts are for screenings that have occurred in the last 12 months]. At the same time, count the number of adults age ≥ 51 who have received colon cancer screening within the last 12 months.</p>
<p>11. Percent of women (age ≥ 42) requiring additional evaluation having it completed within 60 days of the abnormal mammogram</p>	<p>Number of women ≥ 42 years of age having additional required evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram divided by the total number of women ≥ 42 years of age with an abnormal mammogram within the last 12 months. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month, find all women ≥ 42 years of age who have documented required additional evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram, which occurred within the last 12 months. At the same time, the number of women ≥ 42 years of age who have had an abnormal mammogram within the last 12 months will be counted.</p>

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<p>[12. Percent of women (age ≥ 42) with invasive breast cancer or ductal carcinoma in situ [diagnosed within the last 12 months] having initial treatment documented within 90 days of diagnosis divided by the total number of women (age ≥ 42) with invasive cancer or ductal carcinoma in situ [diagnosed within the last 12 months]. Multiply by 100 to get percentage.</p>	<p>Number of women (age ≥ 42) with invasive breast cancer or ductal carcinoma in situ [diagnosed within the last 12 months] having initial treatment documented within 90 days of diagnosis divided by the total number of women (age ≥ 42) with invasive cancer or ductal carcinoma in situ [diagnosed within the last 12 months]. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month count the number of women ages ≥ 42 with invasive breast cancer or ductal carcinoma in situ [diagnosed within the last 12 months] having initial treatment documented within 90 days of diagnosis. At the same time, count the number of women ages ≥ 42 with invasive breast cancer or ductal carcinoma in situ [diagnosed within the last 12 months]. Documentation could include type of surgery (lumpectomy, mastectomy, other), use of chemotherapy (yes, no), radiation therapy (yes, no), hormonal therapy (yes, no). Refusal of care should be documented as well as the reasons for refusal.</p>

14. Percent of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months] having initial treatment documented within 90 days of diagnosis divided by the total number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months]. Documented within 90 days of diagnosis	Number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months] having initial treatment documented within 90 days of diagnosis divided by the total number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months]. Multiply by 100 to get percentage.	On the last workday of the month count the number of women ages ≥ 21 with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months] who have their initial treatment documented within 90 days of diagnosis. At the same time count the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer [diagnosed within the last 12 months].	
15. Percent of adults (age ≥ 51) with positive fecal occult blood testing, having colonoscopy (or sigmoidoscopy and BE) within 8 weeks of the date of the positive result divided by the total number of adults (age ≥ 51) having positive fecal occult blood testing, within the last 12 months. Multiply by 100 to get percentage.	Number of adults (age ≥ 51) with positive fecal occult blood testing, having colonoscopy (or sigmoidoscopy and BE) within 8 weeks of the date of the positive result divided by the total number of adults (age ≥ 51) having positive fecal occult blood testing, within the last 12 months. Multiply by 100 to get percentage.	On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with positive fecal occult blood testing [within the last 12 months] having colonoscopy (or sigmoidoscopy and BE) within 8 weeks of the date of the positive FOB _T . At the same time, count the number of adults (age ≥ 51) who have had a positive FOB _T within the last 12 months.	
16. Percent of adults (age ≥ 51) with polyp or colon cancer [diagnosed within the last 12 months] having initial treatment documented within 90 days of lab confirmation of the diagnosis	Percent of adults (age ≥ 51) with polyp or colon cancer [diagnosed within the last 12 months] having initial treatment documented within 90 days of lab confirmation of the diagnosis	On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with polyp or colon cancer [diagnosed within the last 12 months] who have their initial treatment documented within 90 days of lab confirmation of the diagnosis. At the same time, count the number of adults (age ≥ 51) with polyp or colon cancer [diagnosed within the last 12 months].	

**ASTHMA
COLLABORATIVE**

Measure	Definition	Data Gathering Plan
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1. Current severity assessment	The # of patients with a severity assessment at last contact (visit or phone) divided by the # of patients in the registry. Multiply by 100 to get percent.	On the last workday of each month from the registry: count the # of patients with severity assessment at last contact; count the total # of patients in the registry.
2. Appropriate treatment with anti-inflammatory medication.	The # of patients with an underlying NHLBI classification of persistent asthma at last contact who are on anti-inflammatory medication divided by the # of patients with a NHLBI classification of persistent asthma. Multiply by 100 to get percent.	On the last day workday of each month from the registry: count the # of patients with an underlying severity classification of persistent asthma at last contact on anti-inflammatory meds; count the total # of patients with an underlying classification of persistent asthma at last contact in the registry.
3. Current self-management goal.	The number of asthma patients in the registry with documented self-management goals in the last 12 months divided by the total number of asthma patients in the registry. Multiply by 100 to get percentage.	On the last workday of each month from the registry: count the # of patients with documented self-management goal in the last 12 months; count the total # of patients in the registry.
4. # of symptom-free days in previous two weeks.	At each patient contact, ask the number of days with symptoms in the previous two weeks. Subtract that number from 14 to get the number of symptom-free days for the patient in the previous two weeks. (Sum the symptom-free days over all patients. Divide the sum by the number of patients in the registry who report symptom free days.)	On the last workday of each month, search the registry to find the patients who had a severity assessment at last contact. Use the estimate of symptom-free days provided at this contact.
5. Exposure to environmental tobacco smoke	The # of patients with a reported exposure to environmental tobacco smoke at last visit divided by the # of patients with documented exposure status in the registry. Multiply by 100 to get percent.	On the last workday of each month, from the registry: count the # of patients with reported exposure to ETS at last visit; count the total # of patients in the registry with documented exposure status.

