Together, our voices elevate all.

February Learning Forum: 2021 Launch

02.09.21

THE NACHC MISSION

America's Voice for Community Health Care

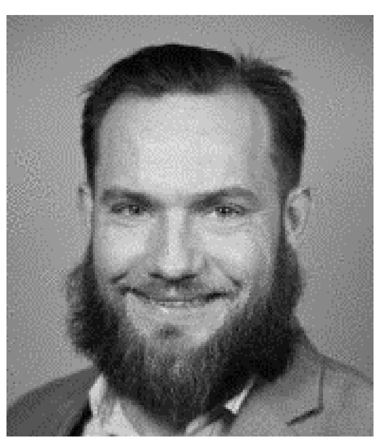
The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director, Quality Center



Luke Ertle

Manager, Quality Center

Camila Silva

Manager, Quality Center
Training & Curriculum

AGENDA

01 Elevate 2021 Journey

02 Learning Forum Goals

03 Measured Impact

04 Our Path: The Value Transformation Framework

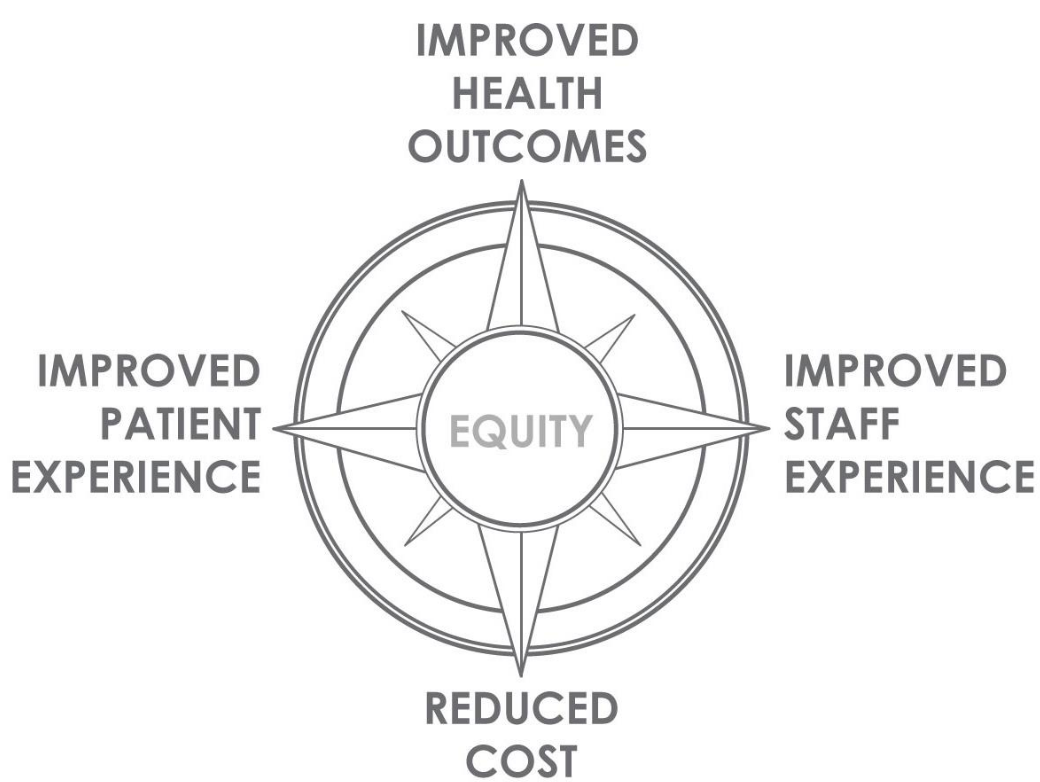
05 Change Areas: Leadership & Risk Stratification

06 Action Steps

Our 2021 Journey

- National network of Health Center Program grantees and partners
- Local, state, and national faculty
- Many modalities to learn and share
- Path to address an area of interest as part of whole-systems change
- View change in real-time "through health center eyes"
- New tracks and content:
  - *Self-pace modules*
  - *Mini messages*
  - *Virtual care elective series*
  - *Innovation*
- Scholarships to support professional development
- Free trial access to Health Center Program Requirements tool

Our Goal



Improved Performance through Transformed Systems

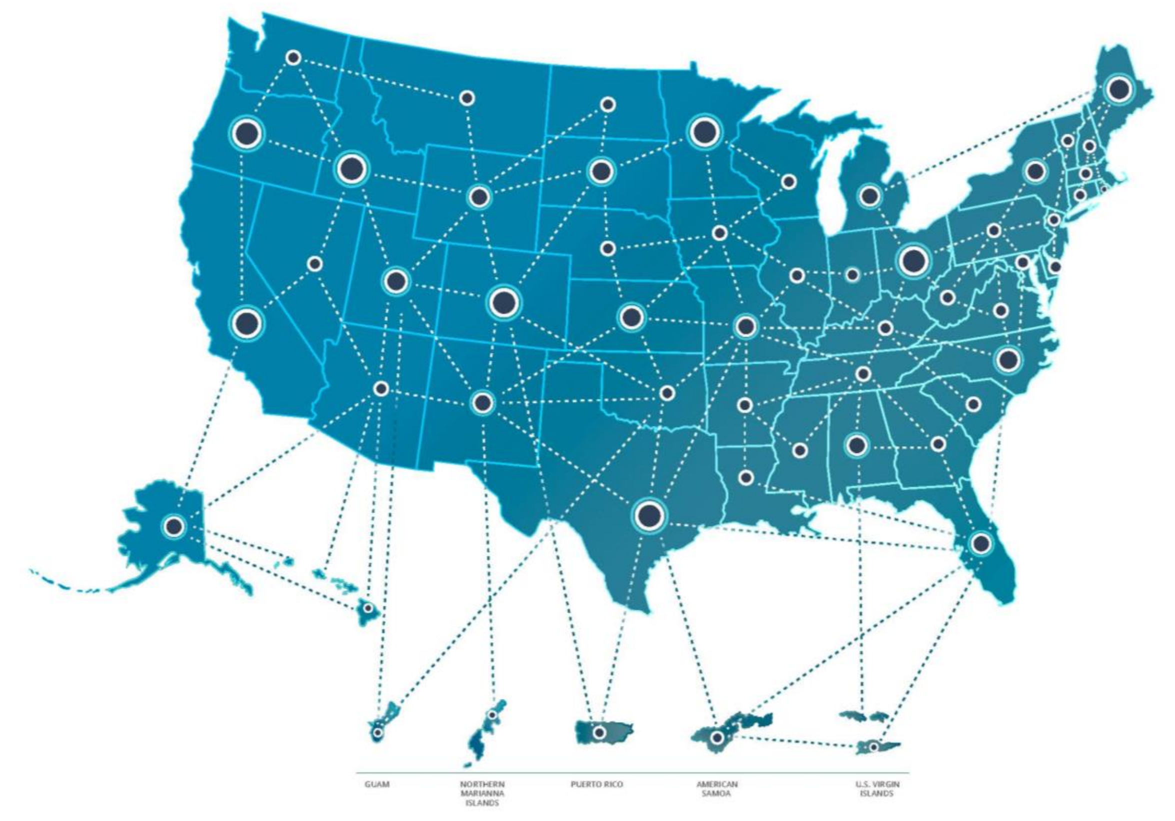
Our Impact

Health centers participating in the 2019 Elevate had statistically significant improvements in average UDS scores of 3 to 10% for six key clinical measures* as compared to the national health center average.

