HEALING HANDS

Vol. 17, No. 1 | Winter 2013

Clinical Leadership in the Health Care for the Homeless Setting

America's health care for the homeless (HCH) projects are community-based and patient-directed health centers that serve families and individuals experiencing homelessness. A major source of care for homeless persons, these health centers recognize the complex needs of homeless persons and strive to provide a coordinated, culturally competent, and comprehensive approach to health care including substance abuse and mental health services. In 2011, the Health Resources and Services Administration (HRSA)-supported HCH Program served over one million individuals experiencing homelessness (Health Resources and Services Administration [HRSA], n.d. a).

While HCH medical directors play an important role in direct patient care and HCH management, there is limited research illuminating their basic characteristics, such as roles and responsibilities, relationships with other administrators, retention, and satisfaction levels. In recent years, HRSA has focused on chronic disease management, health care quality, patient safety, and information management. The complexity of these tasks demands a higher level of leadership skill than ever before (Markuns, Fraser, & Orlander, 2010).

In this issue of *Healing Hands*, we explore several aspects of clinical leadership in the HCH practice setting, such as balancing clinical and administrative responsibilities, building internal and external relationships, delivering quality care, and medical directors' need for training in practice management and leadership skills. This issue is a companion piece to "Enhancing Leadership and Management Skills for Successful HCH Projects" (*Healing Hands*, May 2011), and we invite readers to revisit that issue for more insight and understanding of the roles and responsibilities of both medical and executive directors in homeless health care.

"THIS IS POVERTY MEDICINE"

"Each HCH project has different things that they ask the medical director to do," says **Bob Donovan, MD**, medical director of the Cincinnati Health Care for the Homeless Program, who started with the organization in 1987. "There are few federal guidelines or expectations for the position of medical director so job descriptions vary greatly [see *Health Center Program Expectations*, page 2, for BPHC guidance and HRSA's *Health Center Site Visit Guide*]. What we share, however, is doing the best we can, given limited resources. Since our patients are uninsured for the most part, we work with insufficient resources and are often unable to order lab work or other diagnostic tests that we would like to have to help us feel confident in our diagnosis. Not having test results to rely upon can feel daunting, but that is the reality of our practice much of the time.

"This is poverty medicine," says Donovan. "In homeless health care, providers rely more on their innate and honed clinical skills—such as taking a medical history and performing the physical exam. Our *being* with the person is more relevant to the successful outcome than is relying on a particular test result. Having a relationship with the individual becomes even more critical than in other practice settings so that we can rely on our gut or intuitive instincts about what the person needs. Given how society continually discredits homeless people and marginalizes them in their everyday encounters, the physician's presence and empathy are critical elements to healing. A significant part of clinical care is letting the individual know that you take an interest in their health and well-being. Knowing that you are there for them makes medical treatment more effective."

Online *Healing Hands* Accredited for CME

Go to www.nhchc.org/resources/publications/newsletters/healing-hands to access the online version of this & past issues of *Healing Hands*.

Family physician **Matias Vega, MD**, adds: "When viewed within the context of poverty medicine, medical care can be regarded as the least important component of HCH. The best that medical can do for patients experiencing homelessness is to keep them alive long enough to access other HCH services. The ultimate goal of HCH is to get people out of homelessness. As James Wright, the sociologist from Tulane University, said in the '80s, homeless people are beaten by the conditions of their existence, and we are weary of softening the blows of homelessness when what we really want is to end this national disgrace. Otherwise, we are managing—not ending—homelessness." Vega is medical director of Albuquerque Health Care for the Homeless in New Mexico. Before moving to the Southwest, Vega was medical director of the Homeless Initiative Program (HIP) in Indianapolis for 10 years.

"Our patients are not going to get better until they are housed," Vega continues, "and that is the value of the Housing First approach. Treating a patient's diabetes, for example, is not going to get that person housed. Yes, it is practicing good medicine to get diabetes under control, but clinical leaders must also understand what truly makes a difference in our patients' lives. Since primary care is the least stigmatizing of our services, medicine frequently serves as the legitimate entry point to the HCH system. It is HCH's other services—outreach, case management, social services, peer support, housing, job training, behavioral health services—that make the difference in getting individuals and families off the street."

