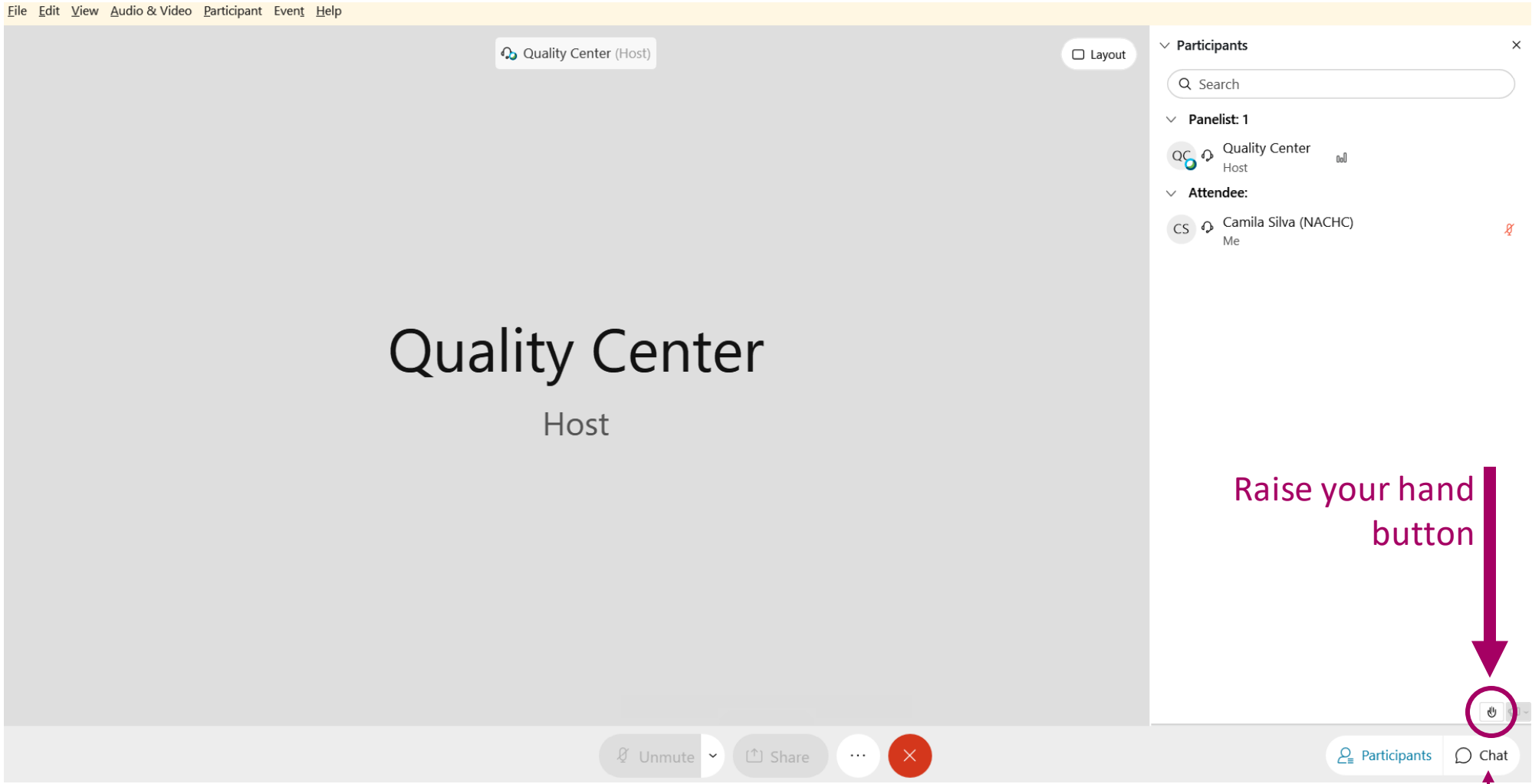
NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

April Learning Forum

04.13.21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Panelist: 1
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Attendee:
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Camila Silva (NACHC)
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Participants
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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.

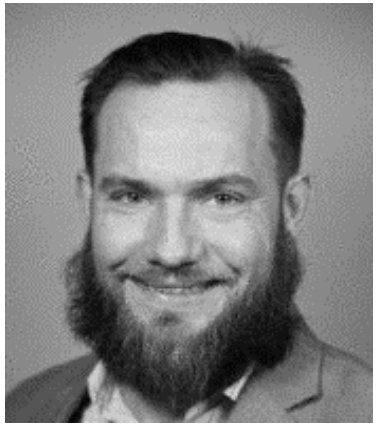
NATIONAL ASSOCIATION OF Community Health Centers®

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

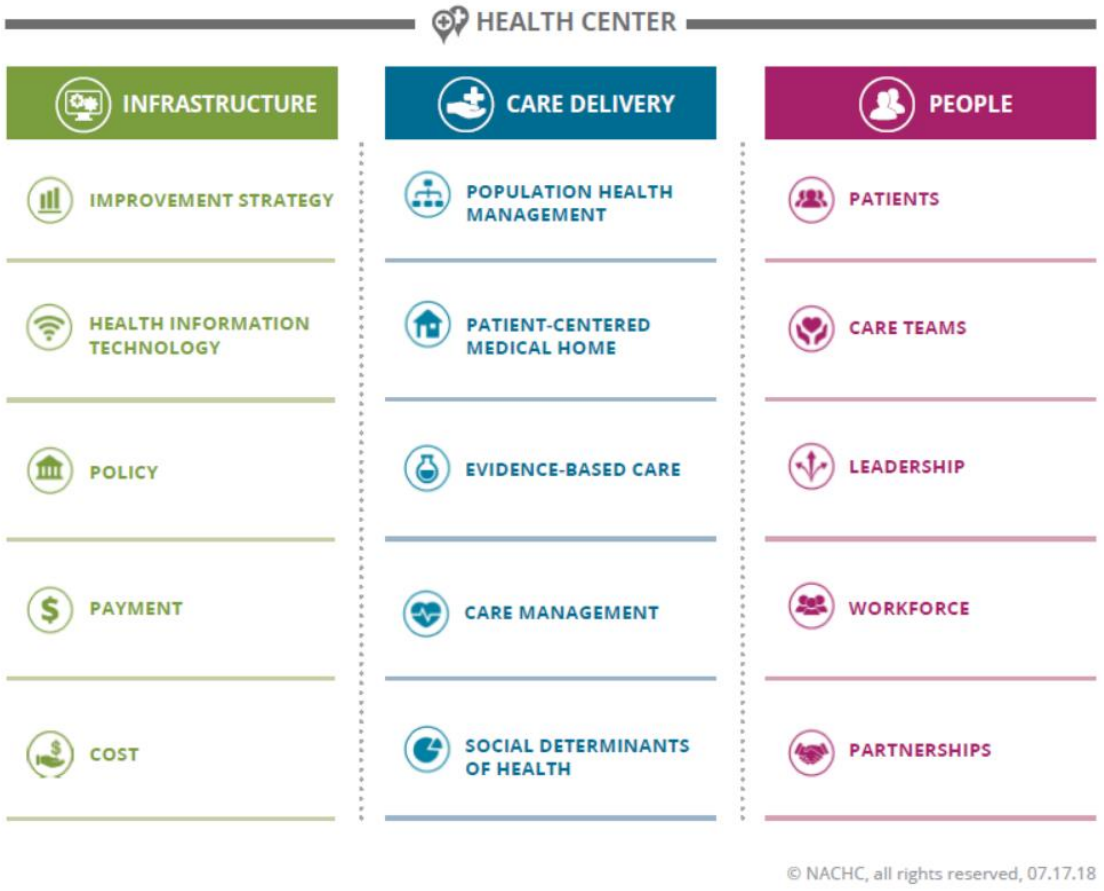
Camila Silva

Manager, Quality Center Training & Curriculum

Lizzie Utset

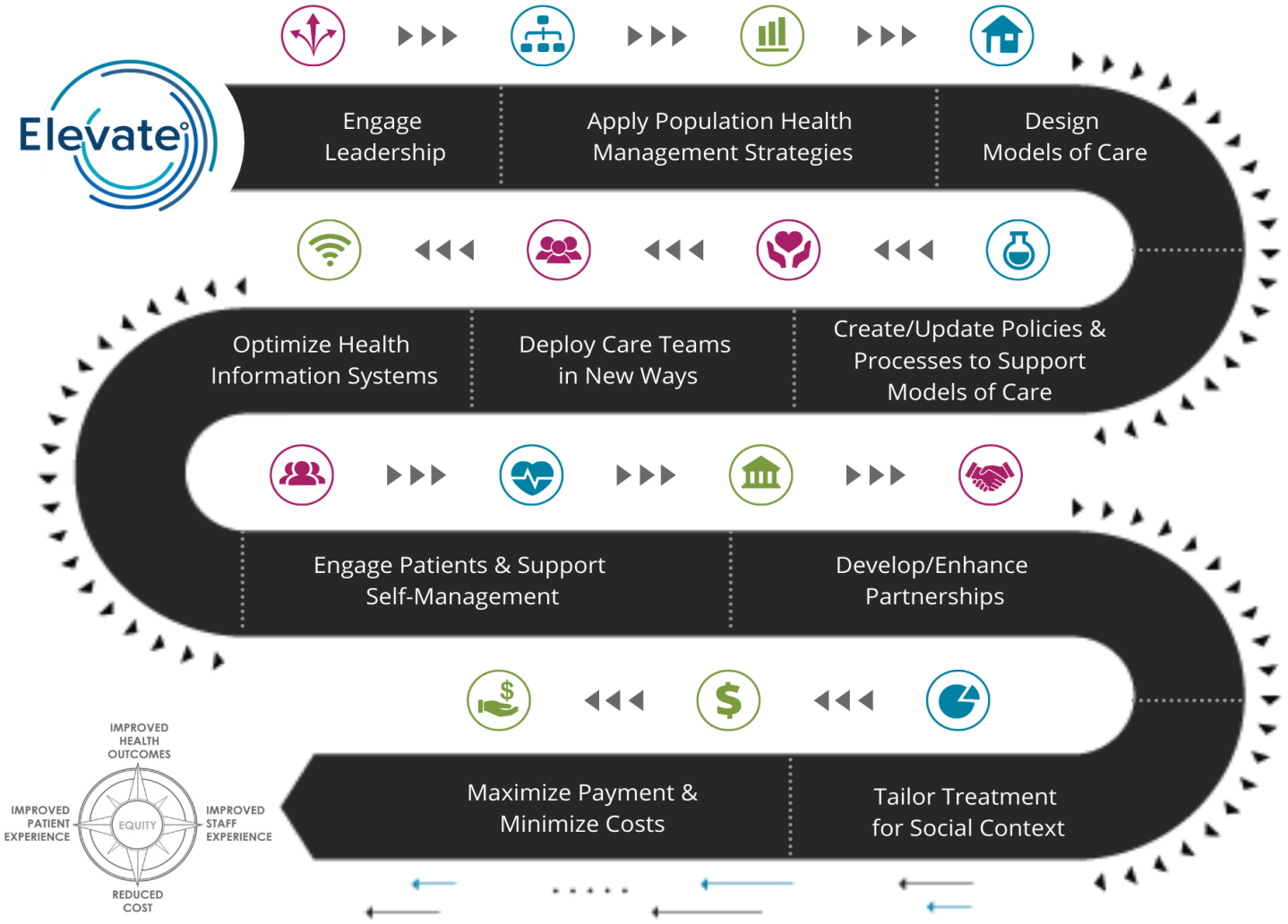
Specialist, Health Science Content

Value Transformation Framework



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

2021 Curriculum



The Elevate 2021 curriculum is designed to support health centers in application of the 15 Change Areas of the Value Transfor mation Framework and transformation toward value-based care. It outlines a path the Elevate learning forum will take over the year while recognizing that transformation is not linear and that organizations will adopt and apply the curriculum in a manner and order that fits their individual needs and circumstances.