**cervical cancer screening, colorectal cancer screening, diabetes, hypertension, obesity, and depression*

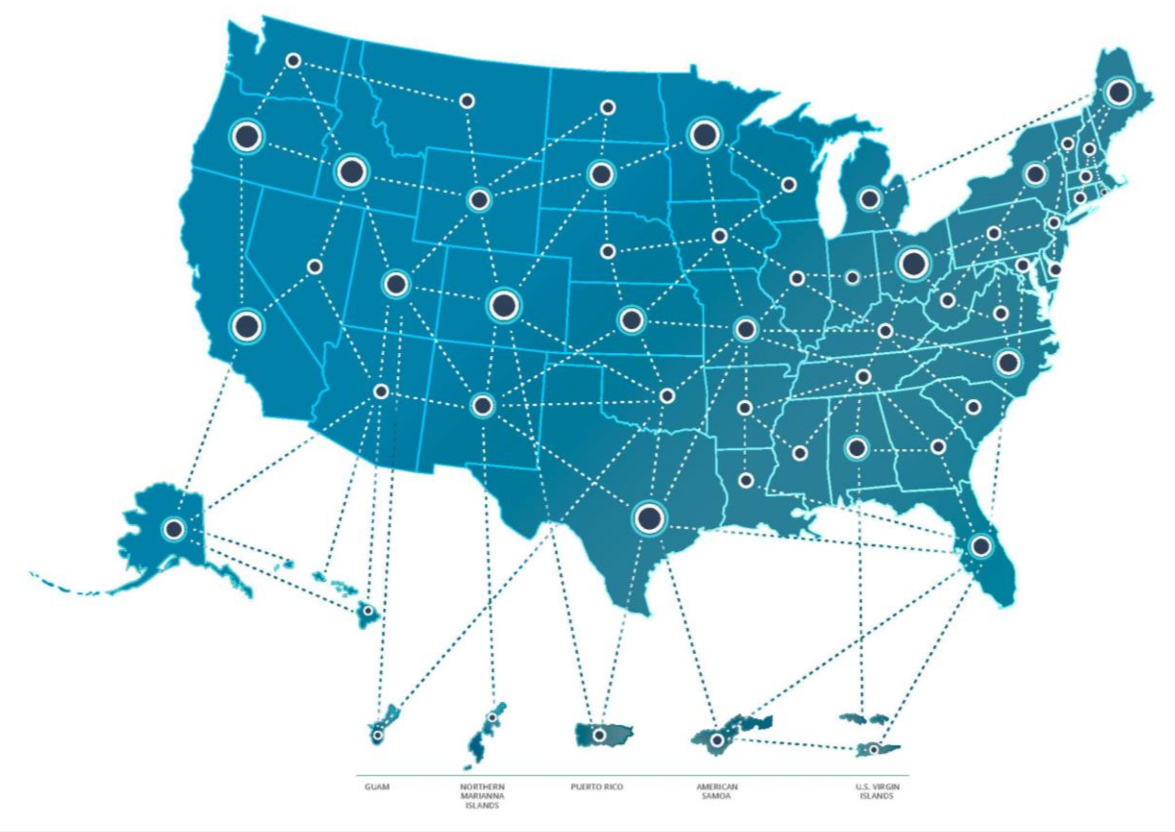
DATA

Our Community: ELEVATE 2021



All	450+	65+	6,000+	Million
States & Territories	Health Centers	PCAs/HCCNs	Peers	Patients

Our Partners: ELEVATE 2021



CDC	NACHC	PCAs	HCCNs	Health Centers	CDC Cancer Grantees	State Health Departments

Djenaba A. Joseph, MD, MPH

Medical Director, Colorectal Cancer Control Program

CDC, Division of Cancer Prevention and Control

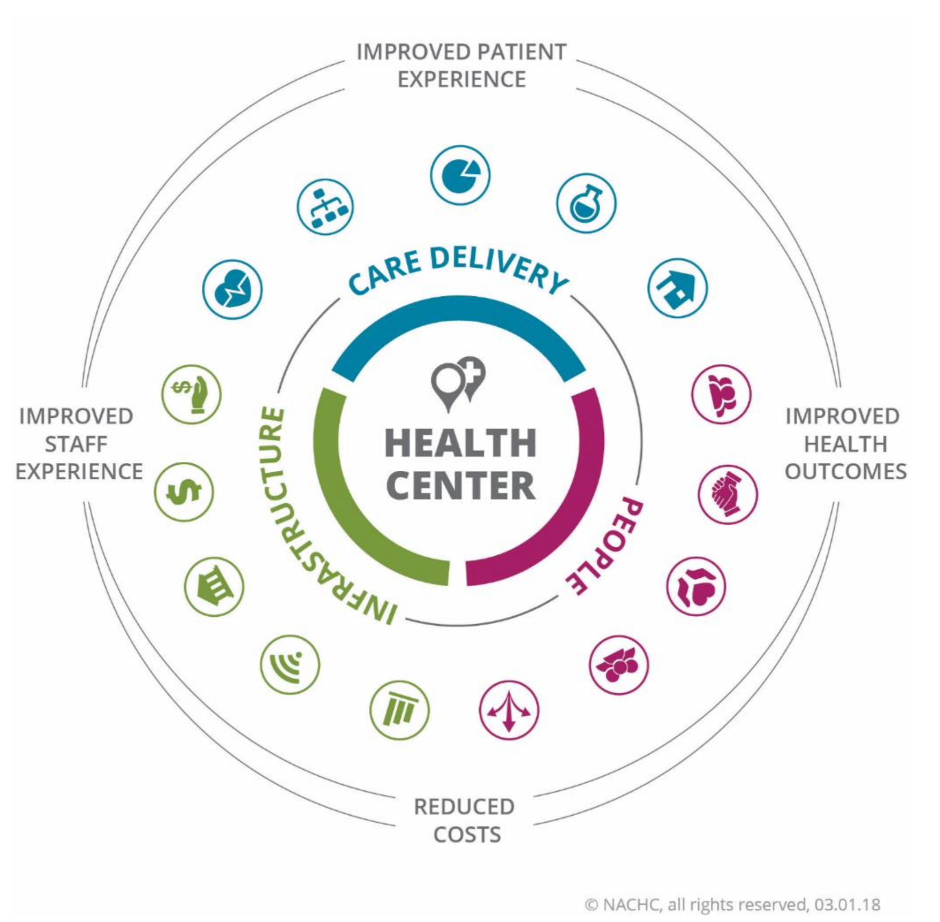
Our Learning Forum

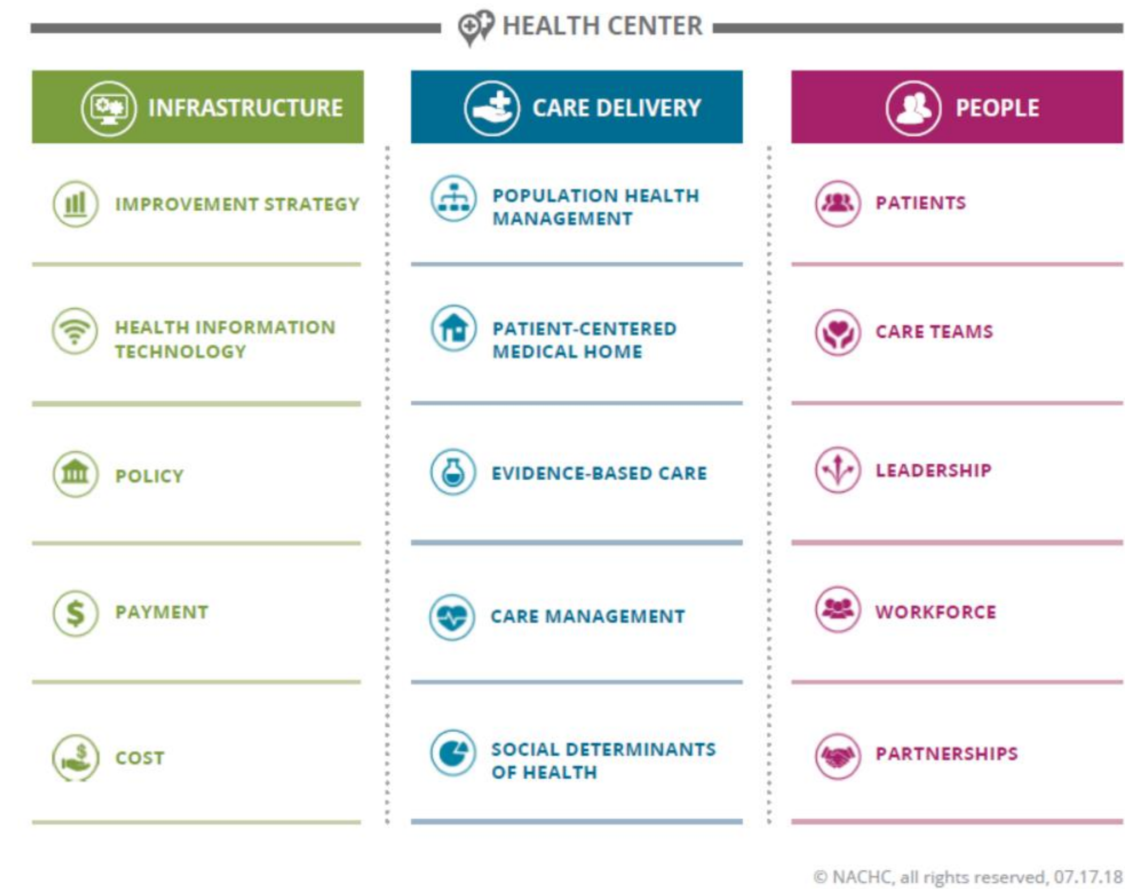
Grounded in a framework…
Operationalized in the real-world

- Guided application of the **Value Transformation Framework**
- Designed to **overlay and leverage** existing health center transformation efforts (e.g., PCA, HCCN, Health Department, Other)
- Supports health center **learning and exchange** through calls, online forums, and peer-to-peer exchange
- A **capacity-building** process to facilitate health center transformation through customized resources

Our Path

Value Transformation Framework





https://www.nachc.org/clinical-matters/value-transformation-framework/

Elevate 2021

NAVIGATE. ELEVATE. INNOVATE.