TREATING A COMPLEX, UNIQUE POPULATION

"Often new patients present with their defenses up because so many people have disappointed them in the past," observes **Karen Moyer, MD**. "They may have been told *no* everywhere they went for help; I want our staff to say, '*Yes, we can help you with that.*' We frequently see patients with complex

Brenda J. Proffitt

Dr. Bob Donovan speaks at a meeting of the NHCHC's governing members.

medical needs complicated by mental illness or addiction along with their poor social situation. We need time to build trust and prove that we are here to help. As a Homeless Health Care Center, we are especially equipped to serve the unique needs of those experiencing homelessness.

"Clinicians must remain calm," Moyer says, "when clients with behavioral health problems exhibit challenging behavior so that we have the opportunity to address their needs. It takes time, patience, and humbling oneself for the good of the patient.

"One's instinct is to try to do everything," Moyer continues, "but providers must have the ability to balance the competing demands of meeting the needs of the person in front of them with meeting the needs of those waiting to be seen. It requires judgment and a certain degree of sensitivity."

An internist, Moyer has been the medical director of the Homeless Health Care Center for ten years. The Chattanooga – Hamilton County [Tennessee] Health Department operates the HCH project, providing administrative and other infrastructural components, including purchasing, data processing, human resources, and information technology.

"It's not uncommon to see a patient with bipolar disorder, traumatic brain injury, post-traumatic stress, diabetes, *and* addiction to heroin and cocaine," Vega says. "This is not a patient that you can treat in 15 minutes. This multiplicity of problems is what forced HCH into being the leader in providing fully integrated care; that is job one for us."

BALANCING ACT

The medical director's job is perhaps the hardest job in the health center given that he or she must connect the worlds of medicine and administration. Most HCH grantees lack the luxury of allowing clinical leaders to focus solely on managerial tasks, so they also carry direct patient care responsibilities. While this division of labor may be unavoidable, it is not practical. Management responsibilities do not stop because the provider is in clinic, so the medical director must have an ability to juggle roles and handle frequent interruptions.

"The key is staying organized," comments Moyer. "Because I spend most of my time on direct patient care and patients are my top priority, it's imperative that I be good at multitasking so I can also manage administrative duties."

Family physician **Danielle Robertshaw, MD**, agrees and advises medical directors to "be very organized, be flexible, and take advantage of being part of the larger team. Learn to embrace chaos." Robertshaw has been a clinical leader for 12 years, having led two HCH grantees. Robertshaw was the medical director of homeless outreach at Unity Health Care in Washington, DC, and moved from there to Health Care for the Homeless, Inc., in Baltimore, where she was medical officer.

PHYSICIANS BECOMING LEADERS

Health care administrators typically have been groomed for leadership for many years, while the physician has been groomed to provide quality health care. This means there is often a gap between where the medical director is and where he or she needs to be to carry out the business of health care effectively (Saunders & Hagemann, 2009).

"A challenge for new clinical leaders," says Robertshaw, "is recognizing and understanding the differences between how we are trained as medical providers versus what it takes to be good managers. Here are several examples. The physician's orientation is one-on-one interaction—provider to patient—while the manager relies on group interaction. The physician is accustomed to autonomy while the manager thrives on collaboration. The physician is trained to be the decider while the manager has learned to be a delegator. Physicians are doers while managers are planners. The physician often identifies with the profession, while the manager identifies with the organization.

"By definition, the medical director must have the ability to perform effectively as a clinician and as a manager," Robertshaw says. "Inherent in this is the desire to be both. Initially, you may lack the manager's skill set, but you may have interest in developing those skills. Physicians must identify gaps in their knowledge and skills and find ways to learn what the job requires."

Medical directors do not need to have the same set of skills as, say, finance directors; instead they need to ability to move from clinical work and engage with a finance director to make decisions collaboratively. For this, affective leadership skills—such as self-awareness, persuasion, communication—are at the core of a leader's skill set (Giordano, 2010).

ROLES & RESPONSIBILITIES OF CLINICAL LEADERS

The composition & structure of a health center's clinical staff are central to the health center's ability to provide high quality care & assure continuity of care for its patients. All health centers are expected, through aggressive recruitment & retention, to maintain a core staff of primary care clinicians with training & experience appropriate to the culture & identified needs of the community.