LAST MONTH

CHANGE AREAS

LEADERSHIP

Create leadership messaging around transformation & engagement in Elevate.

Share press release

Share video

IMPROVEMENT STRATEGY

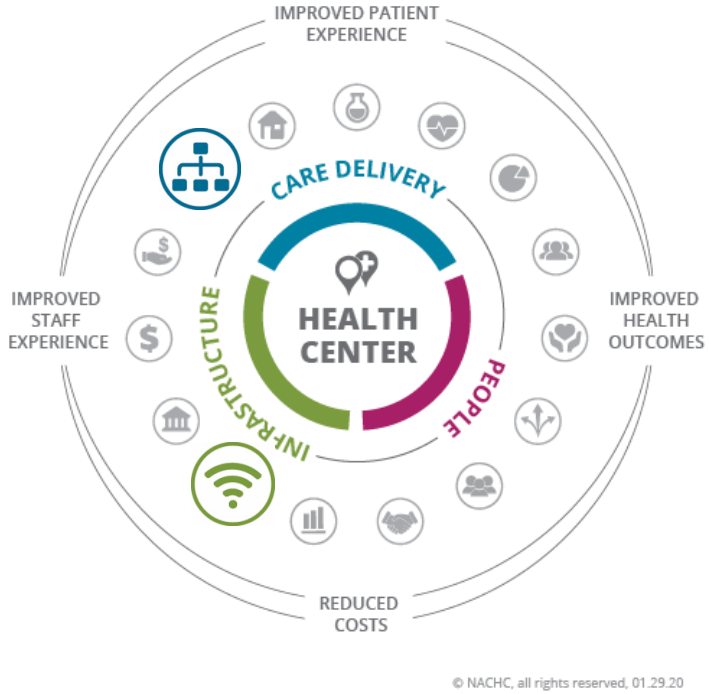
Develop strategies to measure, monitor, and drive improved performance and transformation. Create a clear vision, plan, **goals**, and timeline.

HEALTH INFORMATION TECHNOLOGY

Use and **leverage HIT systems and workflows** to improve performance.
Configure HIT to push care team action and pull needed data.

TODAY

CHANGE AREAS

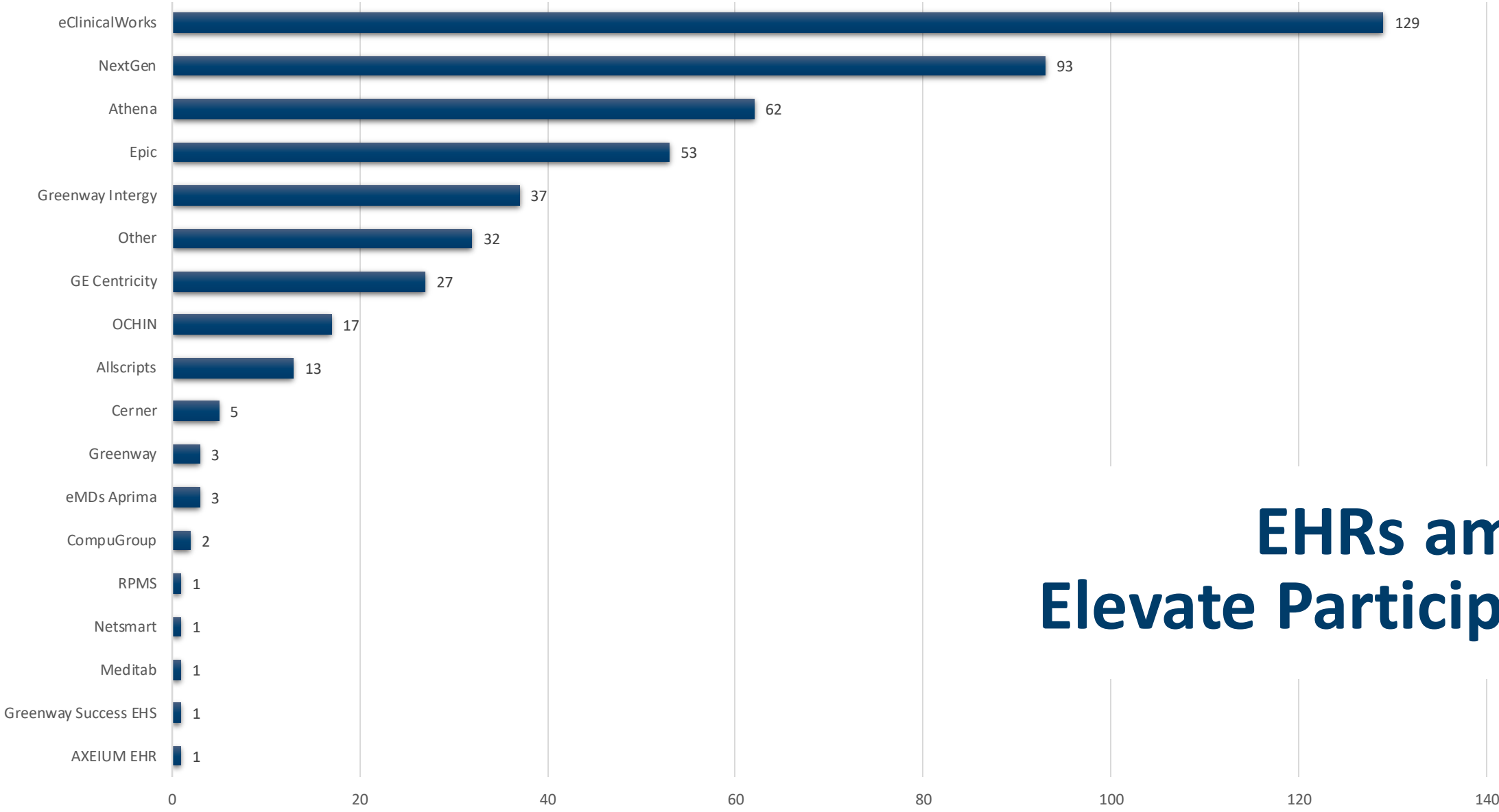


HEALTH INFORMATION TECHNOLOGY

Use and **leverage HIT systems and workflows** to improve performance. Configure HIT to push care team action and pull needed data.