6. Evaluation of environmental triggers	<p>The # of patients evaluated for environmental triggers other than ETS (dust mites, cats, dogs, molds/fung), cockroaches) either by history of exposure and/or by allergy testing divided by the # of patients in the registry. Multiply by 100 to get percent.</p>	<p>On the last workday of each month from the registry, count the # of patients who have been evaluated for the specific environmental triggers other than ETS; count the total # of patients in the registry.</p>
7. ED/Urgent Care visits for asthma	<p>The # of patients who have had a visit to an ED/Urgent Care office for asthma in the past six months reported at last contact divided by the # of patients in the registry with documented query about ED/Urgent Care visits. Multiply by 100 to get percent.</p>	<p>On the last workday of each month from the registry: count the # of patients at last contact who have had a visit to ED/Urgent Care for asthma in the previous six months; count the total # of patients in the registry with documented query about ED/Urgent Care visits.</p>
8. Average Lost Workdays/School days	<p>At each patient contact, ask the number of days in the past 30 lost at work or school because of asthma. (Sum the lost days over all patients who report lost work or school days. Divide the sum by the number of patients in the registry who have been queried about lost work or school days at last contact.)</p>	<p>On the last workday of each month from the registry: get the number of lost days reported at last contact for each patient. Count the number of patients with documented lost work or school days at last visit.</p>
9. Establishment of Personal Best Peak Flow	<p>The # of patients older than 5 years with an NHLBI classification of moderate or severe persistent asthma who have established a "Personal Best" peak flow through multiple measurements during a period of relative disease stability divided by the # of patients with a NHLBI classification of moderate or severe persistent asthma older than five years. Multiply by 100 to get percent.</p>	<p>On the last day workday of each month from the registry: count the # of patients older than five years (with a NHLBI classification of moderate or severe persistent asthma) who have established a "Personal Best" peak flow through multiple measurements during a period of relative disease stability; count the total # of patients older than five years with a NHLBI classification of moderate or severe persistent asthma.</p>

DIABETES COLLABORATIVE		Data Gathering Plan	
Measure	Definition		
1. Average HbA1c	Average HbA1c value for diabetic patients in the registry	On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had an HbA1c in the past 12 months. Add all of these patients' most recent HbA1c values together and divide by the number of such persons.	
2. Patients with 2 HbA1c's in last year (at least 3 months apart)	The number of diabetic patients in the registry who have had two HbA1c's (at least 91 days apart) in the last 12 months, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage	On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had two HbA1c's within the last 12 months (at least 91 days apart). At the same time, count the number of patients in the registry.	
3. Documentation of self-management goal setting	The number of diabetic patients in the registry with documented self-management goals in the last 12 months divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM who have documented self-management goals set with a clinician in the past 12 months. At the same time, count the number of patients in the registry.	

4. Cardiac Risk Reduction Option 1: ACE inhibitors or ARB medication	The number of diabetic patients in the registry 55 years and older who have a current prescription for ACE inhibitors or ARB medication divided by the number of diabetic patients older than 55 years in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients older than 55 with a diagnosis of DM who have a current prescription for ACE inhibitors or ARB medication. At the same time count the number of patients with a diagnosis of DM 55 years and older in the registry.
5. Cardiac Risk Reduction Option 2: Statins	The number of diabetic patients in the registry 40 years and older who have a current prescription for statins divided by the number of diabetic patients older than 40 years in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients 40 years and older with a diagnosis of DM who have a current prescription for statins. At the same time count the number of patients with a diagnosis of DM 40 years and older in the registry.
6. Patients with BP <130/80	The number of diabetic patients in the registry with blood pressure reading less than 130/80 at last reading within the past 12 months, divided by the diabetic patients in the registry with a documented blood pressure in the last 12 months. Multiply by 100 to get Percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM with a BP < 130/80 in the last 12 months. At the same time count the total number of patients with a diagnosis of DM who have a documented blood pressure in the registry in the last 12 months.
7. Patients with LDL < 100	The number of diabetic patients in the registry who have had a fasting LDL less than 100 in the last 12 months, divided by the number of patients with a fasting LDL in the past 12 months. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM with a fasting LDL < 100 in the last 12 months. At the same time, count the number of patients with a diagnosis of DM who have had a fasting LDL in the last 12 months.
8. Aspirin or other antithrombotic Agent Use	The number of patients 30 years and older in the registry who are currently taking aspirin or other antithrombotic agent divided by the total number of diabetic patients 30 years and older in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients 30 years and older with a diagnosis of DM who are currently taking aspirin or other antithrombotic agent. At the same time count the total number of patients 30 years and older with a diagnosis of DM in the registry.