Value

Assessment

Learning Forum

Peer Exchange

Self paced modules

Webinars

IMPROVED HEALTH OUTCOMES

IMPROVED PATIENT EXPERIENCE

EQUITY

IMPROVED STAFF EXPERIENCE

REDUCED COST

ELEVATE LEARNING COMMUNITY

INNOVATE
REIMAGINING CARE 2021

Volume

RENEW/REGISTER

HEALTH CENTERS: bit.ly/Elevate2021_CHC

PCAS/HCCNS/NCAS: bit.ly/Elevate2021_PCAHCCN

COMPLETE ONLINE ASSESSMENT

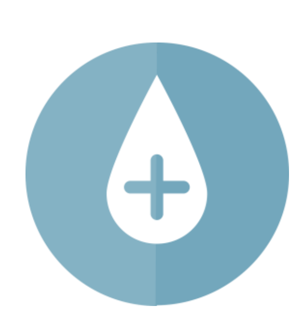
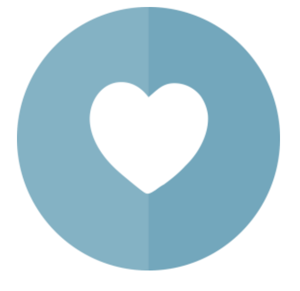
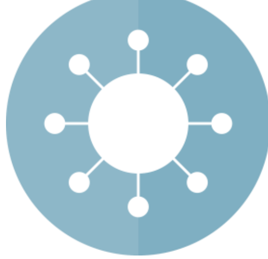
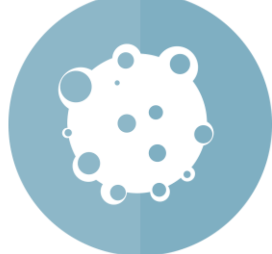
reglantern.com/vtf

LET’S GET STARTED

What is the overlay for YOUR health center?

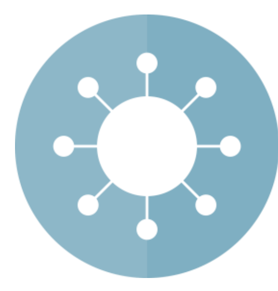
On what improvement efforts* do you plan to overlay Elevate’s systems transformation approach?

- COVID-19 Vaccination?
- Colorectal cancer screening?
- Cervical cancer screening?
- Diabetes control?
- HTN management?
- Obesity?
- Depression?

**Elevate includes attention to evidenced-based recommendations for these 6 high-cost, high-burden conditions*

Systems Approach…Cancer Screening, Diabetes, HTN, COVID-19…or Other

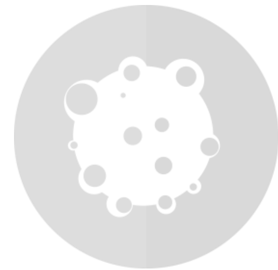


1 Leadership Support

2 Risk Stratification

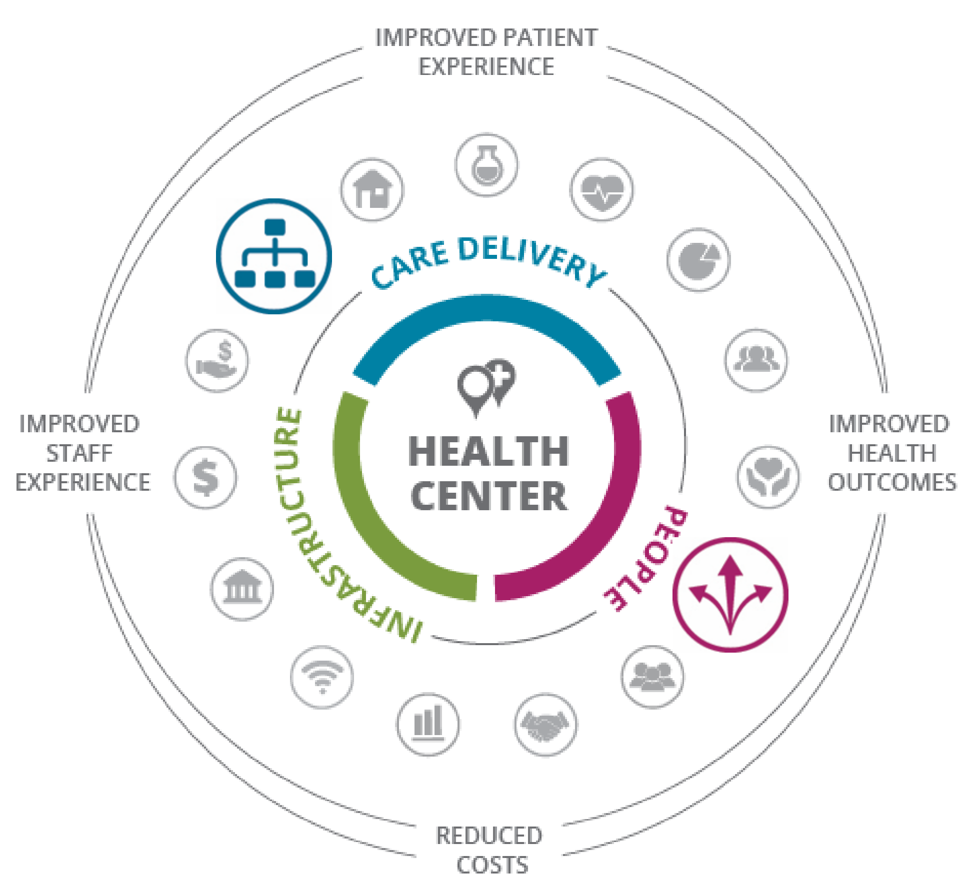
3 Models of Care
QI
HIT

4 Optimized Care Teams



Whole Patient Care

Attention to: Leadership & Population Health Management change areas



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Leadership

Population Health Management

LEADERSHIP

Leadership: Evidence-Based Action Steps

Communicate the Business Case for Transformation: Elevate Participation

Speak to the business imperative

Communicate ‘why change’ and ‘why now’

Provide a unified vision and guide next steps

Create understanding and buy-in among staff and the Board

Sharing the Message

- ☑ In-person at staff meetings
- ☑ Written document / email communication
- ☑ Video messages to multiple sites
- ☑ Informal conversations
- ☑ Formal board presentations
- ☑ Message boards

Press release for health centers participating in Elevate 2021!

Share with everyone your participation.

Leadership Highlights

Action Guide

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

LEADERSHIP

WHY is Leadership Critical to Transformation?

As healthcare moves from volume to value-based reimbursement, the business model and care model must connect and support one another. How a leader or governing body uses their position and knowledge to lead people, care delivery systems, and infrastructure is essential to reaching improvements in the Quadruple Aim goals: improved health outcomes, improved patient and staff experience, and reduced costs. Leaders who embrace this shift early can advance their organizations to deliver better care with more efficiency, gaining a competitive advantage. This Guide focuses on actions that leaders can take to create the environment, skills, and structure needed to support transformation.

LEADERSHIP within the Value Transformation Framework speaks to how a leader or governing body uses their position, responsibility, and knowledge to lead people, care delivery processes and infrastructure to reach transformational goals. This Action Guide defines a discrete set of proven actions leaders can take to provide a foundation for organizational transformation.

WHAT is Leadership's Role in Transformation?