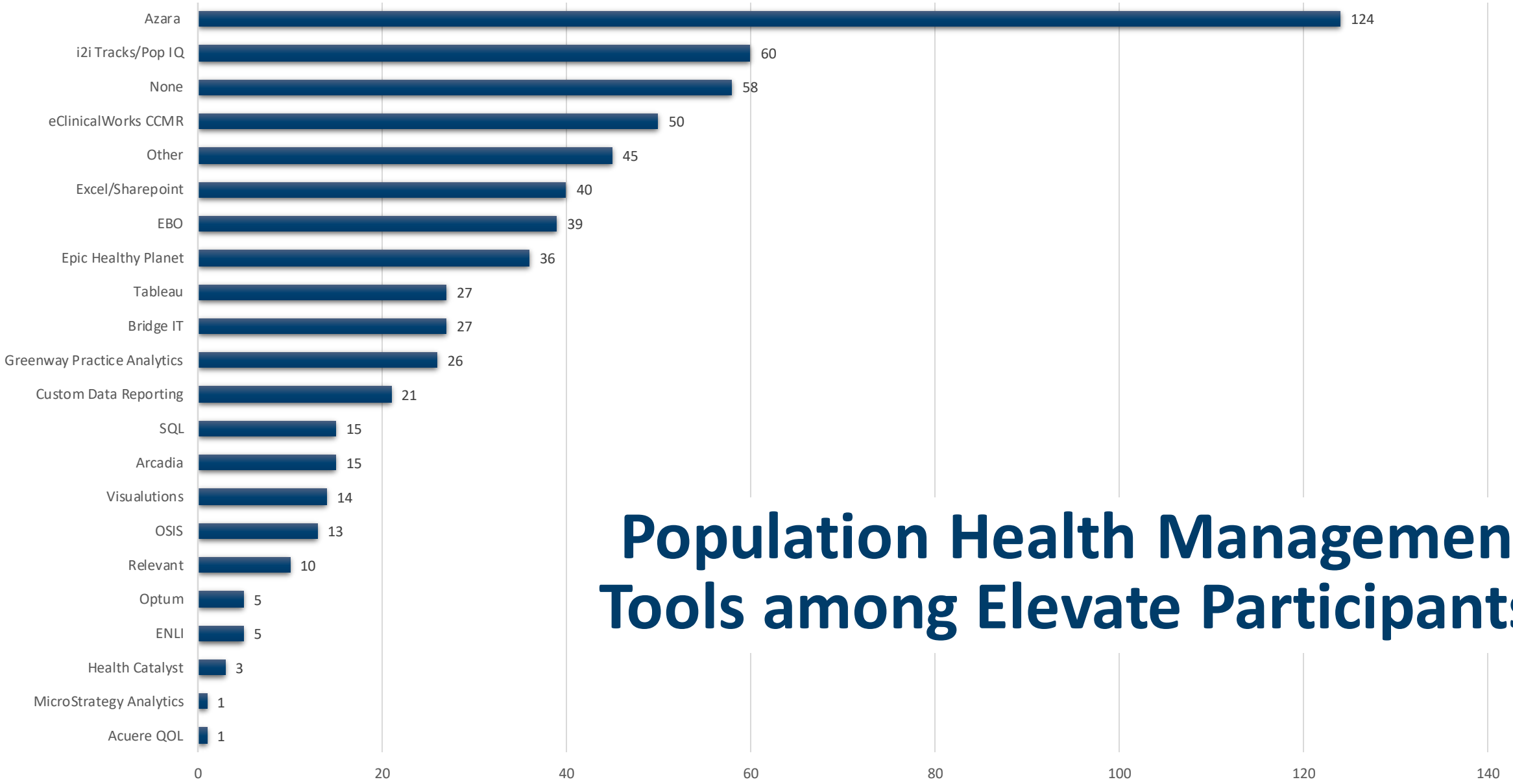
POPULATION HEALTH MANAGEMENT – MODELS OF CARE

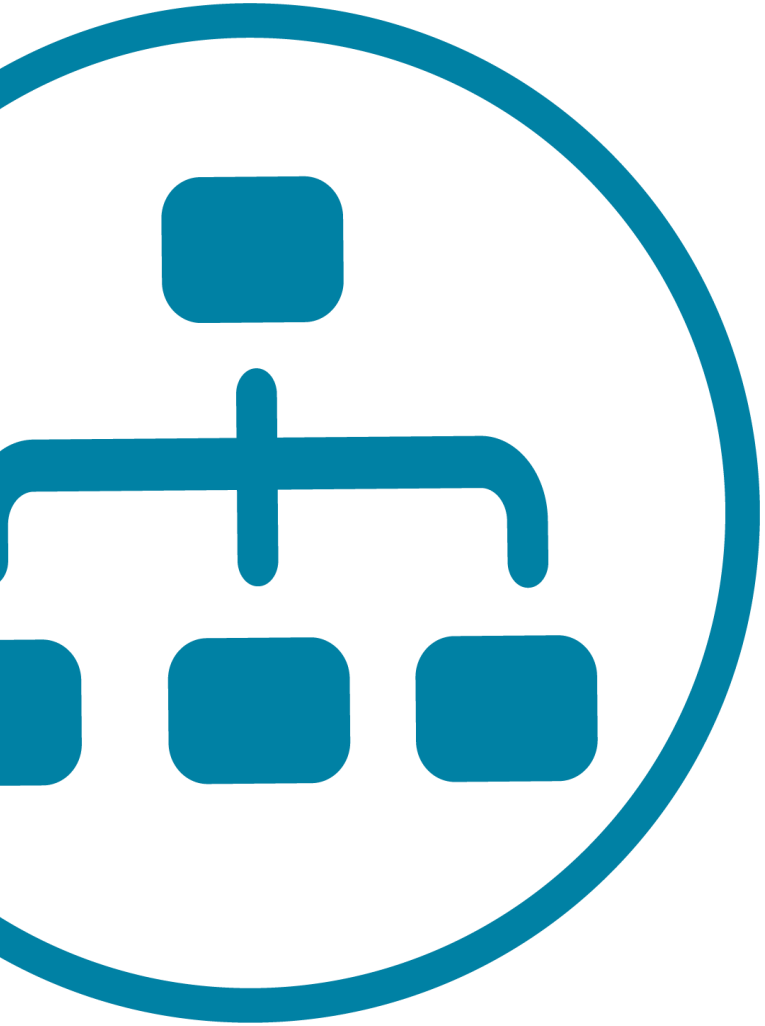
Design **care models to meet the need of targeted patient subgroups** and more appropriately direct clinical care and interventions.



EHRs among Elevate Participants

Population Health Management Tools among Elevate Participants





MODELS OF CARE

Population management is key to **successful value-based care**. Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost-effective care to patients who fall into different levels of risk, rather than using a “one size fits all” approach.

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

Models of Care

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

MODELS OF CARE

WHY

Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

WHAT

are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

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

Highly complex. Require intensive, pro-active care management.

High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.

Rising-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).

Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.

Transforming toward Value: The Indiana Experience

April 13, 2021

Prepared for the National Association of Community Health Centers

Angela M. Boyer, M.H.A.

Chief Strategy Officer, Indiana Primary Healthcare Association

Director, Indiana Quality Improvement Network

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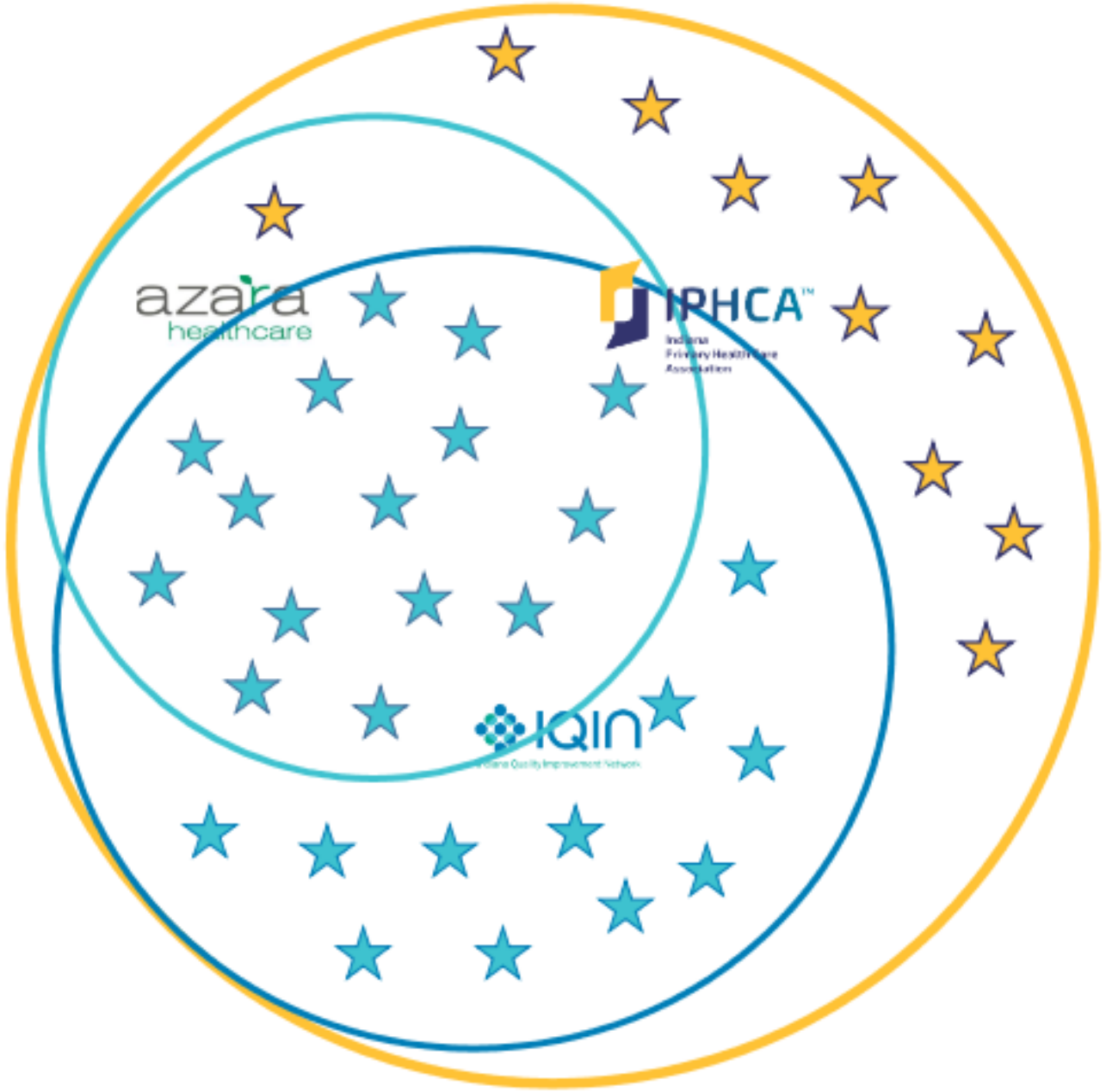

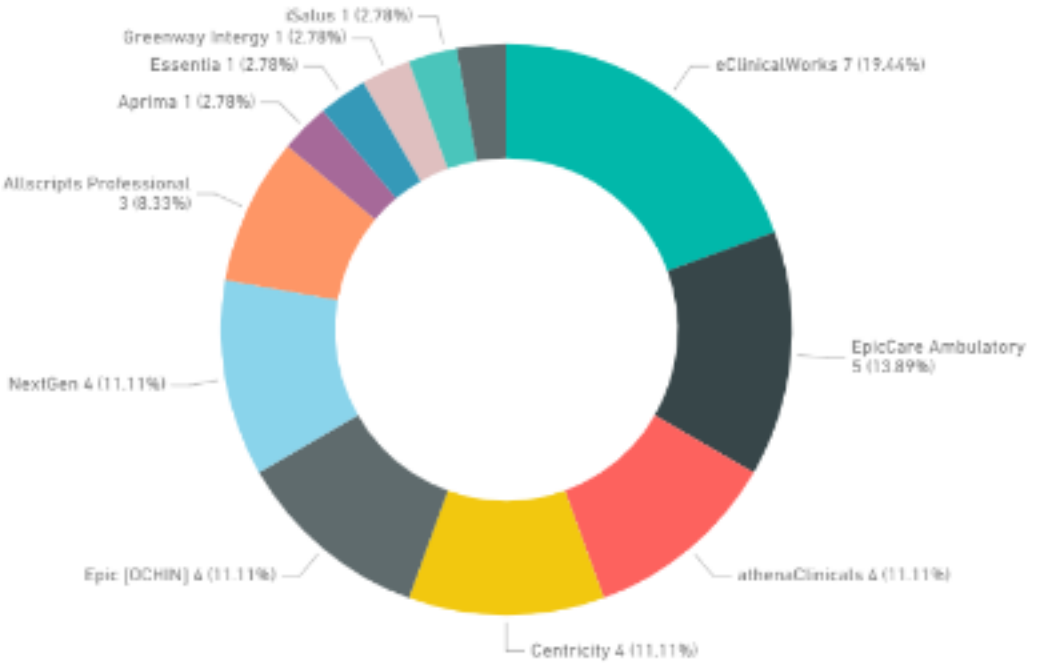

State of the State

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Our North Star…

Source: Health Information Technology, Evaluation and Quality (HITEQ) Center

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IQIN's Health IT Roadmap

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Our Journey…

2018: Focus on Population Health and High Risk/ High-Cost Patients

Source: Azara Healthcare

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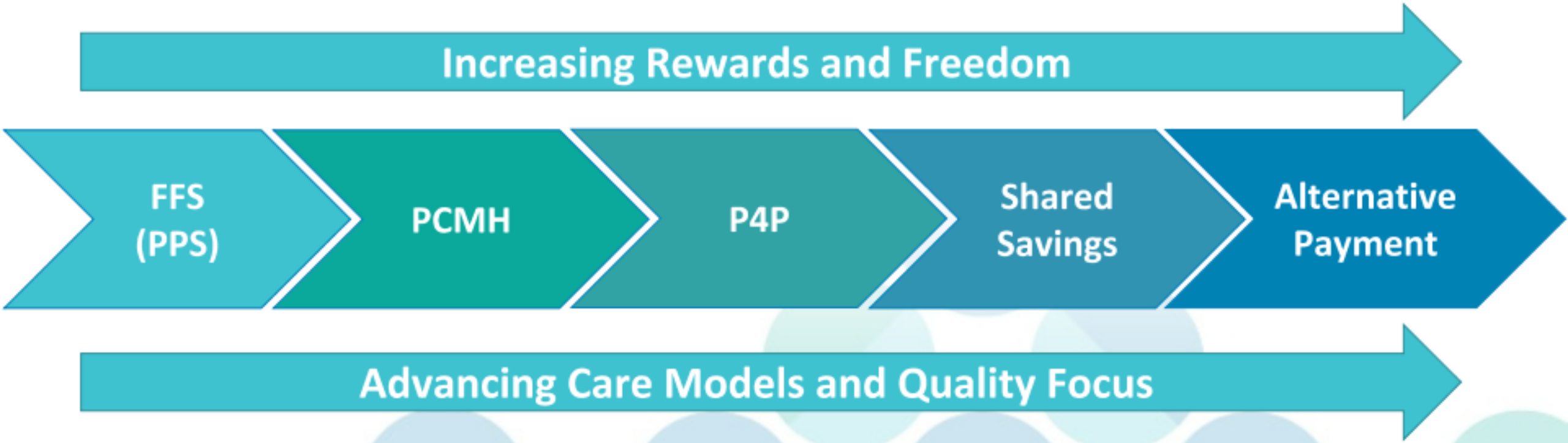
Our Journey…