9. Patients who are current smokers	The number of patients in the registry who are current smokers (documented in the last 12 months), divided by the total number of diabetic patients in the registry with smoking status documented in the last 12 months. Multiply by 100 to get percentage.	[On the last workday of each month, search the registry for all patients with a diagnosis of DM who are current smokers. At the same time count the total number of patients with a diagnosis of DM in the registry who have smoking status documented in the past 12 months.]
10. Dilated eye exam in past year	The number of patients in the registry who have had a dilated eye exam in the last 12 months, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	[On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had a dilated eye exam in the last 12 months. At the same time count the total number of patients with a diagnosis of DM in the registry.]
11. Comprehensive foot exam in the past year	The number of patients in the registry who have had an annual comprehensive foot exam documented in the last 12 months, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	[On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had a documented annual foot exam in the last 12 months. At the same time count the total number of patients with a diagnosis of DM in the registry.]
12. Microalbuminuria screening in past year	The number of patients in the registry 12 years and older but less than 70 years of age who are not already on ACEI or ARB and who have had a microalbuminuria screening test in the last 12 months, divided by the total number of diabetic patients in the registry 12 years and older but less than 70 years of age who are not already on ACEI or ARB. Multiply by 100 to get percentage.	[On the last workday of each month, search the registry for all patients with a diagnosis of DM between 12 years and older but less than 70 years of age who are not on ACEI or ARB and who have had a microalbuminuria screening test in the last 12 months. At the same time count the total number of patients with a diagnosis of DM in the registry who are 12 years and older but less than 70 years of age and who are not on ACEI or ARB.]

		Data Gathering Plan	
Measure	Definition		
13. Influenza vaccination	The number of patients in the registry who obtained an influenza vaccination in last 12 months, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM who obtained an influenza vaccination in last 12 months. At the same time count the total number of patients with a diagnosis of DM in the registry.	
14. One pneumococcal vaccine	The number of patients in the registry who have had one pneumococcal vaccination at any time, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had one pneumococcal vaccination at any time in the past. At the same time count the total number of patients with a diagnosis of DM in the registry.	
15. Dental exam in past year	The number of patients in the registry who obtained a dental exam in last 12 months, divided by the total number of diabetic patients in the registry. Multiply by 100 to get percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of DM who have had a documented dental exam in the last 12 months. At the same time count the total number of patients with a diagnosis of DM in the registry.	
16. Depression Screening (12 months)	The # of patients with a documented screening for depression in the past 12 months divided by the # of patients in the registry. Multiply by 100 to get percent.	On the last day workday of each month from the registry; count the # of patients with a documented screening for depression in the past 12 months; count the total # of patients in the registry.	
CARDIOVASCULAR COLLABORATIVE		Data Gathering Plan	
1. Hypertensive Patients with BP < 140/90 mmHg	The number of patients with a diagnosis of hypertension whose last BP (taken with the last 12 months) was less than 140/90, divided by the number of patients with hypertension who have had a BP taken within the last 12 months. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of hypertension whose last BP (taken with the last 12 months) was less than 140/90. Also, count the number of patients with a diagnosis of hypertension who have had a BP taken within the last 12 months.	

2. Patients with 2 BP's in Last Year	The number of CVD patients in the registry who have had two BP's in the last 12 months, divided by the total number of CVD patients in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with CVD who have had two BP's within the last 12 months. At the same time, count the number of CVD patients.
3. Documentation of Self-management Goal Setting	The number of CVD patients in the registry with documented self-management goals in the last 12 months divided by the total number of CVD patients in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of CVD who have documented self-management goals set with a clinician in the past 12 months. At the same time count the number of CVD patients.
4 Patients with Fasting Lipid Profile Documented	The number of CVD patients in the registry with a documented fasting lipid profile within the condition appropriate time frame (1 year for CAD, Dyslipidemia, or DM, if last LDL \geq 100; 2 years for CAD, Dyslipidemia, or DM, if last LDL $<$ 100; 5 years for hypertension only) divided by the total number of CVD patients in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients with a documented fasting lipid profile within the condition appropriate time frame (1 year for CAD, Dyslipidemia, or DM, if last LDL \geq 100; 2 years for CAD, Dyslipidemia, or DM, if last LDL $<$ 100; and 5 years for hypertension only). At the same time count the total number of patients with a diagnosis of CVD.
5 LDL Cholesterol < 100 mg/dl	The number of CVD patients with CAD or DM whose last fasting LDL value (documented within the last 24 months) is less than 100 mg/dl in the registry divided by the number of CVD patients with CAD or DM in the registry with a fasting LDL (documented within the last 24 months). Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients with CAD or DM whose last fasting LDL value (documented within the last 24 months) is less than 100 mg/dl. At the same time count the number of CVD patients with CAD or DM who have had a fasting LDL (documented within the last 24 months).
6. Aspirin or Other Antithrombotic Agent Use	The number of patients with CAD in the registry who are currently taking aspirin or other antithrombotic agent divided by the number of patients with CAD in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with CAD who are currently taking aspirin or other antithrombotic agent. At the same time count the number of patients with a diagnosis of CAD.

7. ACE Inhibitor Use	The number of CVD patients, age \geq 55, with CAD or DM in the registry who have been prescribed ACE inhibitors, divided by the total number of CVD patients, age \geq 55, with CAD or DM in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients, age \geq 55, with CAD or DM in the registry who have been prescribed ACE inhibitors. At the same time count the total number of CVD patients, age \geq 55, with CAD or DM.
8. Beta Blocker	The number of patients with CAD in the registry who have a prescription for a beta blocker, divided by the number of patients with CAD. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with CAD in the registry who have a prescription for a beta blocker. At the same time, count the number of patients with a diagnosis of CAD.
9. Patients Who Have Been Screened for Depression	The number of CVD patients in the registry who have been screened for depression in the past 12 months, divided by the total number of CVD patients in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients in the registry who have been screened for depression in the past 12 months. At the same time count the total number of CVD patients.
10. Patients with 2 HbA1c's in Last Year (at Least 3 Months Apart)	The number of patients with CVD and DM in the registry who have had two HbA1c's (at least 91 days apart) in the last 12 months, divided by the total number of patients with CVD and DM in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with a diagnosis of CAD and DM who have had two HbA1c's within the last 12 months (at least 91 days apart). At the same time, count the number of patients with both CAD and DM.
11. Weight Reduction \geq 10 Pounds	The number of CVD patients with a BMI >25 at any time in the last 12 months who have lost 10 pounds (by comparing their maximum recorded weight in the 12 months period to their latest recorded weight), divided by the total number of CVD patients who have or had a BMI >25 at any time in the last 12 months. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients with a BMI >25 at any time in the last 12 months who have lost 10 pounds (by comparing their maximum recorded weight in the 12 months period to their latest recorded weight). At the same time count the total number of CVD patients who have or had a BMI >25 at any time in the last 12 months.