Organizational transformation requires that leaders develop organizational will, identify change ideas that can advance the organization, and then execute those ideas[1]. A key role in this process of Will-Ideas-Execution is providing the structure that allows for success[2]. Transformation from a volume to value-based health care organization requires leadership attention to the infrastructure, care delivery and people systems. While leadership encompasses such roles as administrators and the Board, this Action Guide is focused on steps that can be taken by the Chief Executive Officer in support of transformation. This begins with establishing a well communicated strategic vision for the organization and then translating that vision into an operational plan, with systems that can evolve as needed with bottom-up and top-down improvements. This requires a relentless focus on achieving Quadruple Aim goals while progressing toward these goals one step at a time. And while "leading" is critical to whole system change, one of the most important elements in this process of transformation is staff engagement and support[3,4].

Leaders can drive and inspire change by engaging the entire team and valuing ideas for improvement at all levels[5].

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https://bit.ly/VTF_Leadership

Actions

Support factors that contribute to successful teams of high achievers:

- psychological safety
- dependability
- structure and clarity
- meaning of work
- impact of work

Utilize Staff Huddles

Problem-solve and escalate. Tiered escalation huddles

Resources

Build a psychologically safe workplace

Amy Edmondson | TEDxHGSE. https://www.youtube.com/watch?v=LhoLuui9gX8.

Wisdom, J. (2017, February, 21). Cultivating Great Teams: What Health Care Can Learn from Google. Retrieved from: http://catalyst.nejm.org/psychological-safety-great-teams/

Population Health Management: Risk Stratification

Why Risk Stratify?

Segment patients into distinct groups of similar complexity and care needs

Target the right level of care and services for distinct subgroups of patients

Support individual care planning and population health management (e.g., different models of care based upon different subgroup needs)

RISK STRATIFICATION STEPS:

Outlined below is a straightforward process to categorize patients' risk level by number of clinical conditions. Grouping patients by risk level allows a health center to direct care and resources to the needs of each subgroup.

STEP 1 **Compile a List of Health Center Patients:** Create a complete list: include not only patients who come in for care, but also individuals who have been assigned to your health center.

STEP 2 **Sort Patients by Condition:** Use the Uniform Data System (UDS) Table 6A measures or a list that's appropriate to your patient population.

STEP 3 **Stratify Patients to Segment the Population into Target Groups:** Start by using the simple but effective method of "condition counts" (the number of conditions per patient).

STEP 4 **Design Care Models and Target Interventions for Each Risk Group:** Each cohort (highly complex, high-risk, rising-risk, and low-risk) should be matched to a care model that meets their needs. (See Models of Care Action Guide.)

Step 1: Generate a list of all adult* patients *assigned* to your health center

- This list provides the foundation for all risk stratification efforts: to segment your population and target specific clinical or other initiatives (COVID vaccination, cancer screening, HTN control, diabetes control, etc.)
- For Elevate 2021, narrow the list to adults* (16 years of age and older)
- This list of adult patients can be broken down by age group (using UDS parameters) to target specific segments of your patient population, for example:
    - 16-17
    - 18-29
    - 30-49
    - 50-64
    - 65-69
    - 70-74
    - ≥ 75

**'Adults' in this example include individuals 16-17 years of age given CDC COVID-19 Vaccination Recommendations to include individuals 16-64 years with high-risk medical conditions.*

Step 2: Sort adult patients by condition

Working from your patient list, match patients to UDS high-risk conditions

Patient	UDS High-Risk Conditions								
	Cancer	Heart Disease	Respiratory Disease	Asthma	Diabetes	HTN	Obesity	Depression	Mental Health
1									
2									
3									
4									
5									
Etc.									

Crosswalk to HRSA UDS 2020 Selected Diagnosis, Table 6A, p. 66, HRSA 2020 UDS Manual.

Step 3: Stratify Patients by Risk Level (using condition counts+)

# of Conditions	Risk Level	List of Patients
6-7+	Highly complex	
4-5	High-risk	
2-3	Rising-risk	
0-1	Low-risk	

+or other acceptable risk stratification methodology in use at your health center

Step 4: Design Care Models and Interventions for each Risk Group

Driven by clinical or improvement focus

For Example: COVID-19 Vaccination

1. Pull all patients ≥ 75 years of age from each risk group; create plans to vaccinate

2a. Pull all patients 65-74 years from all risk groups; create plans to vaccinate

2b. Pull all patients 16-64 years in ‘high-risk’ and ‘highly complex’ group; create plans to vaccinate

Phase 1b: ≥75 years old
Phase 1c: 65-74 years old &
16-64 years of age with high-risk medical conditions
CDC COVID-19 Vaccination Recommendations

Step 4: Design Care Models and Interventions for each Risk Group

For Example:

Colorectal Cancer Screening± (CRCS):
Pull all patients 50-75 years of age from each risk group; target CRCS

Cervical Cancer Screening:
Pull all female patients 21*-64 years of age from each risk group; target for cervical cancer screening

Breast Cancer Screening:
Pull all female patients 50-74 years of age; target for mammography

Hypertension (HTN) Control:
Pull all patients 18-85 years of age with a diagnosis of HTN from each risk group; target for HTN control.

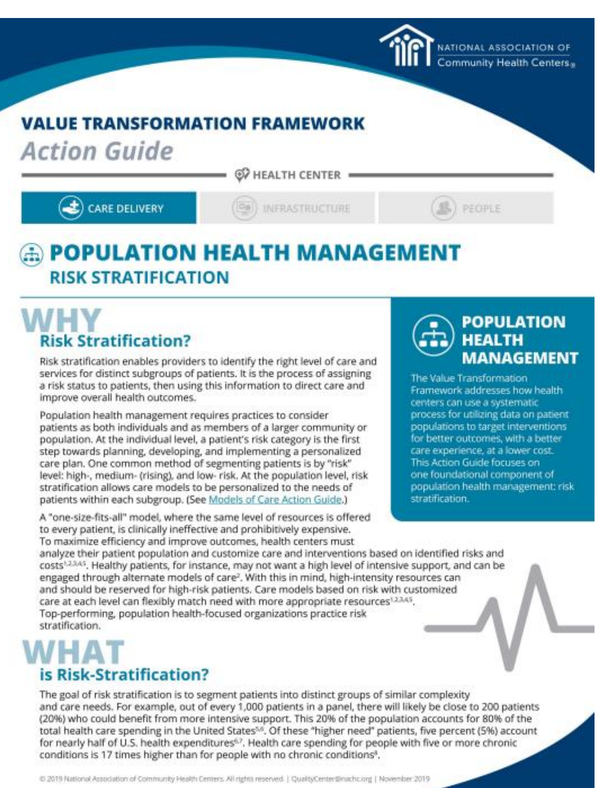
Diabetes Control:
Pull all patients 18-75 years of age with diabetes from each risk group; target for diabetes control.

Obesity (Body Mass Index/BMI):
Pull all patients > 18 years of age; target for weight control intervention.

UDS Denominator (HRSA 2020 UDS Manual):
±see UDS manual for list of appropriate screenings and frequency.
**women 23-64 years of age with a medical visit during measurement period.*
+women 51-73 years of age with a medical visit during measurement period.

Risk Stratification Highlights

Action Guide


NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
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HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT
RISK STRATIFICATION

WHY Risk Stratification?

Risk stratification enables providers to identify the right level of care and services for distinct subgroups of patients. It is the process of assigning a risk status to patients, then using this information to direct care and improve overall health outcomes.

Population health management requires practices to consider patients as both individuals and as members of a larger community or population. At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan. One common method of segmenting patients is by "risk" level: high-, medium- (rising), and low- risk. At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup. (See Models of Care Action Guide.)

A "one-size-fits-all" model, where the same level of resources is offered to every patient, is clinically ineffective and prohibitively expensive. To maximize efficiency and improve outcomes, health centers must analyze their patient population and customize care and interventions based on identified risks and costs[1,2,3,4,5]. Healthy patients, for instance, may not want a high level of intensive support, and can be engaged through alternate models of care[2]. With this in mind, high-intensity resources can and should be reserved for high-risk patients. Care models based on risk with customized care at each level can flexibly match need with more appropriate resources[1,2,3,4,5]. Top-performing, population health-focused organizations practice risk stratification.

POPULATION HEALTH MANAGEMENT

The Value Transformation Framework addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better outcomes, with a better care experience, at a lower cost. This Action Guide focuses on one foundational component of population health management: risk stratification.

WHAT is Risk-Stratification?