2019: Transformation Along the Value-Based Continuum



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Value-Based Care Continuum

Historical	PCMH/ Population Health	P4P	Shared Savings	Alternative Payment
My Patients	Care Coordination	Assigned Patients	ED and Hospital Utilization	Capitated Patients
Visit	Panel Management	HEDIS	Transitions of Care	PMPM: Patient Complexity for Risk Adjustment
UDS	Risk Stratification	Well Visits	Chronic Care Management	Alternative Care Delivery Models
Social Risk		Closing Care Gaps	Total Cost of Care	

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Azara's Solutions

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IPHCA/IQIN Strategies

Programming

- Focus on Quality: Transformation Series
- Azara DRVS User Group
- Elevate: Value Transformation Framework
- Transformation Change Packages
- PRAPARE: protocol for assesses and responding to patient social risks
- IQIN Transformation Summit

Quality Conceptual Framework

- QI Toolkit
- Focus on Systems

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Change Packages toward Value-based Care

Focus Area	Change Processes	Azara DRVS Tools	Tools for All
Closing Care Gaps at Point of Care	1. Clinical Decision Support – ID Alerts 2. ID PVP standing actions for care team 3. ID huddle workflows 4. Test and Track Closures	• Azara Alert Administration • PVP Report • Point of care alert closure measure report	• EHR CDS Alerts • NACHC Care Teams Action Guide • AMA STEPSforward Pre-Visit Planning • AMA STEPSforward Team-Based Care
Finding Care Gaps and In-reach for Existing Patients	1. Identify target care gaps 2. Identify gap registry/reports 3. Identify outreach workflows 4. Test and track appointments and closure	• Azara Care Gap Report • Adult and Child Registries • Disease and prevention registries • Dashboards	• EHR gap registries • EHR quality measure reports
Finding Care Gaps and Outreach for Payer-Assigned Panel	1. Pull down payer care gaps 2. Identify outreach scheduling workflows 3. Test and tract appointment and closure 4. Improve Billing/coding for HEDIS	• Azara Payer Integration Care Gap Reconciliation Report*	• Payer portals • MHS HEDIS Billing Guides
Patient Engagement	1. Identify target patient populations 2. Implement Motivational Interviewing 3. Implement patient specific education 4. Identify care plan follow-up workflows	• Azara Care Gap Report • Disease registries (or measure analyzer) for out of range or untested	• NACHC Patient Engagement Action Guide • EHR dashboards • Elevate
Digital Patient Engagement	1. ID populations for digital engagement 2. ID patient barriers to digital engagement 3. Identify digital engagement workflows 4. Test and track appointments and outcomes	• Azara Care Gap Report • Disease registries • Risk registries	• HITEQ Electronic Patient Engagement
Care Coordination and Referral Management	1. ID Care Coordination staff referral process 3. Identify overdue referrals 4. Identify referral closure workflow 5. Test and Track referral closure	• Azara Referral Module: Referral measures and referral registry*	• EHR dashboards • Elevate • IHIE CareWeb
Assess Social Determinants of Health	1. Identify questions and target populations 2. Identify workflows 3. Collect SDOH in EHR or Spreadsheet 4. Share SDOH with care team	• Azara SDOH mapping in DRVS* • SDOH Dashboard* • SDOH filters*	• NACHC (PRAPARE) • SDOH templates in EHR • AMA STEPSforward: SDOH
Care Coordination & Navigation with Community-Based Organization	1. Report and ID common social needs 2. Identify community resources and gaps 3. Partner with community agencies 4. ID community referral staff and workflows		• Aunt Bertha • Indiana 2-1-1

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Change Packages toward Value-based Care

Focus Area	Change Processes	Azara DRVS Tools	Tools for All
Risk Stratification	1. Identify risk stratification method 2. ID priority risk populations 3. ID workflow for care management referral	• Azara Risk Registry and filters • Care management passport • Azara care management*	• AAFP Risk Stratification Rubric • NACHC PHM Risk Stratification Action Guide
Care Management for High Risk Patients	1. Identify care management model 2. ID care management staff & workflows 3. Implement Medicare CCM billing 4. Test and Track outcomes	• Azara care management* • Care management passport	• NACHC PHM Models of Care Action Guide • NACHC Care Management Action Guide • IQIN PHM for High Risk/Cost Patients
Utilization Tracking	1. Identify ADT data source(s) 2. ID ADT process staff and workflows 3. Define and ID high utilizers 4. ID workflows for high utilizers	• Azara Transitions of Care with IHIE ADTs*: TOC report, dashboard, measures • PVP report with TOC* • Payer Integration Azara*	• Payer Portal • IHIE CareWeb • IHIE ADTs
High ED Utilizers	1. Identify staff for follow-up 2. Identify patient engagement messages 3. Identify patient engagement workflow 4. Test and Track ED utilization	• Azara Care Management Passport • Care Management* • ED TOC Measure*	• IHIE ADTs
Inpatient to Outpatient Transitions of Care (Medicare Transitional Care Management)	1. Identify transitions of care model 2. ID transitions staff & workflows 3. Implement Medicare TCM billing 4. Test and Track outcomes	• Azara Chronic Care Management Registry • Care Management* • Transitions of Care IP Measure*	• IHIE ADTs • CMS Medicare Transitional Care Management Services
Total Cost of Care	1. Identify cost of care data source 2. ID cost of care reporting 3. ID high-cost patients for care management 4. Identify payer engagement strategy	• Azara Payer Integration: Members and PMPM*	• Payer portals
Patient Complexity	1. Improve ICD-10 complexity coding 2. Add SDOH Z-codes to ICD-10 codes 3. Add codes for enabling services 4. Track social community-based referrals		• SDOH ICD-10 Z-Codes • PRAPARE ICD-10 Z-codes • Enabling Services Data Collection • HCPLAN APM Framework

*Azara add-on module or mapping (not standard as part of Azara DRVS Core)

Care Models to Support Value

- Patient Center Medical Home
  - Knowing your patients
  - Optimized Care Teams: PVP/Huddles
  - All the rest…
- Transitions of Care
  - Understanding ED/IP Utilization
  - Preventing Rehospitalization
  - Leveraging Medicare TCM Payment
- Chronic Care Management
  - Identifying high risk populations
  - Leveraging Medicare CCM Payment
  - Engaging, motivating and managing
- CHC Virtual Care@ Home
  - COVID-19 Emergency Response
  - Remote monitoring & daily check-ins
  - Leveraging telehealth &

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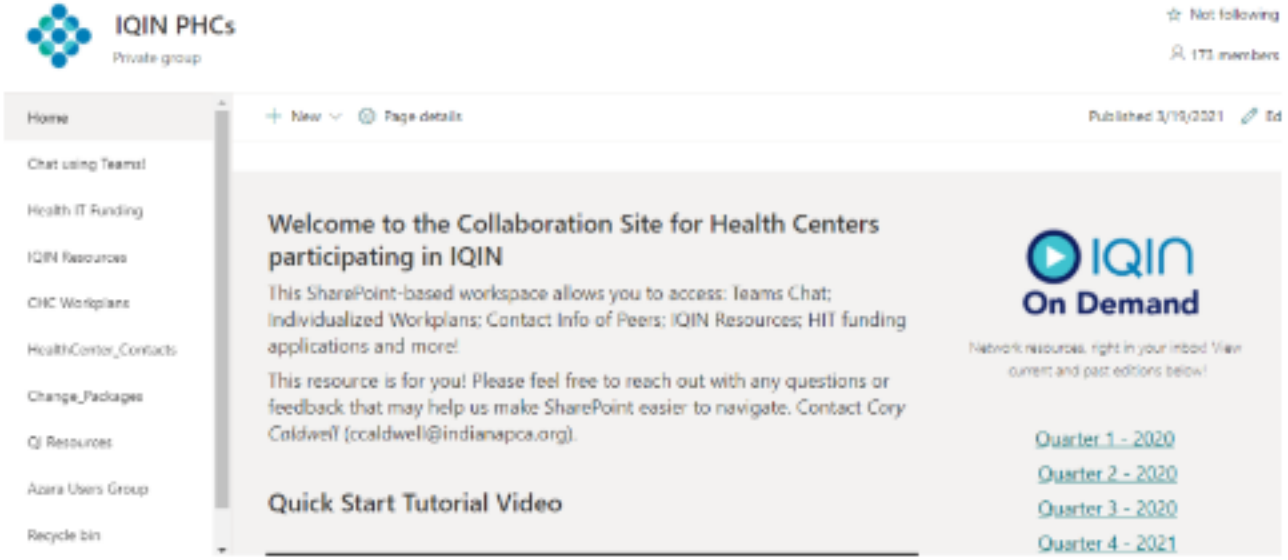
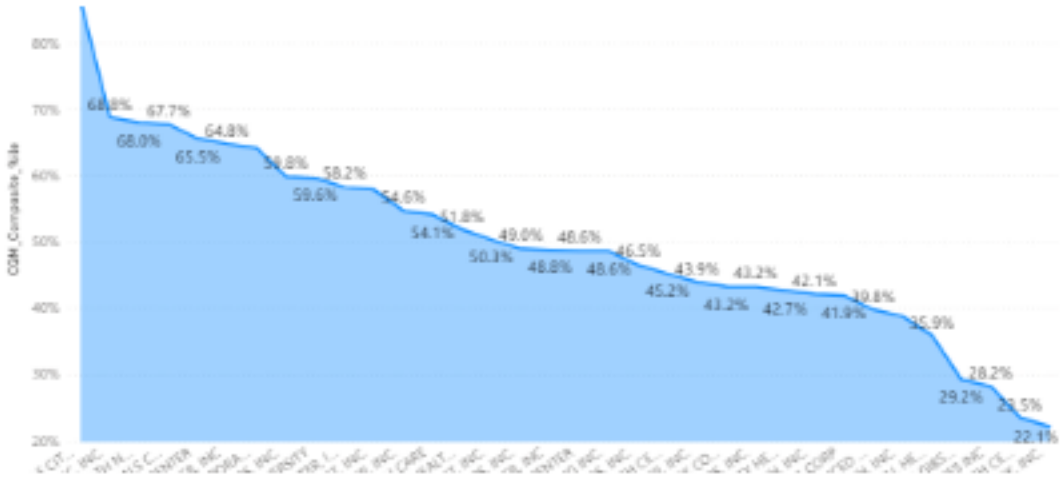
IQIN PHCs SharePoint Site