12. Regular Exercise (3 Times or More per Week at Least 20 Minutes)	The number of CVD patients whose last documented exercise rate (within the last 12 months) was 3Xweek @ least 20 minutes, divided by the total number of CVD patients. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients whose last documented exercise rate (within the last 12 months) was 3Xweek @ least 20 minutes. At the same time count the total number of CVD patients.
13. Patients who are current smokers	The number of patients in the registry who are current smokers (documented within the last 12 months), divided by the total number of CVD patients in the registry with smoking status documented within the last 12 months. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all patients with CVD who are current smokers (documented within the last 12 months). At the same time count the total number of patients with CVD in the registry with smoking status documented within the last 12 months.
14. Medication Self Management Training	The number of CVD patients in the registry who have had medication self management training in last 12 months, divided by the total number of CVD patients in the registry. Multiply by 100 to get a percentage.	On the last workday of each month, search the registry for all CVD patients in the registry who have had medication self management training in the last 12 months. At the same time count the total number of CVD patients.

DEPRESSION COLLABORATIVE		Definition	Data Gathering Plan
Measure			
1. CSD* patients with 50% reduction in PHQ	Percent of CSD* patients with a 50% reduction in PHQ (comparing last New Episode PHQ** to the most recent Current PHQ). The Current PHQ must be dated later than the New Episode PHQ.	Numerator = all patients with a diagnosis of CSD* who have a 50% or greater reduction in PHQ; Denominator = all CSD* patients.	On the last workday of the month, search the registry and count the number of patients with CSD* and ≥50% reduction in PHQ (comparing last New Episode PHQ** to the most recent Current PHQ). The Current PHQ must be dated later than the New Episode PHQ. Then, count the number of CSD* patients in the registry. Divide the first number by the second and multiply by 100.
2. Patients who have a diagnosis of depression and a documented PHQ score within the last 6 months	Percent of patients in the registry with a diagnosis of depression and a documented PHQ score within last 6 months.	Numerator = all patients with a diagnosis of depression and a documented PHQ score within last 6 months;	On the last workday of the month, search the registry and count the number of patients with a diagnosis of depression and a documented PHQ score within the last 6 months (New Episode and/or Current). Then, count the number of patients with a diagnosis of depression in the registry. Divide the first number by the second and multiply by 100.
3. Depressed patients with documented self-management goal setting in the last 12 months	Percent of patients with a diagnosis of depression in the registry with documented self-management goals set within last 12 months.	Numerator = all patients with a diagnosis of depression with documented SM goal setting within last 12 months; Denominator = all patients with a diagnosis of depression in the registry.	On the last workday of the month, search the registry and count the number of patients with a diagnosis of depression in the registry who have had documented self-management goals within the last 12 months. Then, count the number of patients with a diagnosis of depression in the registry. Divide the first number by the second and multiply by 100.

7. CSD* patients with Percent of CSD* patients with a PHQ score less than 5 at least 4 months after last New Episode PHQ**	<p>On the last workday of the month, search the registry and count the number of CSD* patients whose last New Episode PHQ was at least 4 months ago and whose last Current PHQ is less than 5 (Current PHQ must be later than the New Episode PHQ)</p> <p>Numerator = all patients with a diagnosis of CSD*, 4 months or longer after their last New Episode PHQ**, whose most recent Current PHQ score is less than 5;</p> <p>Denominator = all patients with a diagnosis of CSD* 4 months or longer after their last New Episode PHQ**</p>	<p>Then, count the number of CSD* patients whose last New Episode PHQ was at least 4 months ago.</p> <p>Divide the first number by the second and multiply by 100</p>
8. Patients with a diagnosis of major depression or dysthymia on an antidepressant*** at last visit	<p>Percent of patients with a diagnosis of major depression or dysthymia who, as of their last visit, are taking an antidepressant**</p>	<p>On the last workday of the month, search the registry and count the number of patients with a diagnosis of major depression or dysthymia who are taking an antidepressant** at the time of the last visit.</p> <p>Numerator = all patients with a diagnosis of major depression or dysthymia taking an antidepressant** at the time of the last visit.</p> <p>Denominator = all patients with a diagnosis of major depression or dysthymia.</p>
9. Patients with diagnoses of minor depression, depression NOS, or adjustment disorder (New Episode PHQ <10) NOT on an antidepressant*** (recommended to be used in conjunction with measure #8)	<p>Percent of patients with a diagnosis of minor depression, depression NOS, or adjustment disorder (New Episode PHQ <10) NOT on an antidepressant***</p>	<p>On the last workday of the month, search the registry and count the number of patients with a diagnosis of minor depression, depression NOS, or adjustment disorder (last New Episode PHQ** <10) NOT on an antidepressant***</p>