Leadership

Strong clinical leadership is essential for all health centers. Health centers should have a clinical director with training & skills in leadership & management who works closely with other members of the health center's management team. Typically, the clinical director is a physician, although other types of clinicians may fulfill the role, particularly in very small programs, which may be staffed by non-physicians. In some marketplaces, a physician clinical director may be essential to effectively position the health center.

Clinical directors are expected to

1) provide leadership & management for all health center clinicians whether employees, contractors, or volunteers;
2) work as an integral part of the management team;
3) establish, strengthen & negotiate relationships between the health center & other clinicians, provider organizations & payers in its marketplace; and
4) monitor & improve quality of care.

Because it is critical that the clinical director always represent the interests of the health center, its patients & the community it serves, it is preferred that a health center directly employ its clinical director. If this individual is not directly employed, the chief executive should retain authority to select & dismiss the individual.

Source: Bureau of Primary Health Care, HRSA, 1998

These are additional critical skills for the effective health care leader (Saunders & Hagemann, 2009):

- **Delegation.** In general, physicians are accustomed to being totally responsible for their patients care, so they may try to do everything themselves. Delegation of duties and allowing the delegate to act independently without hovering is a useful art to cultivate.
- **Influencing & negotiating.** "Perhaps the best advice I can give is to be ready with a good rationale for your requests," says Moyer. Effective leaders know how to state their case and are able to support the management team if an alternative course of action is taken. Honing negotiating skills and mastering the art of give-and-take will serve the medical director well.
- **Teambuilding.** It is important for the medical director to participate in and build effective, cohesive teams. Mentoring team members is an equally important role. Good leaders know how to engender shared values and bring along staff when difficult decisions need to be made (Giordano, 2010).
- **Conflict management.** Conflict management skills are required for any leadership role. Clinical leaders must be able to find the root cause of disagreements and reach compromises that are acceptable to all. To do this, the leader must demonstrate impartiality, trustworthiness, and facility in conflict resolution.
- **Effective communication.** Communication skills are fundamental to effectiveness both as a leader and as a clinician. "HCH physicians who are well trained in skills such as motivational interviewing can be better communicators than the more traditionally trained physicians," Donovan says.

DELIVERING QUALITY PATIENT CARE

"It's a challenge to get buy-in from staff given the tendency to keep doing things the way they've always been done," says Moyer, "so it's not always easy getting staff to support and commit to new initiatives, best practices, or the latest guidelines for evidence-based care. Patients should not experience a difference in care from provider to provider. Our participation in HRSA's Health Disparities Collaboratives and using the planned care model (or chronic care model) has been extremely valuable in helping standardize care—especially for patients with chronic illness."

HRSA expects health centers, such as HCH grantees, to have ongoing quality improvement/assurance programs that include clinical services and management, to focus provider responsibilities on improving care processes and outcomes, and to maintain the confidentiality of patient records. The medical director is typically the one in the health center responsible for establishing quality and performance goals for their organization and patient populations and assessing progress toward these goals. There are 16 clinical and five financial performance measures for the 2012 UDS (Uniform Data System). These measures are in concert with performance improvement initiatives within the broader health care community and are in alignment with those of national standard setting organizations as well as Medicare, Medicaid, and other health insurance programs to assess quality performance (HRSA, 2012a; HRSA, 2012b).

A freestanding HCH grantee, Project HOPE (Homeless Outreach Program Enrichment) serves approximately 2,500 patients with nearly 10,000 visits annually in Camden, New Jersey's poorest city. **Lynda Bascelli, MD**, is a relatively new medical director, having been in this position for less than a year now.

"Over the past nine months, we redesigned Project HOPE's quality program from the ground up," Bascelli says. "We initially started with lofty goals and too many measures, but quickly realized it was impossible to do it all. We found we were spending too much time reviewing charts instead of improving quality. My advice to new medical directors is to start slowly. Prioritize the required UDS clinical and financial performance measures, especially those that you know will help your patient population. Select a few aspects of care to improve, and don't be afraid to pick the low-lying fruit—measures where it's easy to make a difference. As you have success in affecting change and improving outcomes, you'll gain staff buy-in to the quality improvement process and be poised to tackle more challenging measures.

"While medical directors must be quality champions and assure that quality is part of the health center culture," Bascelli continues, "it doesn't mean that they must do everything themselves." In a quality culture, all staff—whether clinicians or not—come to share a common aim: delivering excellent care efficiently. More thought is given to patients and their needs, not only patients' clinical outcomes, but the overall quality of the patient experience. In a broad sense, this means that clinicians extend the responsibility they feel for their patients to the organization itself (Mountford & Webb, 2009).