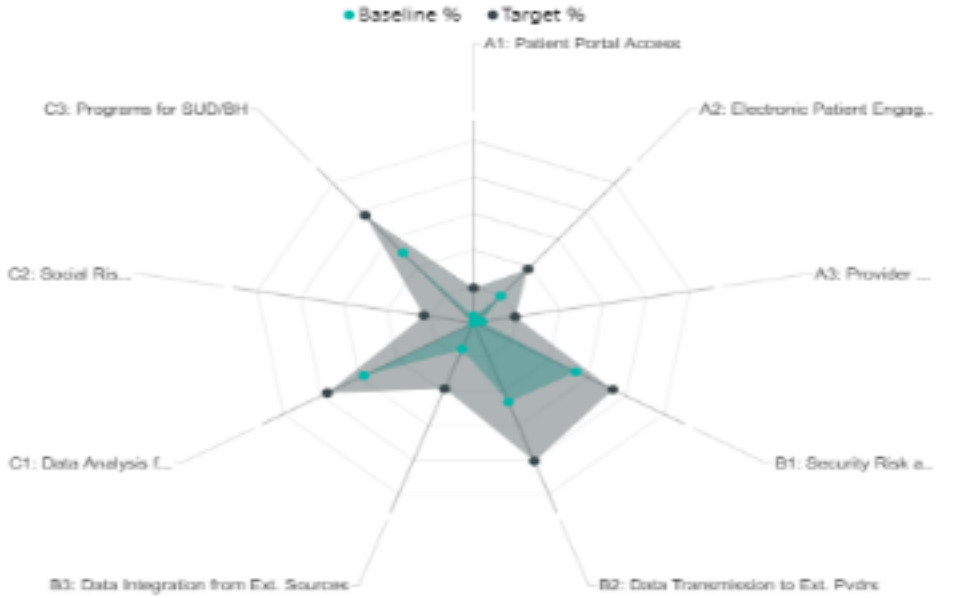


IQIN CQM Composite Percentile Dashboard

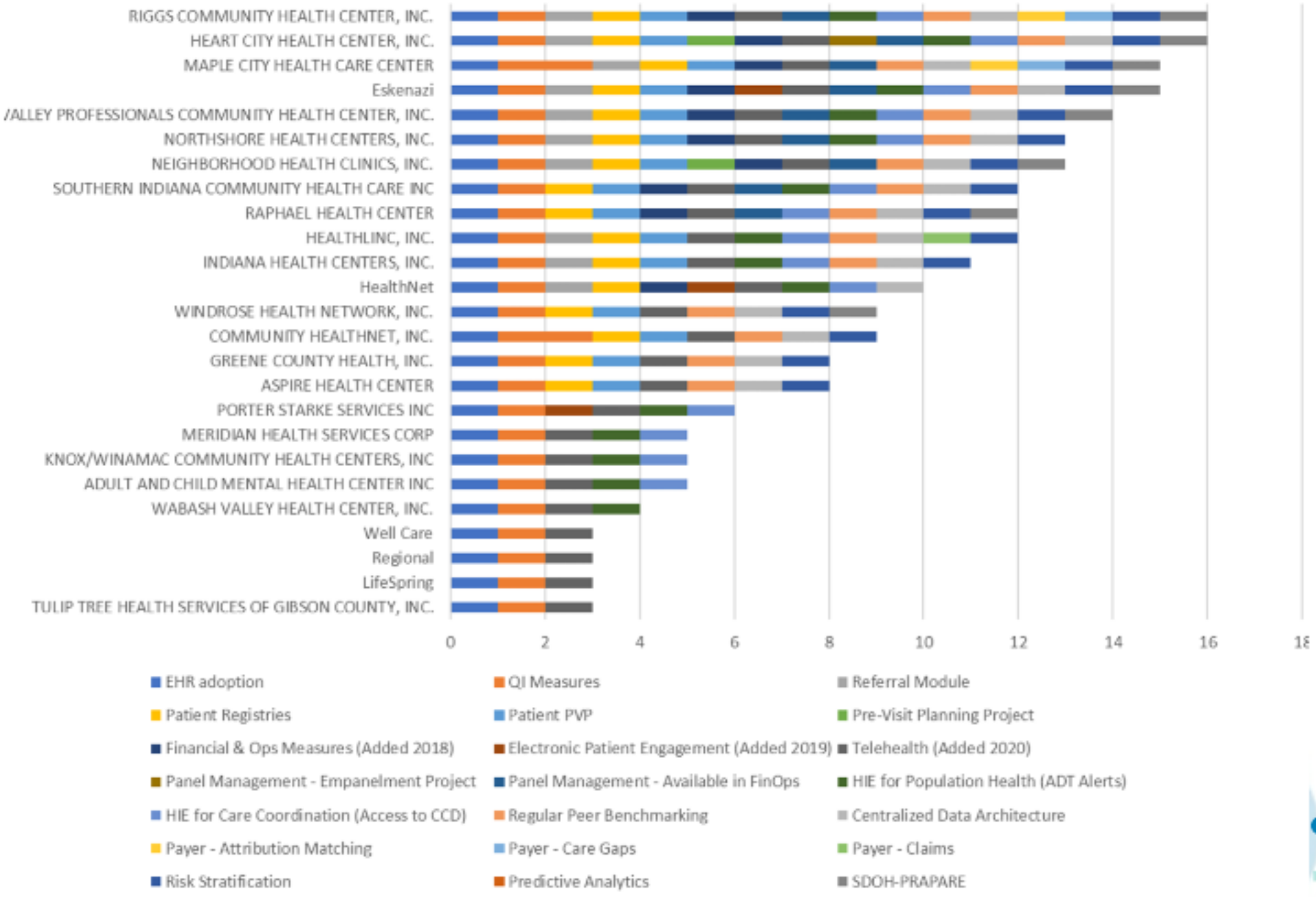


Dashboard for Health Centers in Indiana

IQIN Health Center Performance Tracking Dashboard



IQIN Health IT Roadmap Progress



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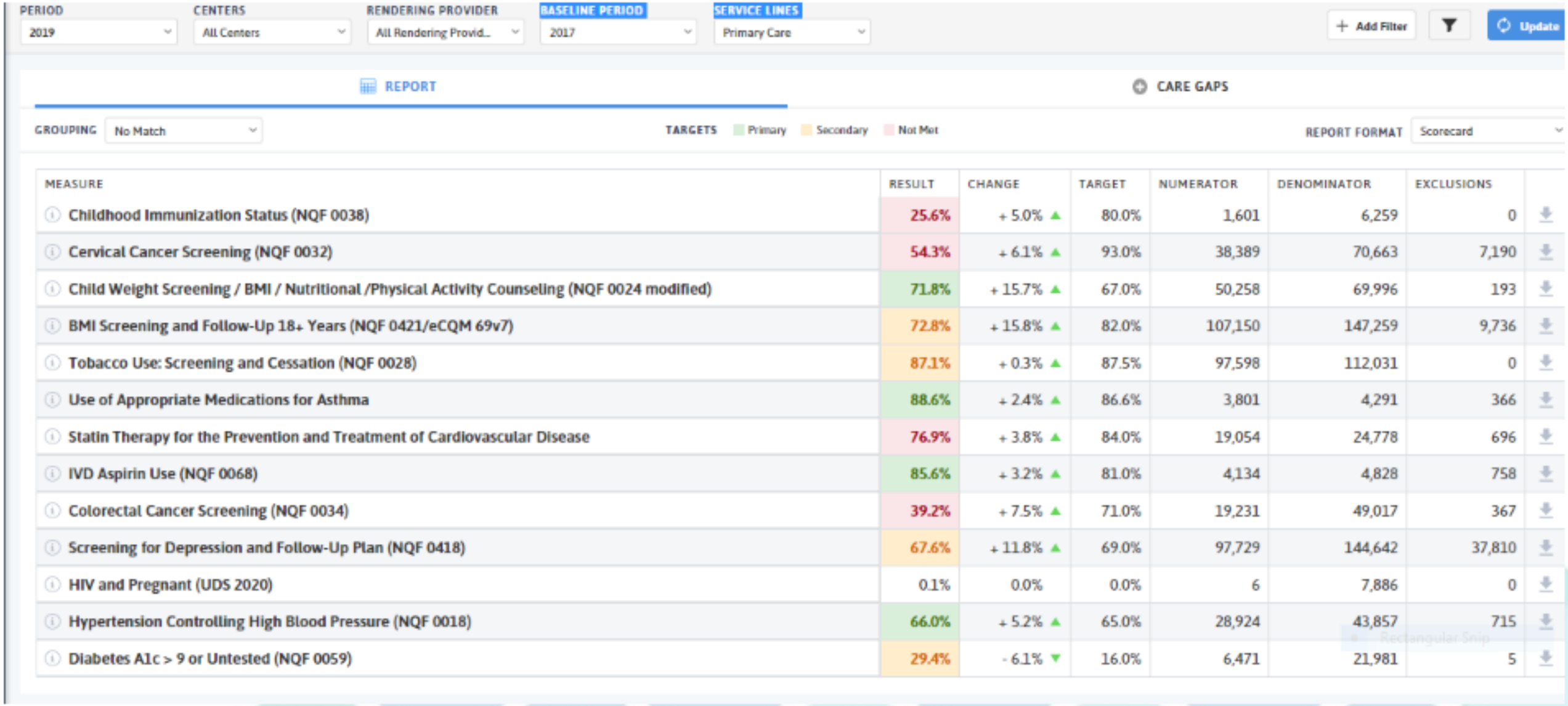
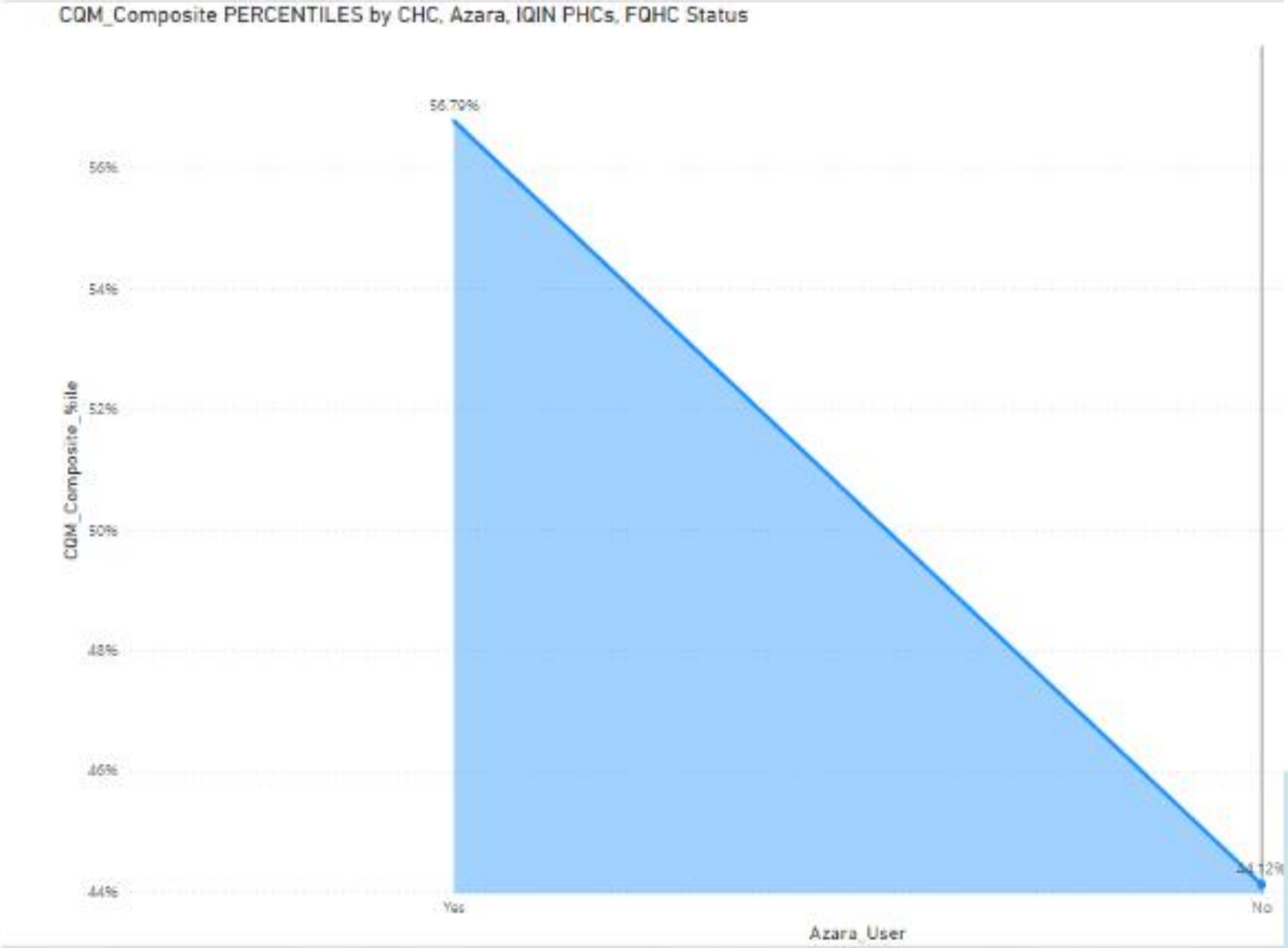
All Health Centers on Azara



MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (NQF 0038)	25.6%	+ 5.0% ▲	80.0%	1,601	6,259	0
Cervical Cancer Screening (NQF 0032)	54.3%	+ 6.1% ▲	93.0%	38,389	70,663	7,190
Child Weight Screening / BMI / Nutritional /Physical Activity Counseling (NQF 0024 modified)	71.8%	+ 15.7% ▲	67.0%	50,258	69,996	193
BMI Screening and Follow-Up 18+ Years (NQF 0421/eCQM 69v7)	72.8%	+ 15.8% ▲	82.0%	107,150	147,259	9,736
Tobacco Use: Screening and Cessation (NQF 0028)	87.1%	+ 0.3% ▲	87.5%	97,598	112,031	0
Use of Appropriate Medications for Asthma	88.6%	+ 2.4% ▲	86.6%	3,801	4,291	366
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	76.9%	+ 3.8% ▲	84.0%	19,054	24,778	696
IVD Aspirin Use (NQF 0068)	85.6%	+ 3.2% ▲	81.0%	4,134	4,828	758
Colorectal Cancer Screening (NQF 0034)	39.2%	+ 7.5% ▲	71.0%	19,231	49,017	367
Screening for Depression and Follow-Up Plan (NQF 0418)	67.6%	+ 11.8% ▲	69.0%	97,729	144,642	37,810
HIV and Pregnant (UDS 2020)	0.1%	0.0%	0.0%	6	7,886	0
Hypertension Controlling High Blood Pressure (NQF 0018)	66.0%	+ 5.2% ▲	65.0%	28,924	43,857	715
Diabetes A1c > 9 or Untested (NQF 0059)	29.4%	- 6.1% ▼	16.0%	6,471	21,981	5

Azara Users out-perform others



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Project UTILIZE : Utilization Tracking: Information Linking with IHIE through AZara Exchange

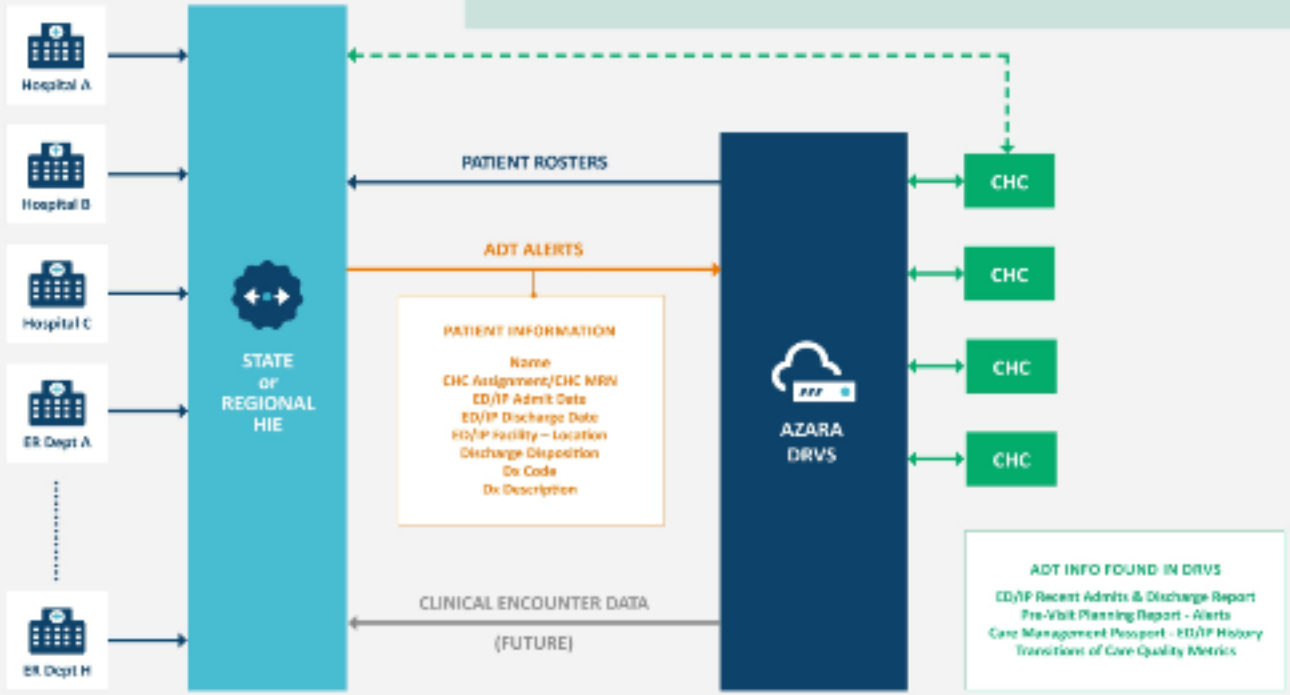
PRE-IMPLEMENTATION
- Contracting
- Connectivity Assurance
- Identify project lead

PHASE I
TECHNICAL IMPLEMENTATIONS
- IHIE VPN Connection
- IHIE data into DRVS

PHASE II
KICK-OFF
- Understanding TOC Project
- Review Existing Data & Validate

PHASE III
WORKFLOWS AND MAPPING
- Follow-up Workflows
- Map DRVS measures

PHASE IV
TRAINING
- IHIE's CareWeb
- Azara Reports & Measures
- TCM training



- Utilize Azara DRVS population health technology to support community health centers':
- Quality improvement efforts;
- Access to health information exchange;
- Ability to effectively coordinate care;
- Ability to manage transitions of care between care settings; and
- Advancement along the Health IT Roadmap toward value-based care and payment models
- State secured CMS matching funds to cover 54% of the project

CHC Virtual Care @Home

CHC Virtual Care @ Home allows patients to stay in their home to recover from an illness or manage an acute illness that does not require the full level of care available at a hospital, but more regular check-in with providers than usual, without the need to travel to a provider. Patients receiving care through ***CHC Virtual Care @ Home*** can have nursing check-ins, periodic monitoring of vitals, and virtual visits by a physician or other clinician so that they can stay at home.

Why ***CHC Virtual Care @ Home***?

- Social Distancing: During times of public health emergency, like the current COVID-19 pandemic, patients who are at risk for serious health complications if they are infected need to limit their exposure to other individuals who may not be infected.
- Hospital Surge Capacity: Hospitals may need to divert their precious resources to caring for the most critical patients when the disease surges. Some hospitals may need to discharge patients to home who are medically able to receive ***CHC Virtual Care @ Home*** services, allowing space to provide critical care to new patients.
- High Value Care Delivery: This model is aligned with high value care delivery and population health strategies that health centers are already embarking on for Chronic Care Management and Transitional Care Management. This is all aligned with PCMH efforts.

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So what?