The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For example, out of every 1,000 patients in a panel, there will likely be close to 200 patients (20%) who could benefit from more intensive support. This 20% of the population accounts for 80% of the total health care spending in the United States[5,6]. Of these "higher need" patients, five percent (5%) account for nearly half of U.S. health expenditures[6,7]. Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions[8].

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https://bit.ly/VTF_Risk

Actions

Segment the population into target groups.

Example: segment by # of conditions

Highly complex	6-7+ conditions
High risk	4-5 conditions
Rising risk	2-3 conditions
Low risk	0-1 conditions

Resources

NACHC Models of Care Action Guide
https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf

Models of Care: Whole-Person Care

Patient:________________ Date: ____________

As a ***woman age 50-75 years of age***, your doctor wants you to receive the following screenings based upon the *BEST MEDICAL information. Our team would like to talk with you about getting tests and care which can ***save your life*** ☺.

ROUTINE CARE:

- Blood Pressure
- Depression screening
- Weight screening and counseling for better weight control
- Screening for use of aspirin or a cholesterol lowering medication to prevent heart disease

CANCER SCREENINGS:

- Breast cancer (mammogram every 2 years)
- Cervical cancer (Pap test every 3 years ages 21-64 or every 5 years for women age 30-64 who get HPV test alone or a combination of Pap and HPV test.
- Colon cancer (FIT test annually or other screening/ diagnostic tests and frequencies depending on risk.

BLOOD TESTS:

- HbA1c for diabetes
- Hepatitis C screening
- HIV
- Diseases transmitted through sexual activity

LIFESTYLE:

- Tobacco use
- Alcohol use
- Relationship violence

***US Preventive Services Task Force (USPSTF):**

- Aspirin Use in some adults 50-59 years can lower your risk for heart attack, stroke and colorectal cancer. Drugs that lower cholesterol may be used in some adults 40-75 years of age with risk factors to prevent cardiovascular disease. Check with your doctor before taking aspirin or any medication. Cervical Cancer screening recommended through age 65 years. Blood glucose monitoring recommended in overweight adults 40-70 years of age. Hepatitis C one-time monitoring or additional screening as needed. HIV Screening through 65 years of age.

New for 2021

Highlighted Health Centers

- Coastal Family Health Center
- Generations Family Health Center

Judith Gaudet, Systems of Care Director
jgaudet@genhealth.org

Anne Kenny, Clinical Informatics Director
akenny@genhealth.org

Fun Fact: Generations Family Health Center values “Joy in the Workplace” The management team has been known to create flash mob dances to perform for the staff at our annual all staff, themed meetings.

2020 = 18402/15842 Patients Served

4 Multidiscipline Clinics, 1 SBHC, Mobile Dental Unit, 220 Staff

Intergy EHR by Greenway

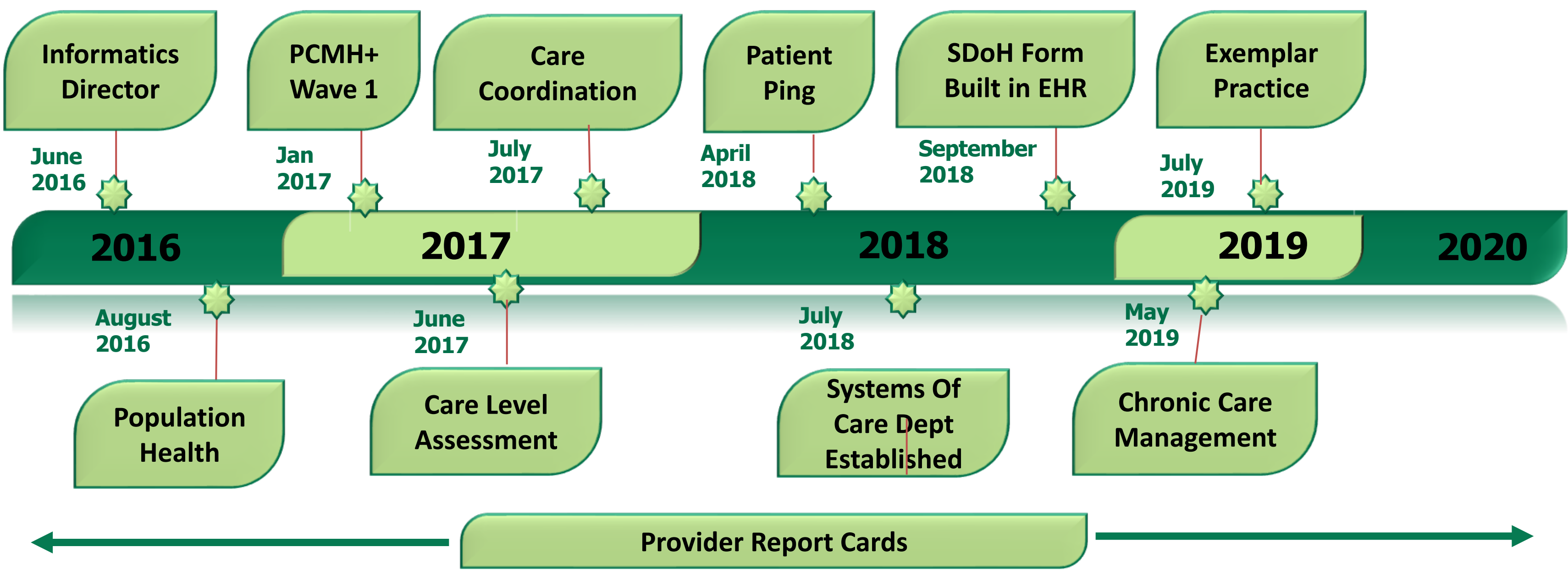
Intergy Practice Analytics

Population Health Dashboards: Patient Care Patient Registry dashboards

Greenway Patient Messaging, Patient Ping, Care Analyzer, Connecticut Health Network dashboards, Husky Health Dashboards, Prescription Drug Monitoring Program

Telehealth Platforms adopted 2020: Updox, Doximity, Jot Forms

Timeline to Risk Stratification



Care Level Assessment For Risk Stratification

Form: Care Level Assessment - 4.2017

Auto Neg | Uncheck All

Care Level Assessment | Draft | Search | Outline | Preview

Medical Assessment

- Y HgA1c > 8%
- Y BP > 140/90
- Y High BMI/Obesity/ Family Hx Diabetes
- Y Smoking/Nicotine Dependence
- Y (+) Screenings (PHQ9-A/CAGE-A+/MCHAAT)
- Y Diagnosis of Asthma
- Y Diagnosis of COPD
- Y Diagnosis of Heart Disease
- Y Patient is positive for HEP C and/or Cirrhosis.
- Y Patient is HIV positive.
- Y Diagnosis of Cancer
- Y Dx Dental/Oral Health/Ped Caries
- Y Pregnancy
- Y Chronic Debilitation/Disability/Ped Med Dx

Mental Health

- Y Psychiatric Diagnosis
- Y Suicide attempt in the past 12 months.
- Y Substance abuse/Addiction.
- Y Patient Disch From Inpatient Facility Within Last 60 Days
- Y TAY (Transition Aged Youth)

Utilization

- Y Five MEDICAL visits in the past 12 months.
- Y Recent ER visit within the past 90 days.
- Y Frequent No Show (2 out of last 5 visits.)
- Y Inpatient Admissions witin 90 days.

Social Risk Factors

- Y Unable to meet daily needs.
- Y Economic/Finacial Issues/Unemployment
- Y Homeless/Migrancy
- Y Uninsured.
- Y Language Barrier/Low Literacy
- Y Transportation/Social Issues.
- Y Legal Issues

Age

- Y Age 0 to 18
- Y Age 65+

FAMILY PRACTICE MENU V6.0

Overall Score

Care Level Assessment - Additional Comments

Care Level Assessment - Overall Score

Scoring:
These scores are meant to give a quick overview of the patient's health care needs and level of health care outcome risk. The score will help to determine and monitor progress for care coordination and necessary services. Scores are not weighted to specific conditions or assessments, but patients with high need and risk will inevitably gain higher scores by gaining points in more categories.

The scoring matches the Care Program "Patient Risk Level" settings already established in our EHR, Intergy:

CARE LEVEL ASSIGNMENT	
Preventative (1 = Dark Green)	0 --> 3
Low Care Level (2 = Kelly Green)	4--> 5
Moderate Care Level (3 = Lime Green)	6--> 7
High Care Level (4 = Yellow)	8--> 9
Highest Care Level (5 = Orange)	10 --> 11
Highest Care Level (6 = Red)	12+

Care Coordination – addresses the complex needs of high risk and high-utilizer populations. Designed to walk patients through their medical neighborhood, care coordinators provide a single contact for communication with the clinical care team. They assess needs and assist with referrals for social services, community resources, hospital follow ups, and scheduling of medical services.