BUILDING A COLLABORATIVE PARTNERSHIP WITH YOUR EXECUTIVE DIRECTOR

"Executive directors and medical directors must rely on each other's expertise and work together to accomplish the organization's goals," Moyer says.

"Don't assume that your goals and approaches are dissimilar to and necessarily incompatible with those of the executive director," adds Robertshaw. "Find ways to complement one another. Get to know the executive director and his or her role. Set standing meeting times and expectations for the meeting, and make sure there is interaction outside these meetings. Don't limit yourself to clinical issues; be active in all areas of the organization. Study the organizational structure and culture to see how and where the medical director role fits."

"Having a good relationship with the executive director is paramount," says Bascelli. "You need to trust one another and share a vision. In our case, we share the mission of increasing access to care for those in our community who are experiencing homelessness. While conflict could easily arise between administration and clinical staff over issues such as productivity, we view productivity in terms of the organization's mission. Having the right attitude can help in dealing with challenges that go along with the position."

Bascelli began as a medical provider at Project HOPE in January 2011. She says, "At that time, I lacked a clear sense of the medical director's work; I had no idea about quality measures, the UDS, or other reporting requirements. Now that I'm medical director, I strive for transparency. I regard our other provider as a medical director-in-training and share administrative responsibilities with her. Not that I have plans to leave, but given the job's complexity, collaboration, delegation, and succession planning are critical. In a small project like ours, we must use staff creatively and allow staff to grow; it helps with staff retention and influences how we provide and improve our medical care."

BUILDING EXTERNAL RELATIONSHIPS

"The medical director is in a unique position to see both the local needs *and* the big picture," Donovan says. "This gestalt view is possible since by definition medical directors link the clinical and administrative realms. As managers, we study UDS and other reporting data, and as providers, we understand our patient population in terms of trends, incidence, prevalence, and any new or emerging problems. As clinician advocates, we can take this information to the local, national—or even international—level, where we can effectively represent and advocate for the needs of our community and the people we serve."

The National Health Care for the Homeless Council (NHCHC) and other organizations, such as state and national coalitions for the homeless, provide a platform for clinicians and others to speak up for people who are experiencing homelessness. "As clinical leaders it is our responsibility to speak to legislators and educate them about the nature of homelessness and propose solutions based on our direct experience,"

Donovan says. "As president of the Council, I went with others to brief legislators on Capitol Hill. Being able to effect change at the systems level is empowering."

Robertshaw agrees with the importance of this role, urging clinical leaders to "participate in local, state, regional, and national forums to promote optimal primary health services for medically underserved populations." Another key advocacy role for the medial director is building relationships with other service providers, linking the HCH project and the larger medical community (e.g., attending local medical society functions or being available for public presentations).

Joshua Myers

Dr. Lynda Bascelli consults with one of her patients at Project HOPE.

PASSING THE TORCH

"Poverty medicine is a long-term responsibility," Donovan says. "Having students and residents rotate through HCH projects is part of passing the torch of leadership to the next generation. Unless we do that, students won't have exposure to our practice, and they won't regard HCH projects as being places to work. When we teach students and residents, not only do we train them, we demonstrate how valuable and rewarding this work is. Working with people experiencing homelessness builds your spirit and challenges your clinical skills." As with many other HCH medical directors, Donovan's responsibilities extend beyond that of being a preceptor to teaching in the university setting. At press time, he is preparing to teach a sociology course on death, dying, hospice, and medical respite care at the University of Dayton.

"Working with students and residents shows them the complexity of our work," adds Vega, "and it demonstrates the model of care for the future—fully integrated care—not just in theory but in practice. We've been practicing like this for the past decade, and once medical students see the power of this model, they will not want to return to a strict medical model." Vega worked closely with the University of New Mexico School of Medicine (UNM SOM) in developing a health equity curriculum, which now spans the four years of medical school.

"Parts of the curriculum have been adopted by other academic medical centers nationwide," says **Cynthia Arndell, MD**, "and we have presented on components of the curriculum nationally and internationally." An internist, Arndell is associate professor in the UNM SOM Department of Internal Medicine and a former medical director of Albuquerque HCH.