- Health centers have resources to advance along a value-based care model and payment model continuum
- We can show network outcomes
- We can share successes with key stakeholders
- We can negotiate discounts for technology and data services
- We have generated interest from state partners and CMS
- We have generated direct financial commitment from payers
- We have opened the doors to value-based payment for health centers

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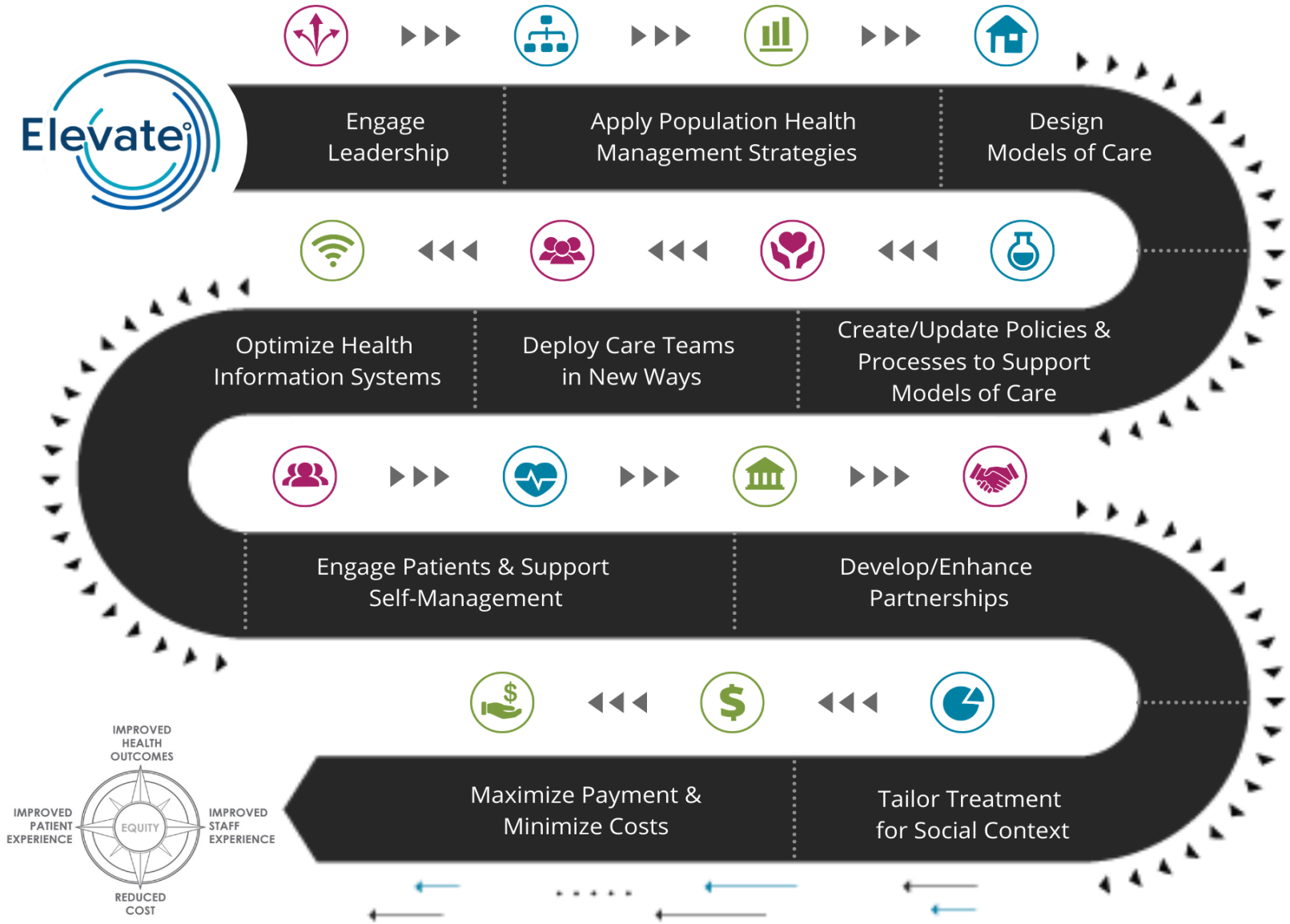

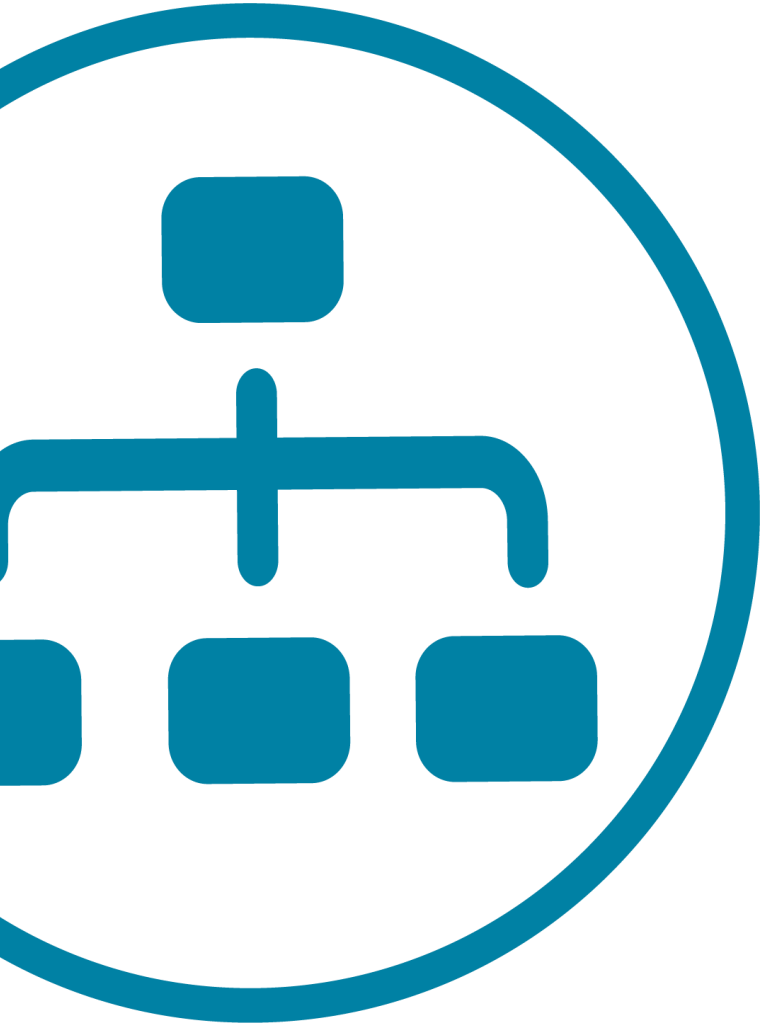

MODELS OF CARE

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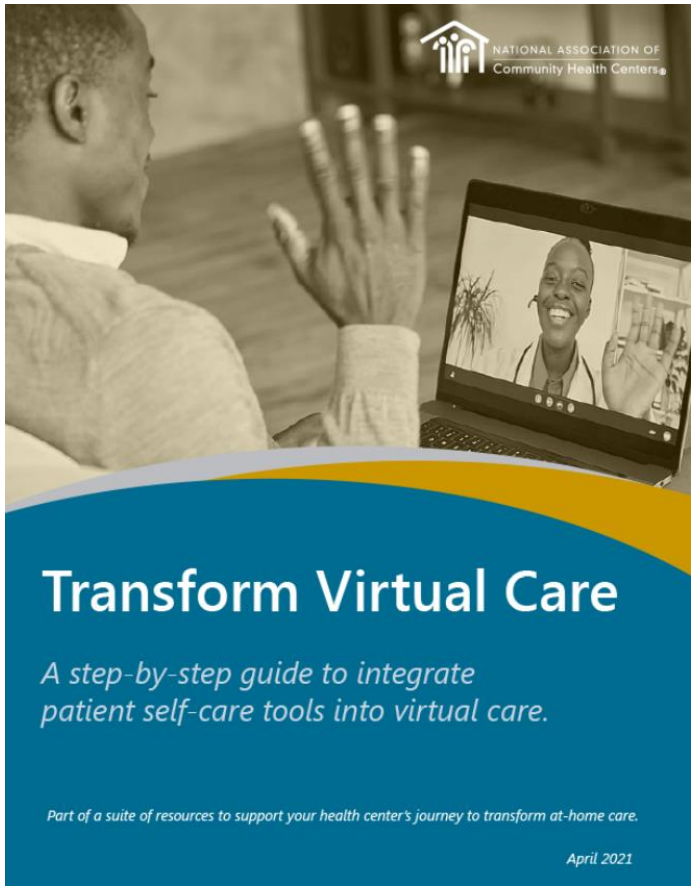
https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf

Dive Deeper

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | Evidence-Based Care | Care Coordination & Management | Social Determinants of Health | Patients | Care Teams | Leadership | Workforce | Partnerships



April 20th

Join us for a special series that walks through this new resource. Learn about an existing health center pilot program and how your health center can transform its virtual care.

Scan QR code to register

CARE TEAMS

A reinvention of the care team model – with more responsibility given to supportive members of the care team – has proven to optimize the experience and outcomes of primary care for patients, providers and staff.

http://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Teams-AG_November-2019.pdf

CARE TEAM ACTION STEPS:

The below action steps assume a health center is practicing empanelment and team huddles with mechanisms to ensure psychological safety (see Leadership Action Guide).

STEP 1 **Define Care Standards:** Identify a minimum set of patient services (standards), by age and/or risk group.

STEP 2 **Distribute Tasks to Meet Standards and Document Workflow:** Reconsider who within the care team completes tasks for each standard. 'Share the care': assign an appropriate staff position to each task defined. Map workflow.

STEP 3 **Update Job Descriptions:** Summarize tasks for each role within the health center. Include this information in updated job descriptions (formalization).

STEP 4 **Train Staff:** Train staff in job-specific tasks based on their redefined roles within care teams, including quality improvement.

STEP 5 **Montior Task Performance in Dashboards:** Provide dashboard access to each staff member and encourage regular performance reviews (accountability).

STEP 6 **Hardwire Accountability into Personnel Systems and Performance Reviews:** Create role-specific dashboards that monitor performance on job tasks. Create team dashboards that monitor team performance on key clinical, quality, and cost metrics. Document individual and team accountability via dashboards and performance reviews.

STEP 7 **Educate Patients on Redesigned Care Team:** Create patient education tool(s) that orient patients to new roles of care team members, including their own role with self-care.

Dive Deeper

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | Evidence-Based Care | Care Coordination & Management | Social Determinants of Health | Patients | Care Teams | **Leadership** | **Workforce** | Partnerships

A business continuity plan is a critical tool that helps manage the business operations of an organization during such an event and supports faster and more complete recovery following a disruption. This 3-part series will guide organization through the development of a Business Continuity Plan.

Dive Deeper

Improvement Strategy | **Health Information Technology** | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | **Evidence-Based Care** | Care Coordination & Management | Social Determinants of Health | Patients | Care Teams | Leadership | Workforce | Partnerships

Invited Panelists:

Centers for Disease Control and Prevention (CDC), NACHC, Health Federation of Philadelphia, American Medical Association (AMA), Hillrom-WelchAllyn, Omron, & A&D

ACTION STEPS

CHANGE AREAS

MODELS OF CARE

- Design care models that based on subgroups identified through risk stratification. Create **unique models of care for each targeted subgroup** of your patient population.

HIT

- Outline steps to use population health management tools and other HIT resources to **push care team action and pull required data.**

CARE TEAMS

- **Define care standards and services** within each targeted care model. **Reorganize care team roles** within each care model, giving more responsibility to supportive members of the care team.