Social Determinants Of Health | TAY Assessment | AUDIT-C / HARK | Depression / Social Isolation | Social Determinants Of Health

☐Y TAY (Transition Aged Youth) Assessment (Age 1... ☐Y CYSHCN (Children & Youth With Special Healthcare Needs) ☐Y Social Determinant of Health Assessment

Race and Ethnicity

Obtaining broader categories of race and ethnicity must be done with each SDOH form. ☐Y ☐N Patient Information Entered Into System (If declined, click no and document "Declined" in

We Ask Because We Care? is a national campaign to collect more granular data related to Race , Ethnicity and Linguistic preferences using drilled down CDC codes. It is used to ensure we?re understanding and meeting the unique ethnic and cultural needs of our patients. This data collection marks an

☐Y Race Sub P... ☐Y Ethnicity Sub...

RISK/UTILIZATION

☐Y Needs additional Care Plan Managem...
☐Y Recent ER visit within the past 90 days.
☐Y Inpatient Admissions witin 90 days.
☐Y Patient Disch From Inpatient Facility Within Last 60 Days

SOCIAL HISTORY

CAGE AID AND HARK 2018

Alcohol Usage/Treatment

Alcohol use

If any concerns complete a CAGE AID (3 or more drinks)

☐Y ☐N Therapy For Alcohol Abuse/Dependence

Drug Usage/Treatment

☐Y ☐N Drug Use

If any concerns (Y) complete a CAGE AID

☐Y ☐N Therapy For Drug And Alcohol Abuse/Dependence

HOUSING & EMPLOYMENT STATUS

Are you worried about losing your housing?

☐Y Patient is homeless ☐Y Economic Issues /Unemployment

EDUCATIONAL/FINANCIAL RESOURCES/TRANSPORT

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

What is the highest grade or level of school you have completed or the highest degree you have received?

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. (14P)

Food | Clothing
Utilities | Child Care
Phone | Other (please write):

Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. (15P)

Patient kept from medical appointments or from getting medications

Patient kept from non-medical meetings, appointments, work, or from getting things that he/she needs

Physical Activity [SAMHSA]

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?

Social and Emotional Health

How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled. How stressed are you?

Optional Additional Questions

In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Do you feel physically and emotionally safe where you currently live?

In the past year, have you been afraid of your partner or ex-partner?

Using Practice Analytics For Risk Stratification

Detail Information

DN Pat Person Nbr sort	Appt Date	Reason Class Code	Reason Class Desc	Reason Code	Reason Desc	Appt Status Desc	Appt Svc Cntr Name
62019	1/31/2020	H&E	CC Hosp & ED Follov	ED&HOS	CC Hosp & ED Follov	Occurred	Generations FHC, Inc. (Willimantic
71042	3/9/2020	H&E	CC Hosp & ED Follov	ED&HOS	CC Hosp & ED Follov	Occurred	Generations FHC, Inc. (Willimantic
857	2/25/2020	H&E	CC Hosp & ED Follov	ED&HOS	CC Hosp & ED Follov	Rescheduled	Generations FHC, Inc. (Willimantic
857	2/25/2020	H&E	CC Hosp & ED Follov	ED&HOS	CC Hosp & ED Follov	Occurred	Generations FHC, Inc. (Willimantic
63653	2/19/2020	H&E	CC Hosp & ED Follov	MFUER	F/U Emergency Roo	Occurred	Generations FHC, Inc. (Willimantic
58229	3/3/2020	H&E	CC Hosp & ED Follov	MFUER	F/U Emergency Roo	Occurred	Generations FHC, Inc. (Willimantic
64872	1/30/2020	H&E	CC Hosp & ED Follov	ED&HOS	CC Hosp & ED Follov	Occurred	Generations FHC, Inc. (Willimantic
23915	1/6/2020	H&E	CC Hosp & ED Follov	MFUER	F/U Emergency Roo	Occurred	Generations FHC, Inc. (Willimantic

Selected Item	Pat Person Nbr sort	Pat Person Nbr sort
Calculation	Count	Count Distinct
Global Query	1,527	1,057
Canceled	179	165
No Show	189	169
Occurred	861	807
Pending	5	5
Rescheduled	293	225

Population Health

Dashboard Folders

My Dashboards
Quality Measures
Operational
UDS
Population Health
Patient Care
Patient Registry
PCMH Measures
Demographics Analysis
Patient Demographics
Financial Analysis
Accounts Receivable
Financial Summary
Practice Productivity
Appointments
Charge Revenue and Rece
Tasking Analysis
Help
Dashboard Help

My Reports
Scheduled Reports
Public Reports
Solution Reports
Write a New Report
Dashboards

Current Selections
Bookmarks
Quick Add
Fields Values

Selections (83,853 patients)

Diagnoses
Labs
Vitals
Personal Factors
Visits
Practice/ Providers

Selected Diagnoses
Diagnoses

Reminders
Problems
Meds
Allergies
Vitals

SSN: xxx-xx-
Patient:
Phone: (860)
Chart:
Mobile: --
More
Email: --

PORTAL
Access Not Granted
Send Invite

CARE PROGRAM
CCM-ELIGIBLE

CARE TEAM
None

PROBLEMS

Coastal Family Health Center

Angel Greer, Chief Executive Officer

Angel_Greer@coastalfamilyhealth.org

Coastal Family Health Center

31,606 patients served
12 Clinics, **12** School-based Clinics, **2** Pharmacies, Mobile Unit
262 staff

NextGen EHR
Solutionreach-Patient Management, Chartspan-CCM
Azara-Population Health Management Software
OTTO-Telehealth

Coastal Family Health was originally established as a health care ministry of Back Bay Mission, a local faith-based organization. The program outgrew BBM was established as a separate 501c3 in 1976

Risk Stratification Process:

PREVIOUS	FORWARD
Behavioral Health (BH): 2+ chronic conditions + BH, with consideration of SDOH **Diabetes:** Patients with uncontrolled diabetes + HTN, obesity, and depression **COVID vaccination:** Patients ≥75 years of age **CRCS, Pap, & Mammo screening:** Separately lists with different age ranges. Recently moved to one list ≥ 50 years of age	1. Generate single list of all patients, by age 2. Sort patients by condition; determine condition counts 3. Stratify patients by risk level (condition counts) 4. Target interventions for each risk group For COVID - Pull list of patients ≥75 years from each risk group; create vaccination plan - Pull list of patients 65-74 years from all risk groups; create vaccination plan - Pull list of patients 16-64 years in 'high-risk' and 'highly complex' group; create vaccination plans Apply strategies to cancer screening, diabetes, HTN, obesity, and depression

ELEVATE ACTION STEPS

LEADERSHIP

- Leadership messaging around transformation & engagement in Elevate:
  - Share press release
  - Draft a business case
  - Present at a staff meeting

POPULATION HEALTH MANAGEMENT

- Risk Stratification
  - If your health center already has a methodology: revisit to ensure process allows flexibility for segmentation, as needed (e.g., COVID vaccination, cancer screening, diabetes, etc.)
  - If your health center does not yet have a methodology: test evidence-based risk stratification steps outlined in NACHC Risk Stratification Action Guide.

Conduct Small Tests of Change

Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

RegLantern's Online HRSA Compliance Tools

(March – August)

https://reglantern.com/vtf

Free trial access to the RegLantern continuous compliance tool is only available to health centers that have had **3+ staff** complete the VTF assessment by **February 20th**.