"Research suggested that training exposure positively affects students' attitudes, abilities, and intentions to practice in underserved areas," Arndell says. "Knowing that students lose their altruism as they move through medical school, our goals are to increase medical students' sensitivity to the challenges of impoverished people and to enhance their skills in caring and advocating for vulnerable populations." The curriculum addresses the social determinants' effects on health, social justice and advocacy, and provider self-awareness and self-care. An advisory committee of the HCH Clinicians' Network oversaw the development of the curriculum and helped shape its content as it was being designed. To learn more about the curriculum, search for *health equity* on the UNM SOM Teacher and Educational Development web page at http://som.unm.edu/ume/ted.

LOOKING AHEAD TO 2014 . . .

"America's health care system is undergoing a major transition, and this will affect how HCH looks and operates in the future," Vega says. As the essential primary care medical home for people experiencing homelessness, HCH grantees will play a key role in implementation of the Affordable Care Act (ACA). Health centers reduce costs to health systems, and the health center model of care reduces the use of costlier providers such as emergency departments and hospitals (HRSA, n.d. b). Recent expansions of the Health Center Program provided by the ACA and the American Recovery and Reinvestment Act are helping HCH grantees serve more patients, stimulate new jobs, and meet the increase in demand for services among underserved and uninsured people (HRSA, n.d. c).

Not only do clinical leaders make the frontline decisions that determine the quality and efficiency of care, they also have the technical knowledge to help make sound strategic choices about longer-term service delivery patterns (Mountford & Webb, 2009). The physician leader role is rather unique, and medical directors who perform well as leaders are a highly valued treasure for any HCH project. ■

LOOKING FOR A GOOD MENTOR?

According to a study of health center medical directors, mentoring appears to be one of the most effective methods for achieving success & satisfaction in the medical director position (Markuns, Fraser, & Orlander, 2010). "Identify a mentor early on to help explain why certain aspects of management are important," recommends Bascelli. The trick, of course, is finding a mentor. The Council maintains a database of all HCH clinical leaders & can offer suggestions to match you with a seasoned provider who may be in your region, of your same specialty & working in an HCH project similar to yours. NHCHC's Technical Assistance Coordinator Juli Hishida invites HCH medical directors to request a peer-to-peer visit or consultation. You may reach her at (615) 226-2292 or jhishida@nhchc.org.

Peer networking is another way medical directors enhance skills in practice management & leadership. To meet others doing the same work you do, consider joining the HCH Clinicians' Network. Membership is free; to learn more, go to www.nhchc.org/resources/clinical/hch-clinicians-network.

Another approach is to reach out to your state's primary care association (PCA). Moyer says, "My relationship with the Tennessee Primary Care Association has been invaluable. The Medical Directors' Group meets regularly to share information, triumphs & challenges." Most PCAs have resources, TA & training specifically for clinical leaders. To locate your PCA, visit http://bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html.

Training for New & Seasoned Medical Directors

Physicians are accustomed to continuing education, so taking courses and working to learn new skills is not a barrier (Saunders & Hagemann, 2009). While medical directors seek to build leadership skills in a variety of ways, such as attending conferences, networking with peers, engaging a mentor, or pursuing formal degree training, a study conducted in 2010 of health center medical directors in Massachusetts concluded that there is a need for more leadership training opportunities for active and future medical directors. Increased training correlates with improved leadership skills and leadership skills play a significant role in achieving exemplary health center practices. Further, studies suggest that administrative inexperience and insufficient training may lead to poor retention of medical directors (Markuns, Fraser, & Orlander, 2010).

Any effort to encourage leadership must include support for professional development (Mountford & Webb, 2009). At the suggestion of her HRSA project officer, Bascelli recently attended a four-day course, *Managing Ambulatory Health Care (MAHC) I: Introductory Course for Physicians in Community Health Centers*, sponsored by the Harvard School of Public Health and the National Association of Community Health Centers (NACHC).

"I found the training especially helpful in areas that I might not tackle on my own, such as financial management," Bascelli says. When physicians understand the organization's financials, they are better collaborators with administrators on important clinical decisions—for example, how to expand or reconfigure services—in full knowledge of the resource implications and trade-offs (Mountford & Webb, 2009).

Along with financial management, *MAHC I* covers

- approaches to help make you a more effective and influential physician manager;
- opportunities to improve common operational issues faced by health centers; and
- strategies to positively influence the political process and enhance your leadership role within your community.