UPCOMING EVENTS

April 2021

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

May 2021

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

- **01. RegLantern Trial Starts**
- **13. April Elevate Core Webinar**
- **15. IHI Open School Scholarship Deadline**
- **20. Models of Care: Virtual Care & Patient Self-Care Tools** *(Deeper Dive)*
- **28. Business Continuity, Part 1 of 3** *(Deeper Dive)*

- **01. IHI Open School Scholarships Starts**
- **11. May Elevate Core Webinar**
- **12. Business Continuity, *Part 2 of 3*** *(Deeper Dive)*
- **19. Care Management, Part 1 of 2** *(Deeper Dive)*
- **26. Business Continuity, *Part 3 of 3*** *(Deeper Dive)*

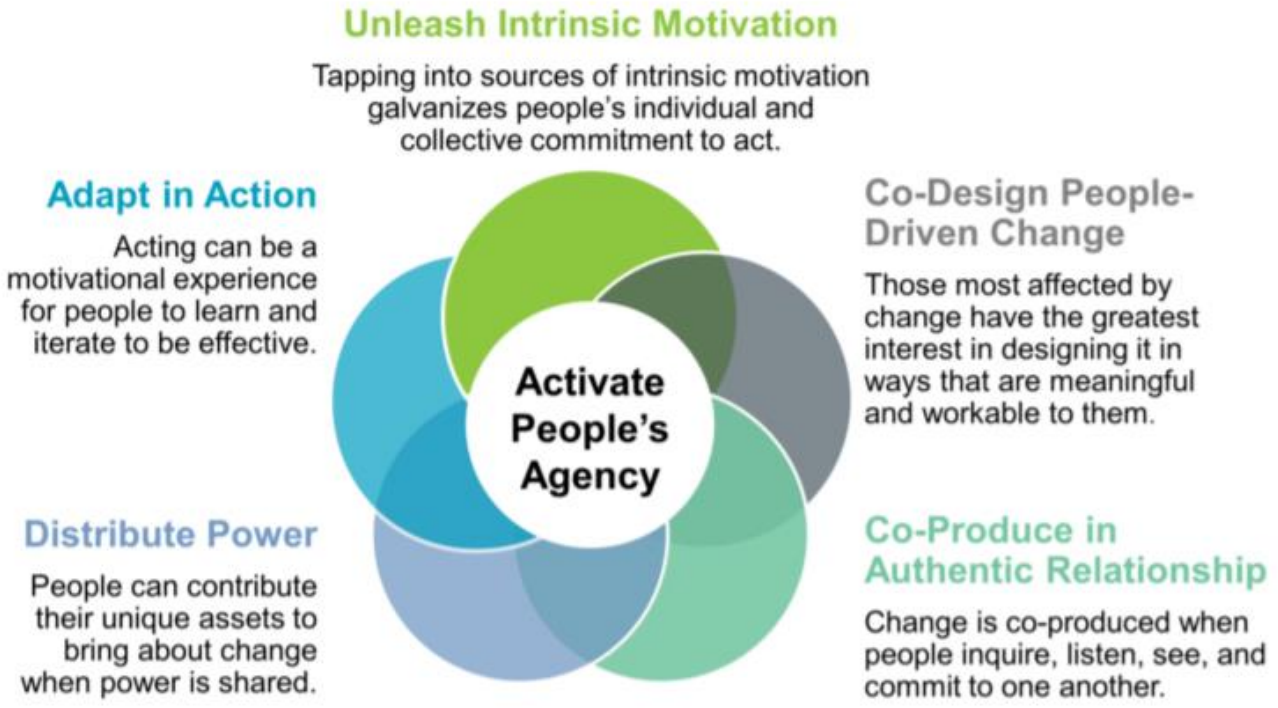
Institute for Healthcare Improvement – *Psychology of Change*

If you have a high degree of belief in a quality improvement solution and struggle to get results, join the Institute for Healthcare Improvement's (IHI's) **Activating Agency with the Psychology of Change** online course to get the adaptive leadership skills and tools you need to address the human side of change.

Next Steps

- Quality Center will reach out to eligible health centers by 4/19
- Limited quantities
- Offered first to health centers with greatest # VTF Assessments across the organization

Figure 1. IHI Psychology of Change Framework



http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx

CHC's with 3+ Assessments (96)

As of April 12th, 2021

- Coastal Family Health Center, Inc.
- Community Hlth Ctrs of the Central Coast
- Healthlinc, Inc.
- Neighborhood Health Center
- Shawnee Health Services
- Will County Community Health Center
- CareSouth Carolina Inc
- Chiricahua Community Health Centers, Inc.
- East GA Healthcare Center, Inc.
- Elica Health Centers
- Greater Baden Medical Services, Inc.
- Honor Health
- Lone Star Circle of Care
- Marias Healthcare Services, Inc.
- Migrants Health Center Inc.
- North Country Family Health Center
- OIC Family Medical Center
- Outer Cape Health Services
- Primary Health Center
- Southeast Community Health Systems
- Southwest Care
- United Community and Family Services
- Valleywise Health
- 1st Choice Healthcare, Inc.
- Aaron E. Henry Community Health Services Center
- Access Family Care
- Ajo Community Health Center
- Bighorn Valley Health Centers
- Brighter Beginnings CHC
- Brockton Neighborhood Health Center
- Chase Brexton Health Care
- Cherry Health
- Community First Health Centers
- Community Health & Wellness Center
- Community Health Center of the North Country
- Community Health Centers Of Pinellas, Inc.
- Community Health of South Florida, Inc.
- Community Medical Centers, Inc.,
- Compass Health Network
- CT Institute for Communities, Inc.
- Denver Health's Community Health Services
- East Jordan Family Health Center
- Family Centers Health Care
- Family Health Center of Worcester, Inc.
- Family Health Centers
- Family Health Services of Darke County
- Family HealthCare Network
- Fenway Community Health Center
- Firstmed Health and Wellness Center
- Generations Family Health Center, Inc.
- Genesee Community Health Center
- GPW Health Center
- Grace Community 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
- Katahdin Valley Health Center
- Kinston Community Health Center
- Kintegra
- Langley Medical Services
- Lee County Cooperative Clinic
- Lower Lights Christian Health Center
- Mariposa Community Health Center
- Mercy Health Services, Inc.
- Muskingum Valley Health Centers
- North Orange County Regional Health Foundation
- Northeast Valley Health Corporation
- OH North East Health Systems, Inc.
- OneWorld Community Health Centers, Inc.
- Open Door Family Medical Center, Inc.
- Optimus Health Care
- Outside In
- Raphael Health Center, Inc.
- Robeson Health Care Corporation
- Rural Health Group
- Rural Health Medical Program, Inc.
- Ryan, William F Community Health Center Inc
- Shingletown Medical Center
- Sonoma Valley Community Health Center
- Southland Integrated Services, Inc.
- St. Francis House NWA Inc. dba Community Clinic
- St. Vincent de Paul Village, Inc.
- Sunset Community Health Center
- Tandem Health
- The Wellness Plan
- Tri-Area Community Health
- TX Tech University Health Sciences Center
- Valley Professionals Community Health Center Inc.
- Vista Community Clinic
- Western North Carolina Community Health Services
- Whitman Walker Health Center
- Zufall Health Center

CHC's with 2 Assessments (29)

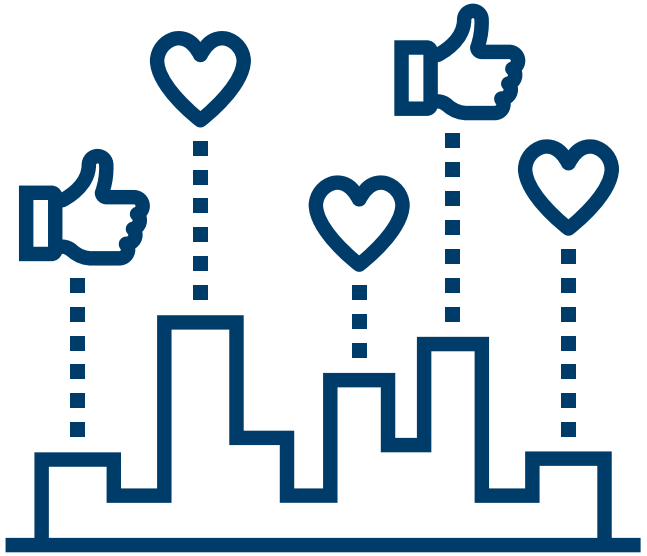
As of April 12th, 2021

- Accordia Health
- Advance Community Health/Wake Health Services Inc
- Alliance Community Healthcare
- Appalachian Mountain Community Health Centers
- Charter Oak Health Center
- Christian Community Health Center
- Community Health Care, Inc.
- Compass Community Health
- Concilio de Salud de Loiza
- Cross Road Health Ministries, Inc.
- El Centro De Corazon
- El Dorado County Community Health Center
- Erie Family Health Center, Inc.
- Family Health Ctr of Southern Oklahoma
- Hidalgo Medical Services
- Houston Area Community Services, Inc.
- InterCare Community Health Center
- Lake Superior Community Health Center
- Manatee County Rural Health Services, Inc.
- North Central Family Medical Center
- Northeast Florida Health Services Dba: Family Heal
- Southbridge Medical Advisory Council Inc
- Southwest Community Health Center, Inc.
- Staywell Health Center
- Suncoast Community Health Center
- The Achievable Foundation
- The Chautauqua Center, Inc.
- Trenton Medical Center, Inc. Dba: Palms Medical G
- Valley Family Health Care, Inc.

CHC's with 1 Assessment (83)

As of April 12th, 2021

- Alliance Medical Center
- Ammonoosuc Community Health Services, Inc.
- 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.
- Bethel Family Clinic
- Cabun Rural Health Services, Inc.
- Capital Area Health Network
- Capitol City Family Health Center Dba: Care South
- Capstone Rural Health Center
- Care Resource
- Caring Hands Healthcare Centers, Inc.
- Central Counties Health Centers, Inc.
- Central Florida Health Care, Inc.
- Central VA Health Services, Inc.
- Centro de Salud de Lares
- Chambers Community Health Center
- Cherokee Health Systems
- Chicago Family Health Center
- Community Clinic, Inc. (CCI)
- Community Health Center of Southeastern IA
- Community Health Centers of Greater Dayton
- Community Health Systems, Inc.
- CommWell Health
- Daily Planet Healthcare for the Homeless
- Duffy Health Center
- East Bay Community Action Program
- El Rio Santa Cruz Neighborhood Health Center, Inc.
- Flint Hills Community Health Center, Inc.
- Fordland Clinic, Inc
- Friend Family Health Center, Inc.
- Gardner Family Health Network, Inc.
- Greater Portland Health
- Health Ministries Clinic, Inc.
- Howard Brown Health Center
- International Community Health Services
- Johnson Health Center
- 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
- Lorain County Health & Dentistry
- Mary's Center For Maternal And Child Care, Inc.
- Mat-Su Community Health Services
- Medical Associates Plus
- MedNorth Health Center
- Mid-Delta Health Systems, Inc.
- Molokai Community Health Center
- Native American Health Center, Inc
- Neighborhood Family Practice
- NEPA Community Health Care
- New Orleans AIDS Taskforce
- North GA Healthcare 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
- Sadler Health Center Corporation
- San Fernando Community Hospital
- School Health Clinics of Santa Clara County
- Share Our Selves
- Shasta Community Health Center
- South of Market Health Center
- TCA Health Inc, NFP
- The Health and Hospital Corporation
- The Wright Center for Community Health
- Union Community Health Center, Inc
- VIP Community Services
- West Cecil Health Center, Inc
- Whitney Young Health Center
- Wood County Community Health Center
- Whitney Young Health Center



Provide Us Feedback

Calling All Partners

Share your evidence-based interventions, projects, tools, or resources on an Elevate learning forum! Contact us @

bit.ly/Elevate2021Partnership

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

May 11th, 2021
1 -2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®