	Numerator = all patients with a diagnosis of minor depression, depression NOS, or adjustment disorder (last New Episode PHQ** <10). NOT on an antidepressant***. Denominator = all patients with a diagnosis of minor depression, depression NOS, or adjustment disorder (last New Episode PHQ** <10)	Then, count the number of patients with a diagnosis of minor depression, depression NOS, or adjustment disorder (last New Episode PHQ** <10). Divide the first number by the second and multiply by 100
10. Depressed patients who improve in function	Percent of patients with a diagnosis of depression reporting an improvement in function (measured by New Episode Function as compared to a later Current Function)	On the last workday of the month, search the registry and count the number of patients with a diagnosis of depression which on their last New Episode Function had a score>0 and whose last Current Function have a reduced score. (Date of Current Function must be later than the date of the last New Episode Function). This could be anywhere from a 1-3 point drop on the function question (#10).
	Numerator = all patients with a diagnosis of depression who on their last New Episode Function had a score>0 and whose last Current Function have a reduced score. (Date of Current Function must be later than the date of the last New Episode Function). This could be anywhere from a 1-3 point drop on the function question (#10).	
11. Patients with diagnosis of major depression or dysthymia remaining on antidepressant*** for at least 6 months	Denominator = all patients with a diagnosis of depression who have a score of >0 on their last New Episode Function.	Then, count the number of patients with a diagnosis of depression who have a score of >0 on their last New Episode Function. Divide the first number by the second and multiply by 100

LAB TRACKER/RYAN WHITE 3 REPORTS		
Ryan-White	Provides detailed HIV and treatment stages. These are multi-level reports that are central to community-based HIV care and treatment.	TBD
LAB TRACKER	Provides extensive functionality and reporting for HIV.	TBD

Measure	Definition	Data Gathering Plan
1. Percent of patients having documentation of self-management goal setting	<p>Number of patients (women ≥ 21 years of age and men ≥ 51) in the registry who have documentation of self-management goal setting (<i>Self management goal setting can and is recommended to include documented shared decision-making* discussion about cancer screening and follow-up when appropriate</i>) in the last 12 months divided by the total number women ≥ 21 years of age and the number of men ≥ 51 in the registry. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month, find all patients (women ≥ 8 years of age and men ≥ 0) who have had at least one visit in the prior three years.</p> <p>Within this population identify those women ≥ 21 and those men ≥ 51 with documentation of self-management goal setting. At the same time, count the number of women ≥ 21 years of age and the number of men ≥ 51.</p>

	<p>On the last workday of the month, the registry will be searched for all women ≥ 42 years of age who have had a mammogram in the previous 2 years divided by the total number of women ≥ 42 years of age in the registry. Multiply by 100 to get percentage.</p>	<p>On the last workday of the month count the number of women age ≥ 1 who have had a pap smear within the prior 3 years divided by the total number of women age ≥ 1. At the same time, count the number of women age ≥ 1 in the registry.</p>
2. Percent of women ≥ 42 years of age who have had a mammogram in the previous 2 years		3. Percent of women age ≥ 1 who have had a Pap smear within the prior 3 years

		On the last workday of the month, the registry will be searched for all adults ≥ 51 who have been screened with at least one of the following:
4. Percent of adults age ≥ 51 who have been appropriately screened for colon cancer	Number of adults ages ≥ 51 have been screened with at least one of the following:	-FOBT within one year -Sigmoidoscopy within 5 years -Colonoscopy within 10 years divided by the total number of adults ages ≥ 51 . Multiply by 100 to get percentage.
		-FOBT within one year -Sigmoidoscopy within 5 years -Colonoscopy within 10 years. At the same time, count the total number of adults ≥ 51 years of age in the registry.

		On the last workday of the month, the registry will be searched for all women (age ≥ 21) having documented notification of mammogram results within 30 days of test completion *** plus the number of women ≥ 21 having documented notification of PAP smear results within 30 days of test completion plus the number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of test completion [these counts are for screenings that have occurred in the last 12 months], divided by the total number of women age ≥ 21 having a mammogram plus the total number of women ≥ 21 having PAP plus the total number of adults ≥ 51 having colon cancer screening. [These counts are for screenings that have occurred in the last 12 months]
5. Percent of patients having documented notification of mammogram, PAP and colon cancer screening results within 30 days	The number of women (age ≥ 21) having documented notification of mammogram results within 30 days of test completion *** plus the number of women ≥ 21 having documented notification of PAP smear results within 30 days of test completion plus the number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of test completion [these counts are for screenings that have occurred in the last 12 months], divided by the total number of women age ≥ 21 having a mammogram plus the total number of women ≥ 21 having PAP plus the total number of adults ≥ 51 having colon cancer screening. [These counts are for screenings that have occurred in the last 12 months]	On the last workday of the month, the registry will be searched for all women (age ≥ 21) having documented notification of mammogram results within 30 days and women ≥ 21 having documented notification of PAP smear results within 30 days of test completion and the number of adults age ≥ 51 having documented notification of colon cancer screening results within 30 days of test completion [these counts are for screenings that have occurred in the last 12 months]. At the same time, count the number of women (age ≥ 21) having a mammogram, women ≥ 21 having PAP, and adults ≥ 51 having colon cancer screening within the last 12 months.