"A three-part advanced training for medical directors who have undertaken significant managerial responsibilities, *MAHC* is designed to go beyond the basics," says NACHC's Director of Clinical Quality Projects, **Katja Laepke**. *MAHC II* focuses on areas such as retaining and recruiting health care providers; strengthening relationships with administrative staff; and advancing QI methods and results using new technology. *MAHC III* addresses areas such as productivity; negotiation and conflict resolution; performance compensation; and enhancing motivation. Confirmed 2013 programs are *MAHC I* in Portland, Oregon, June 24 – 27, and *MAHC II* in Boston, April 22 – 25. Contact **Cindy Thomas** at cthomas@nachc.com for information.

Brenda J. Proffitt

Dr. Matias Vega works with medical student Andrea King at the University of New Mexico School of Medicine.

For those who have been medical director for two years or less, NACHC sponsors a 1 1/2 day *Training for New Medical Directors*, which covers the core knowledge and competencies that all medical directors need to function as effective managers, leaders, and advocates for their health centers and communities. NACHC as well as state and regional PCAs host this training four times annually. Content focuses on developing competency in evolving health care issues such as the patient-centered medical home, electronic health records, and meaningful use. Interested individuals may contact Laepke at (206) 780-4972 or klaepke@nachc.com. **Beth Kujawski**, data-communications assistant, is also able to assist; contact her at (732) 833-1129 or bkujawski@nachc.com. CME credit is available for both *MAHC* programs and *Training for New Medical Directors*. ■

PRACTICE PEARLS: TIPS FOR CLINICAL LEADERS

"Take advantage of the EHR and use its full potential to help you establish and assess your progress toward quality goals."

—Lynda Bascelli, MD, Medical Director
Project HOPE, Camden, New Jersey

"Fit administrative duties into small pockets of downtime. Keep tasks organized in folders and close by so that you can grab a project and work on it easily as time allows."

—Karen Moyer, MD, Medical Director, Homeless Health Care Center
Chattanooga – Hamilton County Health Department, Tennessee

"Develop a good working relationship with the governing board. As medical director, you'll be able to provide valuable insight on clinical services provision, quality assessment and improvement, and recruitment/retention issues."

—Danielle Robertshaw, MD

"A quality indicator for HCH should not just be improving someone's health, it should be getting the person out of homelessness."

—Matias Vega, MD, Medical Director
Albuquerque Health Care for the Homeless, New Mexico

"A key competency for HCH medical directors is the ability to have compassion for the people they serve. Fundamental to this sense of compassion is the ability to regard the patient holistically, seeing not just physical conditions but the individual's most basic needs for acceptance, food, clothing, shelter, and safety."

—Terri Crutcher, MSN, RN, Director of Clinical & Quality Improvement
Tennessee Primary Care Association

"HCH clinicians are trailblazers in integrating primary care and public health. Be part of the ongoing health care transformation by participating in local, state, and national initiatives on quality improvement and Patient-Centered Medical Homes. By doing so, you can contribute enormously to the future direction of health care, not only for those who experience homelessness but for everyone."

—Seiji Hayashi, MD, MPH, Chief Medical Officer
Bureau of Primary Health Care

TOOLKIT OF PRACTICAL RESOURCES FOR CLINICAL LEADERS

Resources for leadership development

American College of Physician Executives (ACPE)	www.acpe.org
Clinical Directors Network	www.cdnetwork.org
Clinical Leaders: Heroes or heretics? | World Scientific | 2010 | e-book	www.worldscientific.com/worldscibooks/10.1142/7697
Clinical Leadership Programme online postgraduate course	http://clinicalleadership.bmj.com
Developing physician-leaders: Key competencies & available programs | Journal of Health Administration Education | 2008	http://academy.clevelandclinic.org/LinkClick.aspx?fileticket=ZGoyLzF1%2FVE%3D&tabid=1846
Enhancing Leadership & Management Skills for Successful HCH Projects | *Healing Hands* | 2011	www.nhchc.org/wp-content/uploads/2011/09/May_Healing_Hands_Web.pdf
Executive & Continuing Professional Education programs for clinical leaders | Harvard School of Public Health	https://ccpe.sph.harvard.edu/finder.cfm?TYPE=search&ProgType=ExecEd
Leadership Development | Onsite training by the t^3 team from the Center for Social Innovation	www.center4si.com/training/our_courses.cfm
Management Training of Physician Executives, Their Leadership Style & Care Management Performance | Archived Webinar	www.cdnetwork.org/NewCDN/LibraryView.aspx
What is clinical leadership & why is it important?	http://onlinelibrary.wiley.com/doi/10.1111/j.1743-498X.2010.00423.x/pdf
When clinicians lead | *McKinsey Quarterly* | 2009	www.mckinseyquarterly.com/When_clinicians_lead_2293