Trial access will kick-off with a RegLantern orientation call on **March 5th @ 3-4 pm ET.**

Value Transformation Framework
Self-Assessment

Infrastructure

- Improvement Strategy — 2 - Basic
- Health Information Technology (HIT) — 5 - Expert
- Policy — 2 - Basic
- Payment — 2 - Basic
- Cost — 2 - Basic

People

- Patients — 2 - Basic
- Care Teams — 3 - Applied
- Leadership — 2 - Basic
- Workforce — 3 - Applied
- Partnerships — 2 - Basic

Care Delivery

- Population Health Management — 2 - Basic
- PCMH — 1 - Learning
- Evidence-Based Care — 2 - Basic
- Care Coordination and Management — 3 - Applied
- Social Determinants of Health (SDOH) — 2 - Basic

- Built around the Value Transformation Framework
- 15 change areas
- 3 domains

CHC's with 3+ Assessments (57)

As of February 8th, 2021

- 1st Choice Healthcare, Inc.
- Access Family Care
- Brighter Beginnings CHC
- Care SC Inc
- Chase Brexton Health Care
- Cherry Health
- Chiricahua Community Health Centers, Inc.
- Community First Health Centers
- Community Health Center of the North Country
- Community Health of South Florida, Inc.
- Compass Health Network
- Denver Health's Community Health Services
- East GA Healthcare Center, Inc.
- East Jordan Family Health Center
- Elica Health Centers
- Family Centers Health Care
- Family HealthCare Network
- Fenway Community Health Center
- GPW Health Center
- Health Help Inc. dba White House Clinics
- HealthCore Clinic Inc
- Heart City Health Center, Inc.
- Heartland Health Services
- Hometown Health Center
- Hyndman Area Health Center, Inc.
- Kaniksu Health Services
- Kinston Community Health Center
- Kintegra
- Lee County Cooperative Clinic
- Lone Star Circle of Care
- Lower Lights Christian Health Center
- Marias Healthcare Services, Inc.
- Migrants Health Center Inc.
- Neighborhood Health Center
- North Orange County Regional Health Foundation
- OH North East Health Systems, Inc.
- OIC Family Medical Center
- OneWorld Community Health Centers, Inc.
- Open Door Family Medical Center, Inc.
- Optimus Health Care
- Outside In
- Primary Health Center
- Raphael Health Center, Inc.
- Robeson Health Care Corporation
- Rural Health Medical Program, Inc.
- Shawnee Health Services
- Shingletown Medical Center
- Sonoma Valley Community Health Center
- Southeast Community Health Systems
- Southwest Care
- St. Vincent de Paul Village, Inc.
- Sunset Community Health Center
- TX Tech University Health Sciences Center
- United Community and Family Services
- Vista Community Clinic
- Will County Community Health Center
- Zufall Health Center

CHC's with 2 Assessments (28)

As of February 8th, 2021

- Advance Community Health/Wake Health Services Inc
- Ajo Community Health Center
- Alliance Community Healthcare
- Appalachian Mountain Community Health Centers
- Beaufort-Jasper-Hampton Comprehensive Health Services, Incorporated
- Christian Community Health Center
- Concilio de Salud de Loiza
- Cross Road Health Ministries, Inc.
- CT Institute for Communities, Inc.
- Family Health Centers
- Family Health Ctr of Southern Oklahoma
- Greater Baden Medical Services, Inc.
- Hidalgo Medical Services
- Lake Superior Community Health Center
- Langley Medical Services
- Muskingum Valley Health Centers
- Neighborhood Health Centers of the Lehigh Valley
- North Central Family Medical Center
- Northeast Florida Health Services Dba: Family Heal
- Rural Health Group
- Ryan, William F Community Health Center Inc
- Southbridge Medical Advisory Council Inc
- St. Francis House NWA Inc. dba Community Clinic
- Suncoast Community Health Center
- The Achievable Foundation
- The Chautauqua Center, Inc.
- Valleywise Health
- Whitman Walker Health Center

CHC’s with 1 Assessment (75)

As of February 8th, 2021

- Accordia Health
- Alliance Medical Center
- Angel Harvey Family Health Center
- Asian American Health Coalition: dba Hope Clinic
- Asian Americans for Commu Involvement
- Bee Busy Wellness Center
- Benewah Medical Center
- Berks Community Health Center
- Betances Health Center, Inc.
- Cabun Rural Health Services, Inc.
- Capital Area Health Network
- Capitol City Family Health Center Dba: Care South
- Capstone Rural Health Center
- Care Resource
- Central Counties Health Centers, Inc.
- Central Florida Health Care, Inc.
- Central VA Health Services, Inc.
- Centro de Salud de Lares
- Charter Oak Health Center
- Cherokee Health Systems
- Coastal Family Health Center, Inc.
- Community Health Center of Southeastern IA
- Community Health Systems, Inc.
- CommWell Health
- Duffy Health Center
- East Bay Community Action Program
- El Rio Santa Cruz Neighborhood Health Center, Inc.
- Erie Family Health Center, Inc.
- Flint Hills Community Health Center, Inc.
- Fordland Clinic, Inc
- Friend Family Health Center, Inc.
- Generations Family Health Center, Inc.
- Genesee Community Health Center
- Greater Portland Health
- Honor Health
- Howard Brown Health Center
- International Community Health Services
- Jordan Health
- Kansas City Care Clinic
- Kodiak Community Health Center
- La Casa De Salud, Inc.
- La Clinica de los Campesinos, Inc
- La Clinica Del Valle Family Health Care Center
- La Comunidad Hispana
- Lake County Health Department CHC
- Lamprey Health Care
- Manatee County Rural Health Services, Inc.
- Mariposa Community Health Center
- Mary's Center For Maternal And Child Care, Inc.
- Mat-Su Community Health Services
- MedNorth Health Center
- Mid-Delta Health Systems, Inc.
- Molokai Community Health Center
- Native American Health Center, Inc
- NEPA Community Health Care
- New Orleans AIDS Taskforce
- North Country Family Health Center
- North Olympic Healthcare Network PC
- Northwest MI Health Services, Inc.
- Oak Orchard Health Center
- Partnership Health Center
- Peak Vista Community Health Centers
- PrimeCare Community Health, Inc
- PryMed
- San Fernando Community Hospital
- School Health Clinics of Santa Clara County
- South of Market Health Center
- Tandem Health
- TCA Health Inc, NFP
- The Wright Center for Community Health
- Valley Professionals Community Health Center Inc.
- VIP Community Services
- West Cecil Health Center, Inc
- Western North Carolina Community Health Services
- Whitney Young Health Center

Health Center Toolkits

Your kit includes one iFOB test which looks for blood in your stool (poop), a sign of colorectal (colon) cancer.

Why is it Important to Check for Colorectal Cancer?

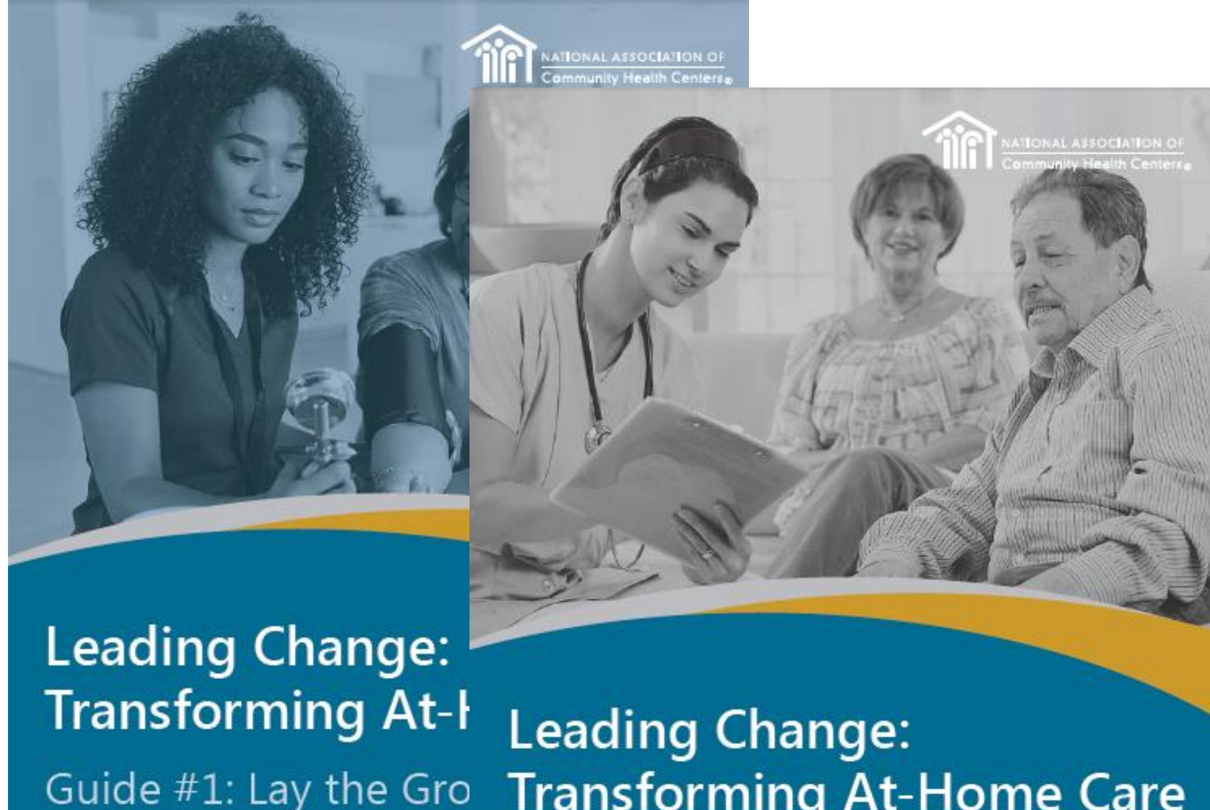
Colorectal cancer kills over 53,000 people each year. It is the third most common cancer in the U.S. It often starts as a small growth (called a 'polyp') in the colon or rectum. The colon is part of the digestive system. It is also called the large bowel or large intestine. The rectum is the tube that leads stool out of the body. If a small growth