	Multiply each by 100 to get percentage.
6. Percent of patients requiring additional evaluation and/or treatment completing that assessment/treatment within appropriate time frame.	<p>Number of women ≥ 42 years of age having additional required evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram plus the number of adults (age ≥ 51) with positive fecal occult blood testing having colonoscopy (or sigmoidoscopy and BE) within 60 days of the date of the positive result plus the number of women (age ≥ 42) with invasive cancer or ductal carcinoma in situ having initial treatment documented within 90 days of diagnosis plus the number of women (age ≥ 21) who require colposcopy** having been evaluated within 90 days of the date of the abnormal test plus the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer having initial treatment documented within 90 days of diagnosis plus the number of adults (age ≥ 51) with polyp or colon cancer having initial treatment documented within 90 days of lab confirmation of the diagnosis [these counts are for screenings and diagnoses that have occurred in the last 12 months] divided by the total number of women ≥ 42 years.</p> <p>On the last workday of the month, find all women >42 years of age who have documented required additional evaluation (imaging, biopsy, clinical) within 60 days of the date of abnormal mammogram. At the same time, the number of women >42 years of age who have had an abnormal mammogram will be counted. On the last workday of the month count the number of women (age ≥ 42) with invasive cancer or ductal carcinoma in situ having initial treatment documented within 90 days of diagnosis. At the same time, count the number of women (age ≥ 42) with invasive cancer or ductal carcinoma in situ in the registry. Documentation could include Type of surgery (lumpectomy, mastectomy, other), use of chemotherapy (yes, no), radiation therapy (yes, no), hormonal therapy (yes, no). Refusal of care should be documented as well with reasons for refusal.</p>

	<p>On the last workday of the month count the number of women (age ≥ 21) who require colposcopy** and have been evaluated within 90 days of the date of the abnormal test. At the same time count the total number of women (age ≥ 21) requiring colposcopy**.</p> <p>On the last workday of the month count the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer who have their initial treatment documented within 90 days of diagnosis. At the same time count the number of women (age ≥ 21) with CIN 2 & 3 or invasive cervical cancer.</p>	<p>On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with positive fecal occult blood testing having colonoscopy (or sigmoidoscopy and BE) within 8 weeks of the date of the positive FOBT. At the same time, count the number of adults (age ≥ 51) who have had a positive FOBT.</p> <p>On the last workday of the month, the registry will be searched for the number of adults (age ≥ 51) with polyp or colon cancer who have their initial treatment documented within 90 days of lab confirmation of the diagnosis. At the same time, count the number of adults (age ≥ 51) with polyp or colon cancer. [These counts are for screenings and diagnoses that have occurred in the last 12 months]</p>

SCHEDULE H
TRAINING AND SUPPORT CERTIFICATIONS

1. CHC staff to attend a 4 day session at Licensor HQ
2. Shadows Licensor training at a site 4-5 days,
3. Shadow second Licensor training at another site, 4-5 days,
4. CHC trainer trains a site and Licensor shadows, 4-5 days,
5. CHC trainer trains a site, Licensor shadows second training session, 4-5 days,
6. CHC trainer will attend a Q&A session with eClinicalWorks product specialist.
7. CHC trainer attends at least 2 days at eClinicalWorks support center to learn the troubleshooting skills.
8. Licensor will review the performance of the CHC trainer and issue certification.

All of the training under this Schedule shall be provided by Licensor to CHC at no additional cost. Except as set forth above, all training shall be provided at a location approved CHC. The above training periods are estimates only and shall be subject to agreement by the parties.

H-1

BRMFS1 910175v6

SCHEDULE I

INTERFACES

Interface Identification

All interfaces are to be fully functional, stable, secure, and HL-7 compliant. Unless otherwise indicated, all interfaces are to be bi-directional, provided the reference labs and hospitals are able to accommodate the bi-directional interface, and will conform to outbound and inbound ADT, lab reports, patient demographics and billing (CPT and ICD-9 codes), as well as future data streams as they become available to CHC. Lessor will designate resources for timely development, configuration, and testing of interfaces necessary for CHC to achieve a paperless and interoperable EHR solution across internal and external data repositories, labs, applications, and registries.

A bi-directional interface will be counted as (1) one interface that accommodates both outbound and inbound messages.

Currently CHC requires interfaces with L&M, Middlesex Hospital, Clinical Lab Partners, and New Britain General Hospital, and Quest. Interfaces will include ED reports, Radiology Reports, RHIO, and School Based DB, and physician portal (MPS) --16 interfaces.

A bi-directional interface is required for the New Britain facility between Centricity Practice Management and eClinical Works EHR.

Updates

Any Updates that effect the performance of interfaces will be identified, communicated to CHC, tested, and resolved as part of Lessor's standard general release, verification, and testing standards. Should Updates prove to compromise system and Software performance due to Lessor's interface functionality loss, Lessor will take full responsibility for its interfaces to trouble-shoot and communicate with third-part companies to resolve the issues within the applicable Resolution Period set forth in Schedule B.

Terms

All interface development, implementation, and functionality requirements are to conform and follow the Initial Acceptance testing and Final Acceptance timelines with the exception of third party's (lab or hospital) lack of response and resources.

The following bi-directional interfaces are to be implemented and tested as part of Initial Acceptance testing for the first Site (New Britain): Reference Labs, hospital labs pertaining to the New Britain Site, and Centricity Practice Management interface. Such interfaces shall be implemented and fully tested and ready for Initial Acceptance testing for the New Britain Site within 16 weeks from the Effective Date. As a result of New Britain Site implementation, each site implemented thereafter will already have Centricity Practice Management interface and Reference Lab interfaces fully tested and operational from New Britain implementation.