Resources for building internal & external relationships

Medical Director & CEO: Collaborative Leadership | Archived Webinar	www.cdnetwork.org/NewCDN/LibraryView.aspx

Resources on health IT (information technology)

Health IT | Association of Clinicians for the Underserved | 2012	http://clinicians.org/category/health-it/
Successful EHR Implementation: The Health Center's Role | Archived Webinar | 2010 | CME credit	www.cdnetwork.org/NewCDN/LibraryView.aspx

Workforce & human resource issues

Clinical Workforce Retention & Recruitment Toolkit | NACHC | 2011	www.nachc.com/client/documents/CLINICAL%20RECRUITMENT%20AND%20RETENTION%20TOOLKIT_final1.6.11.pdf
Health Workforce Information Center	www.hwic.org/
Building the Capacity of the Homeless Service Workforce | *The Open Health Services & Policy Journal* | 2010	http://homeless.samhsa.gov/ResourceFiles/Documents/hrcJournal/Capacity.pdf
Peer Review, Risk Management & Medical Provider Credentialing | Archived webinar | CME credit	www.cdnetwork.org/NewCDN/LibraryView.aspx
Fostering the Empowerment of Employees: Recovery-Oriented Supervision | Self-directed online course	www.center4si.com/training/our_courses.cfm
Onsite face-to-face training in supervision skills	For information, contact t3 at info@thinkt3.com or (617) 467-6014

Resources for advocacy

The Affordable Care Act & Health Centers | HRSA	http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf

continued on page 7

TOOLKIT OF PRACTICAL RESOURCES FOR CLINICAL LEADERS, *continued*

Medicaid Expansion & the ACA: Issues for the HCH Community | Policy Brief | September 2012 | NHCHC	www.nhchc.org/wp-content/uploads/2011/10/PolicyBrief-MedicaidExpansion-Sept20121.pdf
Health Reform Materials | NHCHC	www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials

Resources for building community/campus partnerships

Community-Campus Partnerships for Health	www.ccph.info
Community Health Centers & Primary Care Teaching: A Look at the Future | Archived webinar featuring H. Jack Geiger, MD | June 2012 | CME credit	https://cne.memberclicks.net/index.php?option=com_mc&view=mc&mcid=72&eventId=346531
Poverty & Health | Resources relevant to poverty medicine, including curricula | HCH Clinicians' Network	www.nhchc.org/resources/clinical/tools-and-support/poverty-health
Training Residents in Community Health Centers: Facilitators & Barriers | *Annals of Family Medicine* | 2012	www.annfammed.org/content/7/6/488.full.pdf+html
Widening the Pipeline: Engaging the Next Generation of Health Care Leaders | Archived webinar | 2008	www.cdnetwork.org/NewCDN/LibraryView.aspx

Resources for quality improvement/assessment

Clinical & financial performance measures | HRSA | August 2012	http://bphc.hrsa.gov/policiesregulations/performancemeasures/fy2012measures08152012.pdf
Quality Improvement Tools & Resources | American Academy of Family Physicians	www.aafp.org/online/en/home/practicemgt/quality.html?navid=quality+improvement
HCH Quality Leaders: A Case Study | Key Practices Supporting Quality of Care & Improvement Processes | NHCHC | 2012	www.nhchc.org/wp-content/uploads/2012/11/HCH-Quality-Leaders-Key-Practices-Supporting-Quality-of-Care-and-Improvement-Processes.pdf
Learning Lab: The Nuts & Bolts of Quality Operations | March 22, 2013 | NACHC's Policy & Issues Forum | Washington, DC	For information, contact Katja Laepke at klaepke@nachc.com or (206) 780-4972
Patient-Centered Medical Home | Association of Clinicians for the Underserved | 2012	http://clinicians.org/our-issues/patient-centered-medical-home
Pursuing National Quality Recognition | *Healing Hands* | 2012	www.nhchc.org/wp-content/uploads/2012/03/Spring2012HealingHands.pdf
Quality Improvement & Risk Management | HRSA | 2012	http://bphc.hrsa.gov/technicalassistance/TAResources.aspx?Mode=SubTopicSubResource&STopic=Quality%20Management/Improvement
Quality Improvement Planning Learning Series | HRSA | 2012	http://bphc.hrsa.gov/policiesregulations/quality/index.html
Quality Management in an Age of New Health Care Models | Ambulatory Innovations & NACHC | CME credit	For information, contact Katja Laepke at klaepke@nachc.com or (206) 780-4972
The Quality Management Plan: A Practical, Patient-Centered Template | 2011	http://iweb.nachc.com/downloads/products/M_MONOGRAPH_11.pdf