Patient Care Kit Item

Your Kit includes one cancer screening test kit with:

- Collection Tube.
- Collection Paper with Tape.
- Specimen Pouch (holds your stool sample).
- Absorbent Sleeve (to put around stool sample before putting in the envelope).
- Return-mail box (use to hold specimen; do not put stool in the mail).
- Patient Instructions.
- Pair of gloves (optional).

Your kit includes a return-mail box or envelope to hold the sample but do not return your stool by mail. Use this envelope to hold your stool once you get the sample. The instructions on the other



AVAILABLE IN 4 LANGUAGES

Patient Educational Material

Quality Center Supports Health Center, PCA, & HCCN QI Professional Development

through the Institute for Healthcare Improvement (IHI)

2020 Scholarships to the field:

600 Scholarships to IHI's Open School

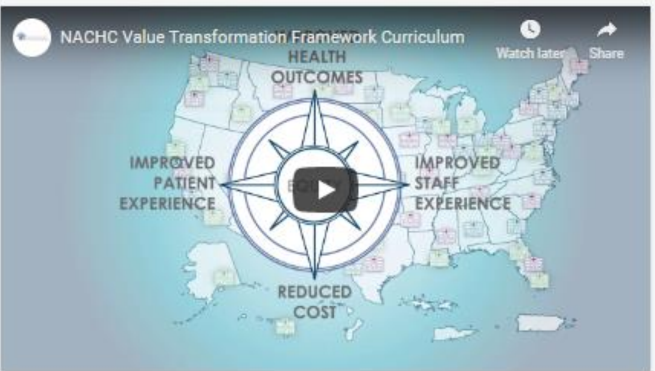
53 Scholarships to 12-week Joy in Work course

14 Scholarships to 4-day National Forum

Our Online Community

ELEVATE LEARNING FORUM

Together, our voices Elevate all



NEW

Redesign Layout and Look

New Online Modules

Cancer Screening

Population Health / Risk Stratification

Care Teams

Coming Soon…

Video 'Press Release' (40 seconds)

Written Press Release

Risk Stratification action step video (<2 mins)

Our Contributors… Calling the Nation

Come Share!

bit.ly/Elevate2021Partnership

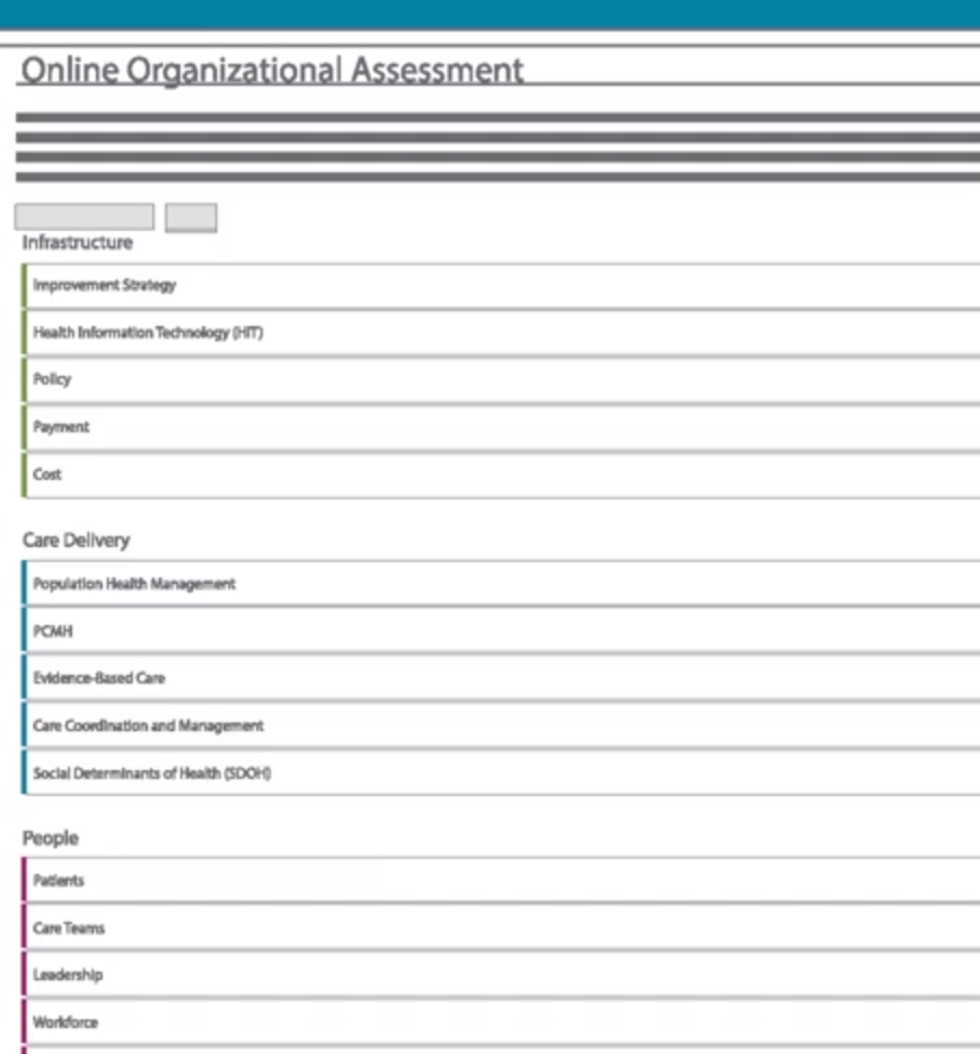
Elevate 2021 Assessment

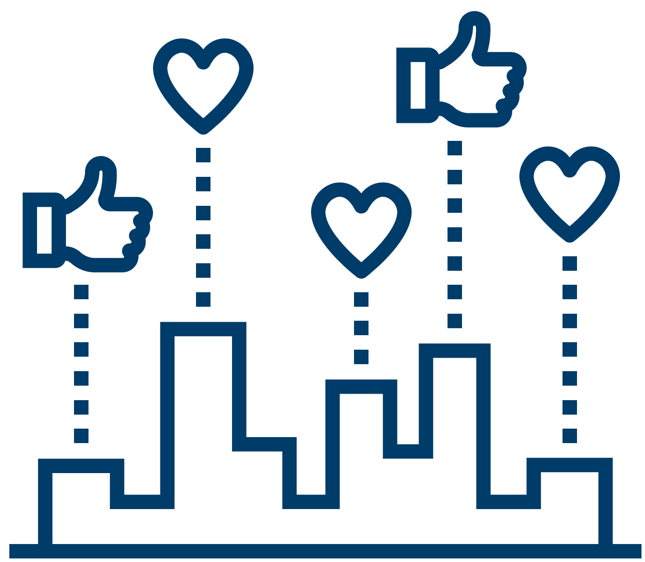
ASSESS

Use 15 minutes left in this hour??

At least three senior staff complete the VTF assessment at reglantern.com/VTF

Note: Certain additional benefits (e.g., IHI Scholarships and access to trial membership of an online OSV continuous compliance tool are only available to participating Elevate health centers who have three or more staff who complete the assessment)





HOW DID WE DO?

Standing on the edge of this tragedy,
embrace the health center opportunity
“TO BUILD A ROAD”
“That is what we [health centers] do: make a road out.”
- Jack Geiger, MD

FOR MORE INFORMATION CONTACT:

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301.310.2250

Next Monthly Forum Call:

March 9th, 2020
1 -2 pm ET