Hospital Lab interfaces are to be implemented and tested as part of Initial Acceptance Testing for each Site as that Site is phased into the overall implementation.

All other bi-directional interfaces including ED Reports, Radiology Reports, RHIO, custom interfaces, and DB's will be implemented and tested 16 weeks after Initial Acceptance Testing of the New Britain Site. In the event that such interfaces are not implemented and tested by the end of such 16 week period, CHC's obligation to pay Maintenance Services fees shall be suspended until such time as such implementation and testing has occurred.

SCHEDULE J

WELCOME PAK

SEE ATTACHED



"eClinicalWorks
Welcome Pak.doc"

J-1

BRMFSI 910175v6

SCHEDULE K
INSTALLATION GUIDE
SEE ATTACHED



K-1
BRMFS1 910175v6

Internal Revenue Service

District
Director

Department of the Treasury

35 Tillary St, Brooklyn, NY 11201

D

Date: MAR 05 1990

Community Health Center, Inc.
631 Main Street
Middletown, CT 06457
Attn: Kenneth P. Scheer

Person to Contact:
Clifton G. Belnavis
Contact Telephone Number:
(718) 780-4501
EIN: 06-0897105

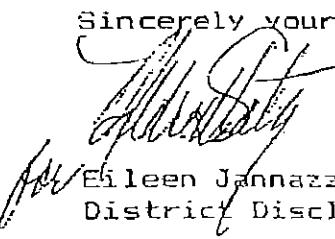
Dear Sir or Madam:

Reference is made to your request for verification of the tax exempt status of Community Health Center, Inc.

A determination or ruling letter issued to an organization granting exemption under the Internal Revenue Code of 1954 or under a prior or subsequent Revenue Act remains in effect until exempt status has been terminated, revoked or modified.

Our records indicate that exemption was granted as shown below.

Sincerely yours,


Eileen Jannazzo
District Disclosure Officer

Name of Organization: Community Health Center, Inc.

Date of Exemption Letter: July 1972

Exemption granted pursuant to 1954 Code section 501(c)(3) or its predecessor Code section.

Foundation Classification (if applicable): Not a private foundation as you are an organization described in sections 509(a)(1) and 170(b)(1)(A)(vi) of the Internal Revenue Code.

Areas Affected by Project

<u>City</u>	<u>County</u>	<u>State</u>
Bristol	Hartford	Connecticut
Danbury	Fairfield	Connecticut
Middletown	Middlesex	Connecticut
Clinton	Middlesex	Connecticut
Enfield	Hartford	Connecticut
New Britain	Hartford	Connecticut
Stamford	Fairfield	Connecticut
New London	New London	Connecticut
Waterbury	New Haven	Connecticut
Meriden	New Haven	Connecticut
Norwalk	Fairfield	Connecticut

List of Program/Project Congressional Districts

The Community Health Center, Inc. sites that are included in this application are located in districts:

CT-001, CT-002, CT-003, CT-004 and CT-005

Project/Performance Site Location(s)

Project/Performance Site Primary Location

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country:

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Project/Performance Site Location 1

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country:

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Project/Performance Site Location 2

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country:

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Project/Performance Site Location(s)

Project/Performance Site Location 3

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of Danbury

DUNS Number: 0659855740000

* Street1: 8 Delay Street

Street2:

* City: Danbury

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06810-6654

* Project/ Performance Site Congressional District: CT-005

Project/Performance Site Location 4

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of Enfield

DUNS Number: 0659855740000

* Street1: 5 North Main Street

Street2:

* City: Enfield

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06082-3372

* Project/ Performance Site Congressional District: CT-002

Project/Performance Site Location 5

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of Meriden

DUNS Number: 0659855740000

* Street1: 134 State Street

Street2:

* City: Meriden

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06450-3293

* Project/ Performance Site Congressional District: CT-005

Project/Performance Site Location(s)

Project/Performance Site Location 6

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of New Britain

DUNS Number: 0659855740000

* Street1: 85 Lafayette Street

Street2:

* City: New Britain

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06051-0013

* Project/ Performance Site Congressional District: CT-005

Project/Performance Site Location 7

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of New London

DUNS Number: 0659855740000

* Street1: One Shaw's Cove

Street2:

* City: New London

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06320-4902

* Project/ Performance Site Congressional District: CT-002

Project/Performance Site Location 8

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: CHC of Waterbury

DUNS Number: 0659855740000

* Street1: 51 North Elm Street

Street2:

* City: Waterbury

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06702-1545

* Project/ Performance Site Congressional District: CT-003

Project/Performance Site Location(s)

Project/Performance Site Location 9

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Day Street CHC

DUNS Number: 0659855740000

* Street1: 49 Day Street

Street2:

* City: Norwalk

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06854-4901

* Project/ Performance Site Congressional District: CT-004

Project/Performance Site Location 10

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Franklin Street CHC

DUNS Number: 0659855740000

* Street1: 141 Franklin Street

Street2:

* City: Stamford

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06901-1014

* Project/ Performance Site Congressional District: CT-004

Additional Location(s)