Training & technical assistance resources

t^3 think • teach • transform | Center for Social Innovation	www.center4si.com/training/our_courses.cfm
TA: The Health Center Program | HRSA | 2012	http://bphc.hrsa.gov/technicalassistance/index.html
Training & TA | Association of Clinicians for the Underserved	http://clinicians.org/education-and-training/training-and-technical-assistance
General clinical practice & administrative resources specific to the HCH practice setting	www.nhchc.org/resources/clinical

Healing Hands

Healing Hands is published quarterly by the National Health Care for the Homeless Council | www.nhchc.org

Brenda Proffitt, MHA, writer | Ben Rock, BS, communications coordinator & program assistant | Lily Catalano, BA, communications & program assistant | Victoria Raschke, MA, director of technical assistance & training | MGroup, layout & design

Subscription Information

Individual Membership in the NHCHC entitles you to a *Healing Hands* subscription. Join online at www.nhchc.org | Council Individual Membership is free of charge

Address Change

Call: (615) 226-2292 | Email: ppetty@nhchc.org

Disclaimer

This publication was made possible by grant number U30CS09746 from the Health Resources & Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Health Resources & Services Administration.

REFERENCES

Bureau of Primary Health Care, Health Resources and Services Administration. (1998). *Health center program expectations*. BPHC Policy Information Notice: 98–23. Rockville, MD: US Department of Health and Human Services. Retrieved from http://www.gchd.org/boards/2003/Pin98-23HCProgExpectations.pdf

Giordano, R. (2010). *Leadership needs of medical directors and clinical directors*. The Kings Fund. Retrieved from http://www.kingsfund.org.uk/publications/leadership_needs.html

Health Resources and Services Administration. (2012a). *Health center program requirements*. US Department of Health and Human Services. Retrieved from http://bphc.hrsa.gov/about/requirements/hcpreqs.pdf

Health Resources and Services Administration. (2012b). *Updated FY 2012 clinical and financial performance measures*. US Department of Health and Human Services. Retrieved from http://bphc.hrsa.gov/policiesregulations/performancemeasures/fy2012measures08152012.pdf

Health Resources and Services Administration. (n.d. a). About health centers: Special populations. Retrieved from http://bphc.hrsa.gov/about/specialpopulations/index.html

Health Resources and Services Administration. (n.d. b). *The Affordable Care Act and health centers. Fact sheet*. US Department of Health and Human Services. Retrieved from http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf

Health Resources and Services Administration. (n.d. c). *What is a health center? Health center expansion*. Retrieved from http://bphc.hrsa.gov/about/index.html

Markuns, J. F., Fraser, B., & Orlander, J. D. (2010). The path to physician leadership in community health centers: Implications for training. *Family Medicine, 42*(6), 403 – 407. Retrieved from http://www.stfm.org/fmhub/fm2010/June/Jeffrey403.pdf

Mountford, J., & Webb, C. (2009). When clinicians lead. *McKinsey Quarterly*. Retrieved from https://www.mckinseyquarterly.com/When_clinicians_lead_2293

Saunders, C., & Hagemann, B. (2009). *Physicians as leaders: What's missing?* Retrieved from http://www.healthleadersmedia.com/content/PHY-231588/Physicians-as-Leaders-Whats-Missing.htm

Websites accessed November – December 2012

Healing Hands received a **2012 APEX Award for Publication Excellence** based on excellence in editorial content, graphic design & the ability to achieve overall communications excellence