Add Attachment

Delete Attachment

View Attachment

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action: <input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. * Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. * Report Type: <input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change
4. Name and Address of Reporting Entity: <input checked="" type="checkbox"/> Prime <input type="checkbox"/> SubAwardee * Name: <input type="text" value="Community Health Center, Inc."/> * Street 1: <input type="text" value="635 Main Street"/> Street 2: <input type="text"/> * City: <input type="text" value="Middletown"/> State: <input type="text" value="CT: Connecticut"/> Zip: <input type="text" value="06457"/> Congressional District, if known: <input type="text"/>		
5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime: 		
6. * Federal Department/Agency: <input type="text" value="SAMHSA"/>	7. * Federal Program Name/Description: <input type="text" value="Substance Abuse and Mental Health Services_Projects of Regional and National Significance"/> CFDA Number, if applicable: <input type="text" value="93.243"/>	
8. Federal Action Number, if known: <input type="text"/>	9. Award Amount, if known: \$ <input type="text"/>	
10. a. Name and Address of Lobbying Registrant: Prefix <input type="text"/> * First Name <input type="text" value="Not applicable"/> Middle Name <input type="text"/> * Last Name <input type="text" value="Not applicable"/> Suffix <input type="text"/> * Street 1 <input type="text"/> Street 2 <input type="text"/> * City <input type="text"/> State <input type="text"/> Zip <input type="text"/>		
b. Individual Performing Services (including address if different from No. 10a) Prefix <input type="text"/> * First Name <input type="text" value="Not applicable"/> Middle Name <input type="text"/> * Last Name <input type="text" value="Not applicable"/> Suffix <input type="text"/> * Street 1 <input type="text"/> Street 2 <input type="text"/> * City <input type="text"/> State <input type="text"/> Zip <input type="text"/>		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.		
* Signature: <input type="text" value="Margaret Flinter"/> * Name: Prefix <input type="text"/> * First Name <input type="text" value="Margaret"/> Middle Name <input type="text"/> * Last Name <input type="text" value="Flinter"/> Suffix <input type="text"/> Title: <input type="text"/> Telephone No.: <input type="text"/> Date: <input type="text" value="04/10/2013"/>		
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

CHECKLIST

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete each page of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last pages of the signed original of the application.

Type of Application: New Noncompeting Continuation Competing Continuation Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

1. Proper Signature and Date on the SF 424 (FACE PAGE) Included NOT Applicable
2. If your organization currently has on file with HHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS 690)

- Civil Rights Assurance (45 CFR 80)
- Assurance Concerning the Handicapped (45 CFR 84)
- Assurance Concerning Sex Discrimination (45 CFR 86)
- Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)

3. Human Subjects Certification, when applicable (45 CFR 46)

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? NOT Applicable
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)
3. Has the entire proposed project period been identified on the SF-424 (FACE PAGE)?.....
4. Have biographical sketch(es) with job description(s) been provided, when required?.....
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?
6. Has the 12 month narrative budget justification been provided?
7. Has the budget for the entire proposed project period with sufficient detail been provided?
8. For a Supplemental application, does the narrative budget justification address only the additional funds requested?
9. For Competing Continuation and Supplemental applications, has a progress report been included?

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Prefix: Dr. First Name: Margaret Middle Name:
 Last Name: Flintner Suffix:
 Title: SVP/Clinical Director
 Organization: Community Health Center, Inc.
 Street1: 635 Main Street
 Street2:
 City: Middletown
 State: CT: Connecticut ZIP / Postal Code: 06457 ZIP / Postal Code4: 2718
 E-mail Address: Margaret@chc1.com
 Telephone Number: (860) 347-6971 ext. 3622 Fax Number:

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

Prefix: First Name: Kasey Middle Name:
 Last Name: Harding Suffix:
 Title: Program Director Int. Care for Special Pop.
 Organization: Community Health Center, Inc.
 Street1: 635 Main Street
 Street2:
 City: Middletown
 State: CT: Connecticut ZIP / Postal Code: 06457 ZIP / Postal Code4: 2718
 E-mail Address: Hardink@chc1.com
 Telephone Number: (860) 347-6971 ext. 3914 Fax Number:

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of HHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: (Agency)

on (Date)

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the Federal Register on June 24, 1983, along with a notice identifying the

Department's programs that are subject to the provisions of Executive Order 12372. Information regarding HHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

BY SIGNING THE FACE PAGE OF THIS APPLICATION, THE APPLICANT ORGANIZATION CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE, COMPLETE, AND ACCURATE TO THE BEST OF THE SIGNER'S KNOWLEDGE, AND THE ORGANIZATION ACCEPTS THE OBLIGATION TO COMPLY WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' TERMS AND CONDITIONS IF AN AWARD IS MADE AS A RESULT OF THE APPLICATION. THE SIGNER IS ALSO AWARE THAT ANY FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS OR CLAIMS MAY SUBJECT THE SIGNER TO CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES.

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR THE APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION:

Civil Rights – Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, and all the requirements imposed by or pursuant to the HHS regulation (45 CFR part 80).

Handicapped Individuals – Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 84).

Sex Discrimination – Title IX of the Educational Amendments of 1972 (P.L. 92-318), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 86).

Age Discrimination – The Age Discrimination Act of 1975 (P.L. 94-135), as amended, and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 91).

Debarment and Suspension – Title 2 CFR part 376.

Certification Regarding Drug-Free Workplace Requirements – Title 45 CFR part 82.

Certification Regarding Lobbying – Title 32, United States Code, Section 1352 and all requirements imposed by or pursuant to the HHS regulation (45 CFR part 93).

Environmental Tobacco Smoke – Public Law 103-227.

Program Fraud Civil Remedies Act (PFCRA)